For the reasons mentioned in the preceding text, coronary angiography can identify a higher rate of defective grafts compared with TTFM (3). The rate of graft revision based on TTFM is between 1% to 8% (2). These rates are well below the average 20% to 30% 1-year saphenous vein graft (SVG) failure rate reported in the literature (2,4). The PREVENT IV (PProject of Ex-vivo Vein graft ENGineering via Transfection IV) trial, a multicenter randomized study of 3,041 patients, has confirmed the clinical impact of vein graft failure. In this study, the common end point of death and new myocardial infarction was 0.9% in patients with patent SVG, while for patients with at least 1 occluded SVG this adverse outcome was 14% (p < 0.001) (4).

In order to improve the long-term outcomes of CABG surgery, graft patency is a key factor. Grafts fail early primarily because of technical errors that could be corrected at the time of the surgery. While the TTFM and other techniques such as intraoperative fluorescence imaging are steps toward improving graft patency, they can identify only a limited number of graft defects, mostly occlusive abnormalities, and cannot reliably identify significant (>50%) nonocclusive graft flow abnormalities. These significant graft abnormalities have important clinical impact on the long-term benefits provided by CABG surgery. For the reasons mentioned in the preceding text, routine angiography after CABG has low periprocedural morbidity. It seems that it should perhaps eventually be routine if available in a hybrid suite.

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The SoS Acronym

The term “acronym” has been used since World War II. It refers to an abbreviation created from the first letters of each word in a series of words. Typical examples are NATO (North Atlantic Treaty Organization) and SOS (Save our Souls).

Acronyms are frequently being used to refer to clinical trials, often with some difficulty. Occasionally even the PI (Primary Investigator) cannot remember the background of such abbreviations.

In 1995 we embarked in a clinical trial comparing 2 treatment options for myocardial revascularization, the use of stents versus surgery. We simply called the trial SoS (Stent or Surgery) (1). The results of this trial have been published in leading journals, and the study is still ongoing.

In the March 27, 2009, issue of the Journal (2), another SOS trial was published. The authors decided to use the same, previously employed acronym to describe a comparison of different stents for the treatment of saphenous vein grafts. The acronym SOS stands in this context for “a randomized controlled trial of a paclitaxel-eluting stent versus a similar bare-metal stent in saphenous vein graft lesions: the SOS (Stenting of Saphenous vein grafts) trial;” the association, apart from the infringement with previous and future SOS publications, seems far-fetched.

Even in the absence of legal guidelines, the reutilization of established acronyms (in particular, if they are still in use) should be discouraged. Authors and editors ought to adopt some common sense to avoid confusion.

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bariatric surgery on cardiovascular risk factors and quality of life (1).

In 1995, the Stent or Surgery trial was initiated, and subsequently compared coronary artery bypass surgery with stent-assisted percutaneous coronary intervention in patients with multivessel coronary artery disease. The study’s main report was published in 2002 (2), and according to the clinical trials website, the study has been completed since 2007.

In 2005, the Stenting Of Saphenous vein grafts trial was initiated to compare a paclitaxel-eluting with a similar bare-metal stent in patients undergoing saphenous vein graft stenting. The study’s primary results were published in 2009 (3).

Although it was never our intention to infringe on the Stent or Surgery trial’s acronym, we apologize to the Stent or Surgery investigators if they feel that a copyright infringement occurred. We would like to highlight, however, that our study was done in a different era, for a different reason, and in a different patient population.

Would adding additional trial regulations, such as “expiration dates for trial names” or additional oversight of the authors and editors improve the trial result reporting process? Should all the ongoing SOS trials change their names? And should future trials be prohibited from using acronyms from trials previously used? Until these questions are answered, we can only hope that the dissimilar nature of the trials serves to limit any confusion that might result from repeated use of the same acronym.

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In Defense of Antimicrobial Prophylaxis for Prevention of Infective Endocarditis in Patients With Hypertrophic Cardiomyopathy

We read with particular interest Bach’s viewpoint editorial and critique (1) of the recent American Heart Association (AHA) revised recommendations for antimicrobial prevention of infective endocarditis (2). The “new” recommendations, which represent a striking change from the original guidelines followed for more than 50 years (1–5), are based largely on 2 risk versus benefit assumptions: 1) significant mortality or morbidity (e.g., anaphylaxis) associated with prophylactic antibiotic therapy; and 2) a lack of evidence (particularly, randomized trials) supporting the efficacy of antibiotic prophylaxis in the prevention of infective endocarditis.

Our concern regarding this debate is focused on hypertrophic cardiomyopathy (HCM) (6), a disease in which infective endocarditis is a well-documented and usually profound complication (6–9). Indeed, a survey of the PubMed archives identified 32 papers detailing the prevalence and the sometimes serious clinical consequences of endocarditis in HCM patients. While infective endocarditis is uncommon within the overall HCM population (8), when it does occur, its impact on valvular and cardiac function and risk for systemic emboli is usually consequential (7–9). Most reported cases have been associated with left ventricular outflow tract obstruction (vegetations most commonly appear on the thickened anterior mitral leaflet or adjacent surface of proximal ventricular septum), and we wish to underscore that fully 70% of HCM patients have the propensity to develop outflow obstruction at rest or with physiologic exercise (10).

We believe that the reversal of the “old” and familiar AHA guidelines on antimicrobial prophylaxis was an unfortunate mistake for patients with HCM, and indeed substantial confusion and uncertainty surrounding this issue has been created within the community of physicians, dentists, and patients with this disease. Notably, cardiovascular conditions that are relatively uncommon in clinical practice and with low event rates (such as HCM) are not amenable to the level of evidence sought by the AHA panel. However, just because it is not possible to assemble such evidence through randomized trials does not mean that a significant relationship between antibiotic treatment and prevention of infective endocarditis is nonexistent—not does it mean that it is justified to simply negate the issue.

Perhaps this would be another matter if the potential benefit of prophylactic antibiotics were outweighed by the risks of treatment. However, as pointed out by Bach (1), and conceded in the AHA document (2), there has never been a documented anaphylactic death attributable to antibiotics administered prophylactically to prevent endocarditis. This is consistent with the authors’ combined