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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REFERENCES


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—nor 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
60 years of experience with HCM, and countless patients who have taken antibiotics for that purpose.

It is obvious to us that following the most recent AHA recommendations and withholding antibiotics from patients with HCM will unavoidably have the effect of unnecessarily creating several new cases of infective endocarditis each year. We are at a loss to understand how these AHA recommendations (2), which we believe should be revised, are in the best interests of the HCM patient population.

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Reply

We rely on guidelines. When large amounts of data exist, we rely on expert summaries to distill the data and to make evidence-based recommendations. When data are more scarce, we rely on experts to thoughtfully weigh the existing data along with their own experience, balancing risks and benefits, and make recommendations in the best interest of patient welfare.

It might be said too often, or might be said not often enough, that guidelines are... only guidelines. It remains imperative, especially when data are scarce, to understand the nature of guideline recommendations, including the presence or absence of data to support them. Ultimately, the savvy clinician should help his or her patients individually weigh the relative risks and benefits of any diagnostic test, or any therapeutic or prophylactic intervention. This author thanks Drs. Maron and Lever for their discussion regarding my paper (1) and for adding their voices to those of other physicians who, having cared for patients at risk of or suffering from endocarditis, raise concern about the new antibiotic prophylaxis guidelines (2), ask whether they represent the best balance of risk versus benefit, and ask whether these recommendations are the most likely means to adequately protect our patients (3–5).

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REFERENCES


Stent Overexpansion and Myocardial No-Reflow

Early revascularization of the infarct-related artery by primary percutaneous coronary intervention has become the mainstay of therapy, especially in ST-segment elevation myocardial infarction. When performed early in the course of acute myocardial infarction,