P2Y\textsubscript{12} inhibitors or to the setting of long-term therapy is unclear and requires further study.

Although limitations of this analysis, including a single-time point assessment of platelet function, the lack of a uniformly accepted bleeding definition, and its observational design, need to be recognized, we do think that the present analysis supports the hypothesis that the association of P2Y\textsubscript{12} receptor inhibition and ischemic events is characterized by a threshold phenomenon and that a therapeutic window of P2Y\textsubscript{12} receptor inhibition does exist, with patients within this range exhibiting low risk for both bleeding and ST.

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REFERENCES
We thank Dr. Symanski for his interest in our article describing a rare coronary anomaly (1). We are grateful that he brings to our attention the post-mortem results of Pete Maravich’s heart (2). We agree that this anomaly, unbeknownst to us, has been previously described.

It was interesting to read the post-mortem examination that described a dilated heart weighing 650 g and having a left ventricular wall thickness of 15 mm. Equally interesting were the findings of myocardial fibrosis consistent with chronic ischemia. Dr. Symanski questions whether a similar pathophysiology may be contributing to our patient’s chest pain.

At follow-up, our patient’s atypical chest pain had completely resolved. On further review, our patient also had normal left ventricular volumes, mass, and ejection fraction. Cocker et al. (3) recently described the finding of myocardial fibrosis in elite athletes using magnetic resonance imaging. We wonder whether Pete Maravich’s history as an elite athlete in combination with this rare coronary anomaly partially explains his chest pain symptoms reported in their 59-year-old female patient.

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REFERENCES


Vertebral Artery Stenting
Not Quite Ready for Prime Time!

Atherosclerotic vertebral artery (VA) stenosis is a significant cause of vertebrobasilar ischemia. However, vertebral artery stenting (VAS) has not received the detailed scientific study that has been accorded to carotid artery stenting (CAS).

In their series, Jenkins et al. (1) show excellent results. These results add to the growing body of nonrandomized studies that demonstrate the feasibility and relative safety of VAS (2). Based on their outcomes, the authors recommend a more liberal use of VAS. However, several issues remain unresolved that beg for a more cautious approach.

No recent study of sufficient size has investigated the impact of optimal medical regimen on the natural history of VA disease or compared it with VAS (3). Further, there are several unresolved issues regarding optimal endovascular strategy. Bilateral VA stenosis presents a clinical challenge. Unlike anterior circulation ischemia, vertebrobasilar ischemia symptoms are difficult to lateralize to one side. It is not known whether unilateral VAS will resolve the symptoms or whether bilateral VAS is indicated. The authors report that 54.3% patients had bilateral VA disease, although only 6.3% of the subjects received bilateral stents. It is unclear how the stented side was chosen and whether symptoms resolved completely.

Subclavian artery stenosis without coexistent VA stenosis can cause vertebrobasilar ischemia (4). In the current study, 29.2% of the subjects had concurrent subclavian artery disease. It will be useful to know whether the subclavian artery was also stented concomitantly.

The present study did not use distal embolic protection, although this is the standard in CAS. This is an important issue in VAS with only limited data available (5).

Another important issue is restenosis. Unlike CAS, which has a low risk of restenosis, VAS has a significantly higher restenosis rate (6,7). Little information is available regarding the use of drug-eluting stents, although initial reports indicate a lower restenosis rate (8).

Jenkins et al. (1) demonstrate that VAS is relatively safe and feasible. However, before more widespread use, VAS should undergo the same meticulous investigation as CAS has been accorded. This will involve a direct comparison with optimal medical therapy and use of current endovascular standards (distal embolic protection and perhaps drug-eluting stents).

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