

CORRECTION

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ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS 2017 Appropriate Use Criteria for Coronary Revascularization in Patients With Stable Ischemic Heart Disease: A Report of the American College of Cardiology Appropriate Use Criteria Task Force, American Association for Thoracic Surgery, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, and Society of Thoracic Surgeons

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To more clearly reflect the relationship between iFR (instantaneous wave-free ratio) and FFR (fractional flow reserve), the following changes were made to the document after its initial publication.

1. Page 2218, the following sentence has been added to the end of the final paragraph of Section 2. “Methods”: “Other physiologic measurements using the ratio of distal coronary to aortic pressure without hyperemia exist, and correlate with FFR, but are not as well-validated and lack the clinical outcomes data existing for FFR.”
2. Page 2218, Section 3. “Assumptions”, “General Assumptions”. Assumption 1 previously comprised the following sentence: “When available, each clinical scenario includes the patient’s clinical status/symptom complex, ischemic burden as determined by noninvasive functional testing, burden of coronary atherosclerosis as determined by angiography, and additional invasive testing evaluations by invasive physiology (e.g., FFR, instantaneous wave-free ratio) or intravascular imaging.” The parenthetical text in that sentence has been amended to read “(e.g., FFR or other physiological pressure measurements not requiring hyperemia)”.
3. Page 2218, Section 3. “Assumptions”, “General Assumptions”. The following sentence has been added to the end of assumption 6: “FFR is the reference standard for invasively assessing the physiological significance of a coronary artery stenosis before PCI. Newer physiological measurements that do not require hyperemia measure the ratio of distal coronary pressure to aortic pressure during the whole cardiac cycle or the wave-free portion of the cycle. Both indices have similar diagnostic concordance with FFR but have different normal values and have not been as well-studied as FFR. Substitution of one of the newer physiological measurements for FFR may be considered provided the appropriate reference values are used.”
4. Page 2224, Table 1.1. “One-Vessel Disease”. The footnote previously read, “*iFR measurements with appropriate normal range may be substituted for FFR.” The footnote now reads, “*Substitution of a newer coronary pressure ratio that does not require hyperemia for FFR may be considered provided the appropriate reference values are used.” The following item has been removed from the list of abbreviations beneath the table: “iFR, instant wave-free ratio”. The same corrections have been made to Table 1.2. “Two-Vessel Disease”, Table 2.1. “IMA to LAD Patent and Without Significant Stenoses”, and Table 2.2. “IMA to LAD Not Patent”.
5. Page 2228, Section 7. “Discussion”. The eighth sentence in the second paragraph previously read, “Fourth, the scenarios expand the use of intracoronary physiological testing, mainly with FFR.” That sentence now reads, “Fourth, the scenarios expand the use of intracoronary physiological testing, which should be performed primarily with FFR as it is a well-validated measurement and is associated with clinical outcomes following PCI.”