percutaneous or surgical approach, depending on coronary anatomy. In fact, in all three trials supporting the benefit of invasive strategy vs. conservative strategy, independently from the possibility to identify and treat the culprit lesion, an aggressive revascularization to all coronary segments presenting with significant (>70% at visual estimation) stenosis was protocol-mandated. The relatively high number of patients who received coronary artery bypass grafting (CABG) at 1 year, among those in whom myocardial revascularization was found to be feasible and clinically indicated in the invasive arm of these trials (50% in FRISC II, 34% in TACTICS-TIMI 18, and 37% in RITA 3), may also indirectly confirm that a multivessel intervention was often accomplished. This is clearly more in line with a complete revascularization strategy rather than a culprit lesion-oriented approach. Yet, it is noteworthy that in the FRISC II and TACTICS trials, despite the fact that the majority of the surgical procedures were performed in patients with left main or multivessel disease early after infarction (<7 days), CABG was associated with a low-risk of mortality (<2%).

Thus, whether early intervention is undertaken in patients with NSTEMI, as currently recommended by ACC/AHA5 and ESC guidelines, any attempt to pursue a complete revascularization should be thoroughly carried out, well beyond and independently from the possibility to identify and treat the culprit lesion. Indeed, complete revascularization in this setting might be beneficial due to the deleterious progression of unstable plaques otherwise left untreated in the non-culprit vessels. The failure of current guidelines to address the issue of adequacy of coronary revascularization in patients affected by NSTEMI should be regarded as a potential source of incomprehension, and a position statement in this regard in the upcoming guidelines updates seems to be highly warranted.

References


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