

## Letters to the Editor

**Are We Following the Recommendations of the Clinical Guidelines? Another Point of View****¿Seguimos las recomendaciones de las guías de revascularización coronaria? Otro punto de vista****To the Editor,**

The publication of the analysis by Vázquez Ruiz de Castroviejo et al<sup>1</sup> shows the decisions made daily regarding ischemic heart disease treatment in real-world cardiology and cardiac surgery services in Spain. The published guidelines for myocardial revascularization offer the best scientific argument for outlining the indications for surgical and/or percutaneous treatment of the various clinical and anatomical diagnoses that we can find in our daily practice in the management of this complex disease.<sup>2</sup> Exhaustive analysis is required, as well as investigation into the reasons for the outcomes indicated in the article<sup>1</sup>; they are surely a reflection of what happens in many centers in Spain and they lead to the differences and discrepancies compared with the published practice of other countries on the rate of percutaneous and surgical revascularization.<sup>2–6</sup>

Now is the time to conduct a major debate, at a local level in each center, and at a national level, through the Spanish Society of Cardiology and the Spanish Society of Cardiothoracic Surgery, to evaluate if we are really doing the best for our patients.

Our pride as clinicians, our professional ethics, and the evaluation of the quality of care that we provide must be based on our results, and we must not be shy of publishing them locally in clinical meetings or nationally in journals, meetings, and conferences. In our opinion, the mutual trust between the cardiologist and the surgeon, and the decision made should be based on those results, which must be objective and periodically audited.

The decisions we make every day about our patients have repercussions not only in the short-term, but also, very importantly, in the long-term, and therefore the best available treatment should be offered, based on current clinical evidence and local results.<sup>7</sup>

Decision-making in our center has historically been done by a real heart team composed of clinical cardiologists, interventional cardiologists, and cardiac surgeons, who assess urgent cases in regular clinical pathology meetings, in the catheterization laboratory, and at the bedside. The decisions made are exclusively based on the patient, the diagnosis, the scientific evidence, and our results, and never on time of day, the surgeon, the interventionalist, or the non-clinical circumstances that can surround the clinical situation. Patients are only declined surgery if they have excessive comorbidity or risk; alternative solutions are sought, and an agreement is always reached between the cardiologists and the surgeons. The care is comprehensive and complete, and therefore there is mutual trust between the cardiologists and surgeons that we are proud of, and that allows us to work as a team of equals on the treatment of all aspects of structural heart disease and treatment of the thoracic aorta.

Our results are regularly reported to members of the cardiology and cardiac surgery service; overall mortality is < 2% in isolated coronary artery surgery and multiple arterial revascularization, 59% of all patients, and 84% of patients < 70 years. In patients who undergo revascularization with double internal mammary artery graft, 7-year survival with no death of cardiac cause, and no requirement for repeat percutaneous or surgical revascularization is 97.5%. Therefore, we wish to highlight that while the results indicated by Vázquez Ruiz de Castroviejo et al<sup>1</sup> could well reflect the practice in many centers, it really is possible to base daily practice on current clinical evidence. We would like to congratulate the authors for the publication of the article,<sup>1</sup> which has opened the door to a debate that is essential in our country.

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