

## Letters to the Editor

**Predictors of Clinical Outcomes in Patients With Stable Coronary Artery Disease****Predictores de eventos clínicos en pacientes con enfermedad coronaria estable****To the Editor,**

We read the article by Panoulas et al.<sup>1</sup> with great interest, in which the authors reported the similar 1-year clinical outcomes with 'Overlapping Bioresorbable Scaffolds' and 'New Generation Everolimus-eluting Stents'. The investigators should be congratulated on this interesting study. Nevertheless, we would like to make some points in addition to the findings of the present article. Although percutaneous coronary intervention (PCI) is one of the most important treatments in stable coronary artery disease (CAD), the COURAGE<sup>2</sup> investigators demonstrated that PCI did not reduce the risk of death, myocardial infarction, or other major cardiovascular events when added to optimal medical therapy in patients with stable CAD. Therefore, optimal medical therapy remains the key point in the treatment of stable CAD regardless of PCI and stent type. In this regard, angiographic success and clinical outcomes should be considered as different topics. Bioresorbable scaffolds and everolimus-eluting stents may have similar angiographic and procedural success. However, when evaluating clinical outcomes, optimal medical therapy including statins, beta-blockers and angiotensin converting enzyme inhibitors should be taken into consideration beyond revascularization and antiplatelet therapy. In the present study by Panoulas et al.,<sup>1</sup> there are no clear data on treatment with optimal medical therapy except antiplatelets. Significant differences in the treatment of these medications may affect prognosis and clinical outcomes independently of PCI and the stent types used.

In conclusion, despite similar angiographic and procedural success, prognostic comparison of bioresorbable scaffolds and

everolimus-eluting stents requires more comprehensive evaluation. Since optimal medical therapy reduces adverse outcomes independently of PCI in patients with stable CAD, it should be proven that both groups were treated equally with optimal medical therapy including statins, beta-blockers, and angiotensin-converting enzyme inhibitors.

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Available online 21 October 2016

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1885-5857/

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**Predictors of Clinical Outcomes in Patients With Stable Coronary Artery Disease. Response****Predictores de eventos clínicos en pacientes con enfermedad coronaria estable. Respuesta****To the Editor,**

We would like to commend Drs Eyuboglu and Kucuk for their thought-provoking letter. We entirely agree that medical therapy is of paramount importance in the treatment of patients with stable angina and, indeed, all of the patients in our study,<sup>1</sup> irrespective of type of stent/scaffold implanted, were treated with optimal medical therapy (OMT) consisting of dual antiplatelet therapy, a high-dose statin, beta-blocker, and an angiotensin

converting-enzyme inhibitor or angiotensin receptor blocker, unless contraindicated. Other anti-anginal agents, such as long-acting nitrates, nicorandil, ranolazine, and calcium channel blockers, were considered when residual small vessel or diffuse disease were present.

We should, however, stress that the field of coronary intervention has advanced considerably from the times of the COURAGE trial.<sup>2</sup>

Patients selected in the COURAGE trial were mainly those with intermediate stenosis (70% or more) and myocardial ischemia (exercise or pharmacologic vasodilator stress) or at least 80% stenosis with classic angina. Patients with very tight stenoses, who derive the most benefit from percutaneous coronary intervention (PCI),<sup>3</sup> were most likely excluded on the basis of a markedly positive stress test, one of the exclusion criteria. Of interest, drug-eluting