Prognostic Assessment of Stable Coronary Artery Disease with a New Score

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Our study group on ischemic heart disease congratulates the authors of the article *Arq Bras Cardiol.* 2011;96(5):411-9[1] referring to a new score for the prognostic assessment of coronary artery disease[1]. The presence of stable *angina pectoris* is known to favor the pretest probability of coronary artery disease[2]. Patients with angina despite being on medicamentous treatment represent a group of more advanced coronary artery disease of worse prognosis than patients with stable angina who have never received medicamentous treatment[3]. In our opinion, the fact itself that a patient has angina, even without considering the use of medicamentous treatment, would form a group of heterogeneous prognosis. What do the authors think about adding to their score the new item: "Angina upon use of full therapy"?

Keywords

Exercise test; coronary disease; angina pectoris; prognosis

References

1. Storti FC, Moffa PJ, Uchida AH, Hueb WA, César LAM, Ferreira BMA,et al. Avaliação prognóstica da doença coronariana estável através de um novo score. Arq Bras Cardiol.2011;96(5):411-9.

2. Diamond GA, Forrester JS. Analysis of probability as an aid in the clinical diagnosis of coronary-artery disease.N Engl J Med. 1979;300(24):1350-8.

3. Hubbard BL, Gibbons RJ, Lapeyre AC 3rd, ZinsmeisterAR, Clements IP. Identification of severe coronary artery disease using simple clinical parameters.Arch Intern Med.1992;152(2):309-12.

Reply

We thank you for your interest on the article and your considerations.

Chest pain is part of the Diamond-Forrester criteria, and once it manifests typically, the pretest probability of coronary artery disease (CAD) increases significantly. The Diamond-Forrester method is a probabilistic way to assess CAD, but it does not apply to our publication, because the entire sample was composed of individuals with documented CAD. Thus, the pretest probability would be 100%. Our study focused on prognostic assessment.

All our patients had CAD with angiographic documentation of two- or three- vessel disease; of those, almost 90% had stable angina, at least functional class II, and were on optimized medications for CAD. Thus, they already were at a higher cardiovascular risk. In our case series, the prognostic analysis did not consider that difference between the angiographic two- or three- vessel patterns because of the low number of outcomes in the follow-up period that would occur for angina dichotomization into with or without full therapy. It is difficult to define full therapy, because the therapy for CAD is complex, involving several categories of medications and individualized doses.

From the clinical viewpoint, the prognosis of the sample studied was based on the type of treatment adopted after randomization: clinical treatment x transluminal coronary

angioplasty (TCA) x surgical myocardial revascularization (MR). The truth is that the clinical profile and the documental evidence of ischemia, considered in the basal profile prior to randomization, could predict the risk in the sample, independently of the type of treatment adopted (more conservative or more invasive).

Thus, although interesting, those data do not apply to this study. They might be incorporated in a new study with another focus, aiming only at clinical treatment and with a longer follow-up than ours, which was of five years, because even in a population at high risk, the number of outcomes was not very elevated.