

novo tumors was expected, given their underlying oncological disease or, on the contrary, whether it was higher than expected. It would therefore be interesting to investigate whether the increase in noncardiovascular mortality in patients with cancer and a history of ischemic heart disease could be due to the use of less aggressive treatments for their disease, such as lower surgical intervention rates, lower use of chemotherapy treatments, or increased use of second-line chemotherapy with less curative capacity but fewer adverse cardiovascular effects. For this reason, "cardio-oncologists" should also play an active role in assessing the stability and severity of cardiovascular disease in this patient subgroup, and thus in assessing the risk/benefit of initiating certain chemotherapeutic treatments.

In contrast, the increase in mortality in the patients with prevalent tumors was due to an increase in both noncardiovascular mortality (sHR = 11.53; 95%CI, 6.07-21.89) and cardiovascular mortality (sHR = 2.21; 95%CI, 1.12-4.33). The authors attribute the increase in cardiovascular mortality to a lower revascularization rate and a decreased use of drug-eluting stents. To date, no data are available on the prognosis of patients with active tumors who are admitted with ACS and undergo invasive diagnostic and therapeutic procedures.⁶ The presence of cancer may limit the use of cardiac catheterization because of frailty caused by aggressive chemotherapy treatments in these patients. Similarly, thrombocytopenia secondary to myelosuppressive chemotherapy or in patients with blood cancers could explain the decreased use of drug-eluting stents due to the need to limit the duration of dual platelet antiplatelet therapy.

The results of this study should provide a starting point to initiate strategies in cardio-oncology units to reduce cardiovascular mortality in patients with ACS and prevalent malignant tumors and to reduce noncardiovascular mortality in patients with de novo tumors following an ACS.⁷

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Available online 17 July 2018

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<https://doi.org/10.1016/j.rec.2017.07.020>

<https://doi.org/10.1016/j.rec.2018.05.033>

<https://doi.org/10.1016/j.rec.2018.06.025>

1885-5857/

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Cancer and Acute Coronary Syndrome. A Close, but Complicated Relationship. Response



Cáncer y síndrome coronario agudo. Una estrecha, pero complicada relación. Respuesta

To the Editor,

We appreciate the points raised regarding our study.¹ Recent acute coronary syndrome (ACS) constitutes a limitation for some oncological treatments, which could explain the increased noncardiovascular mortality in patients with prevalent or incident malignant tumors. Likewise, we agree that prevalent tumors limit revascularization both quantitatively and qualitatively.

However, we would like to qualify the opinion that the results of our study should constitute a starting premise for cardio-oncology units. Cancer affects less than 8% of patients with ACS, which could call into question the efficiency of a having a cardio-oncologist in all care settings. Most patients discharged following ACS receive care at nontertiary hospitals,² where it is virtually impossible to have specific units for ACS, heart failure, imaging, and cardio-oncology. Rather, we would advocate continuity of care in ACS in such a way that patients receive a personalized follow-up depending on their risk of the more common and serious complications, such as heart failure or reinfarction.³ In fact, we have demonstrated that follow-up in a clinic specific for high-risk ACS is associated with better control of risk factors

and improved prognosis.⁴ Thus, we advocate continuity of care in ACS and personalized follow-up depending on each patient's risk, with rational coordination of those involved in each situation.

CONFLICTS OF INTEREST

A. Cordero received a research grant from the Spanish Society of Cardiology in 2017. A. Cordero and V. Bertomeu-González have received research support from CIBERCV.

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Available online 7 August 2018

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SE RELATED CONTENT:<https://doi.org/10.1016/j.rec.2018.06.025><https://doi.org/10.1016/j.rec.2018.05.033>

1885-5857/

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