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EDITORIAL

Clinical decision making and cardiovascular risk factors: What about the Heart Team?



Toma de decisiones clínicas y factores de riesgo cardiovascular: ¿qué sucede con el Heart Team?

In this issue of the journal, a consensus document on clinical decisions in relation to risk factors for cardiovascular disease (CVD) is presented. The worldwide epidemic of obesity and metabolic syndrome has led to an increased risk profile of many subjects. They usually cannot be assessed and treated on evidence based medicine principles since evidence often is lacking or scarce, whereas the long term impact on health care is potentially enormous. As the authors correctly state: *"we have to promote an efficient use of diagnostic and therapeutic proceedings to ensure the viability of public health care systems"*.¹ The consensus document is a good example of translating common knowledge to modern day practice. Part of this very laudable effort to reach practical consensus through expert opinion could be enhanced or may be contradicted by known literature. For example, the expert opinions regarding assessment of cardiovascular risk and treatment of lipid profile disturbances are somewhat at odds and not as detailed as the presented evidence in the latest ACC/AHA guidelines.^{2,3} Still, many down to earth and valuable advices are formulated. Again as an example, life style interventions have proven to be successful in a primary care setting but certainly are not "one size fits all" recommendations and if we are to convince our patients we simply have to do more. This consensus document, where intuitive sense comes into play, may be the first step although additional measures have to be taken. Apart from smoking, diabetes has a predominant role in the identification of patients at risk for CVD, so many of the recommendations relate to diabetes.

Diabetes has profound effects on the cardiovascular system and usually leads to a reduced life expectancy. Accelerated progression of atherosclerosis observed in diabetes necessitates a broad implementation of early and rather aggressive treatment of derangements of glucose metabolism, hypertension, and lipid profile disturbances. Still, in many patients, the presence of diabetes results in the need for cardiac intervention therapies.

Revascularization of narrowed or occluded coronary vessels can be performed by surgeons or by interventional cardiologists. However the modalities are entirely different with regard to their mode of action.⁴ Percutaneous coronary intervention (PCI) is targeted at the "culprit" lesion or lesions, whereas coronary artery bypass grafting (CABG) is directed at the epicardial vessel, including the "culprit" lesion or lesions and future culprits, a difference that may account for the superiority of CABG over PCI, at least in the intermediate term, in patients with diabetes, and in particular in those with multivessel disease.^{4–6} This need for early (partly preventive) medical measures combined with the increased need for invasive procedures necessitates a "shared decision making" and more specifically, a close collaboration between vascular internal medicine, interventional cardiology and cardiovascular surgery and is commonly referred to as the "Heart Team" concept.⁷ Such a collaborative effort is an attempt to come to a "final common pathway" in presenting patients with diabetes and coronary artery disease the best treatment options available, whether it is optimal medical treatment (OMT), PCI or CABG.^{7,8} This applies to stable patients as well as patients presenting with acute coronary syndrome. In many patients a strategy of OMT (with delayed revascularization as needed) is the preferred and cost-effective treatment compared to prompt revascularization, but sometimes it is very difficult to convince patients that revascularization is not the first treatment option and the Heart Team can be of great help in these situations.^{7,9} On the other hand, patients with a high-risk profile may benefit from an invasive approach and should be identified as early as possible, though with an eye for cost-effectiveness and omitting costly, often unnecessary diagnostic procedures.¹⁰

The current consensus document¹ addresses every-day dilemmas in patients with, or at risk for CVD, but does not go beyond diagnostic procedures, medical treatment and/or modifiable risk factors. The next step will be to accomplish

agreement on active treatment decisions made by cooperative efforts as presented with the Heart Team. In this document a practical and comprehensive format is used and it elegantly brings to light a common opinion on complex clinical questions but providing, as the authors state, simple answers. The methodology used in this paper seems to be an efficient and practical approach and may be extended to the "Heart Team" as a tool to optimize complex patient care issues.

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