Ischaemic Heart Disease – Coronary Artery Stents (ACD)

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on behalf of DHSSPSNI

Conflict of Interest Declaration

Please state if, at any time, you have had any involvement with the health care industry or manufacturers (as listed in the list of stakeholders) in relation to the technology being appraised and have personally received payment or material benefit from that work. If so, please provide details including the date of your last involvement.

Dr [redacted] has received support for to enable conference attendance and/or speaker's honoraria from Cordis, Boston Scientific and Medtronic (most recently New Cardiac Centre Network meeting, Coventry, 10 July 2007, sponsored by Boston Scientific).

Comments on Ischaemic Heart Disease – Coronary Artery Stents

Based on currently available randomised clinical trial data the benefit of drug eluting stents (DES) over bare metal stents is reduction in need for re-intervention due to in-stent restenosis (ISR).

It is clear from randomised clinical trial data and from clinical practice that benefits are greatest in patients with small vessels (<3.0mm, particularly 2.25 - 2.5mm), and long lesions. Diabetes is an additional risk factor for ISR although such patients are typically already identified at higher risk given their smaller vessel calibre and/or diffuse disease necessitating longer stent length.

Experienced high volume interventional cardiologists recognise the futility in deploying long lengths of small calibre bare metal stents in clinical practice as they almost invariably restenose. Such data are only partly represented in clinical trials but are well recognised in clinical practice. Thus in the past, many patients deemed as unsuitable for bypass surgery (due to inadequate target vessel calibre) were also deemed unsuitable for stenting. With the advent of DES, such patients can now be offered revascularisation with acceptably low risk of ISR, often gaining symptom relief after years of angina, being able to stop many of their multiple anti-anginal medications and avoiding need for repeated costly primary and secondary care reviews. Not infrequently patients may even be able to return to work after a lengthy period of sickness absence. The true costs to society and to the individual of <u>not</u> offering revascularisation/small vessel stenting because of perceived risk of target vessel failure are thus substantial but are not addressed either in clinical trials or in local audits such as the Liverpool CTC study.

Much of the focus of subsequent BCIS correspondence to the original draft has been to debate true percentage need for re-intervention, the real rather than list price premium for DES, and clopidogrel duration in practice. It is not necessary to reiterate

these or other than to state that Northern Ireland experience broadly concurs with BCIS comments.

The key issue for this guidance is its clinical credibility among practising interventionists in order to achieve consistent standards of clinical effectiveness throughout England, Wales and Northern Ireland. The current draft effectively recommends a step back to bare metal stenting for long length, small calibre vessels which is clinically untenable. From a Northern Ireland perspective, the committee is thus urged to revise the draft so that the final document is of optimum benefit in guiding best contemporary clinical practice.