Are waiting times for coronary artery bypass graft surgery longer than they should be? Implications of the NICE guidelines for coronary artery stents

Tryfonidis, Prendergast and Curzen present their findings of work designed to answer the very pertinent question "Are waiting times for coronary artery bypass grafting (CABG) longer than they should be?". This question requires some reflection before we review the authors' work and comments. We must first ask how long waiting times *should be* before undertaking CABG. Previous work has shown that no protection against the ravages of coronary artery disease is conferred by being on a waiting list. The waiting-list mortality (4% to 5% per year) is considerably greater than that of the procedure itself, making the intention-to-treat mortality for CABG two to four times greater than the recognised perioperative risk. In addition, there have been professional casualties within cardiac surgery arising from political attention to this waiting-list toll. We must applaud the National Service Framework (NSF) for coronary heart disease in its aim to reduce waiting times to a level where the risk of death while awaiting surgery is very much that of the procedure itself (1% at three months). Perhaps this is an appropriate length of time to wait? Perhaps even this is too long!

To be unkind, these authors do not choose to address the question that they have posed. They have headed off in another direction, following some interesting emerging practices. There is a trend towards cardiologists sub-dividing into diagnosticians and interventionists. This is through necessity as more and more revascularisation work presents itself, overwhelming the cardiological polymath. Surgical provision seems to be swamped and expectations of percutaneous transluminal coronary angioplasty (PTCA), with or without stenting, increased.

The NSF for coronary heart disease is pushing to achieve revascularisation rates that can be seen to be appropriate on a world stage. The proposal is 750 per million for CABG and a similar number for PTCA. As an aside, even this impressive hikeup may fail to provide fully for the huge at-risk UK population. New diagnostic centres in district general hospitals are coming on line as government capital is made available for more catheter laboratories. This, coupled with the NICE guidelines of May 2000 encouraging PTCA with or without stenting (in coronary arteries of prescribed size), where possible pushes the cardiological interventionist closer towards an entirely therapeutic role.

In this environment it is essential that our diagnostic colleagues are well supported by us surgical and medical interventionists. This is the issue that Tryfonidis and colleagues are addressing. PTCA is undoubtedly a quicker procedure than CABG, though perhaps no cheaper in the long run. In-stent stenosis demands further revascularisation, although very recent reports involving sirolimus-coated stents suggest that this may be a problem of the past. Despite Dr Curzen's comments elsewhere expressing concern for the future of surgical revascularisation, clear groups will emerge as appropriate for either PTCA or CABG. Tryfonidis, Prendergast and Curzen are right in calling for provision of resources that are directed to ensure appropriate referral of patients troubled by their coronary artery disease. As new catheter labs open in district hospitals we surgical and cardiological interventionists must allocate time for combined meetings. There are bound to be additional benefits for all of us from such meetings: if not educational, certainly social.

Stephen Large

Stephen Large
Consultant Cardiothoracic Surgeon,
Papworth Hospital, Papworth Everard,
Cambridge, CB8 8RE.
(email: stephen.large@papworth-tr.anglox.nhs.uk)

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