EDITORIAL

Interdisciplinary Decision Making

Expert Statement on the Treatment of Chronic Coronary Artery Disease

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Editorial to accompany the article "Different Treatment Options in Chronic Coronary Artery Disease—When Is It the Time for Medical Treatment, Percutaneous Coronary Intervention or Aortocoronary Bypass Surgery?" by Rüß, Cremer, Krian, Meinertz, Werdan, and Zerkowski in this issue of *Deutsches Ärzteblatt International*

What treatment is indicated: bypass surgery (coronary artery bypass grafting, CABG), percutaneous coronary intervention (PCI), or exclusively pharmaceutical treatment? This is a crucial question for the patient with coronary artery disease (CAD). He expects the physician supervising his treatment to give him balanced information and recommend the treatment likely to prove the most successful in his individual case. It is precisely in the treatment of CAD, however, that the information provided by the doctor frequently lacks balance. Therefore, this review of the treatment options in chronic CAD by an interdisciplinary team is very welcome.

In the past, debate between cardiologists and cardiac surgeons has often tended to confuse matters more than clarify them—particularly when the arguments were polemical rather than scientific, with statements like "cardiac surgery will become superfluous because it will never catch up with the advances of PCI" or "cardiac surgery is clearly superior to PCI."

Such one-sided accentuation of a particular discipline is nowadays just as inappropriate as the failure to explain treatment options exhaustively. The credibility of specialists is questioned, and patients' trust in their physicians dwindle.

Rather, it is imperative to point out that the various treatment options can all achieve excellent results depending on the patient's circumstances. Which procedure is the best must be determined on an individual basis. In complex cases, the most promising procedure can only be selected by specialists and primary care physicians working together.

With the aim of helping to achieve a consensus on the differential indications for PCI and CABG and on other controversial treatment issues, between 2002 and 2006 the responsible scientific medical societies—in the context of the German Program for National Disease Management Guidelines (supported by the German Medical Association, the National Association of Statutory Health Insurance Physicians, and the Association of the Scientific Medical Societies in Germany [AWWF])—put together a clinical practice guideline (the Nationale Versorgungs-Leitlinie Chronische KHK [National Disease Management Guideline on Chronic CAD], announced in *Deutsches Ärzteblatt* (Dtsch Arztebl 2006; 103 [44]: A 2968 ff).

The recommendations of this evidence and consensus based guideline were agreed by experts from six professional organizations: the Drug Commission of the German Medical Association, (AkDÄ), the German Society for General and Family Medicine (DEGAM), the Ger-

man Society for Internal Medicine (DGIM), the German Cardiac Society (DGK), the German Society for Prevention and Rehabilitation of Cardiovascular Diseases (DGPR), and the German Society for Thoracic, Cardiac, and Vascular Surgery (DGTHG). The review on the following pages emerges from this National Disease Management Guideline (NDMG) and originated on the initiative of the DGK and DGTHG.

The NDMG on CAD was enacted as a guideline of the German Medical Association in August 2006.

More than two years after publication, however, it has to be stated that the guideline has not been adopted into routine patient care as the editors and authors wished.

The problems associated with the failure to follow the NDMG recommendations in routine daily practice were recently discussed at an expert meeting convened by the Deutsche Herzstiftung (German Heart Foundation, DHS). The invited experts, all leading cardiac surgeons and cardiologists, raised no objections to the statements of the NDMG on Chronic CAD.

The assembled experts identified failure of physicians to confer among themselves and insufficient provision of information to the patient regarding the choice of treatment procedure as the most critical points in the implementation of the guideline recommendations. The decision between bypass surgery and PCI is strongly influenced by who informs the patient. Cardiologists would usually be the first to be consulted by patients with chronic CAD. They would make the diagnosis, assess the circumstances, and act/treat. Without discussion the patients would often not find out that for them, bypass surgery might be the better option. Occasionally the opposite would be the case. A less experienced cardiologist would refer the patient to the cardiac surgeon and the patient would be operated upon without knowing that in his case PCI would have been preferable.

All participants at the expert meeting therefore thought it necessary for cardiologists and cardiac surgeons to decide jointly on the procedure in critical constellations. They also agreed unanimously that provision of proper information and advice to patients in critical areas is possible only after open discussion between cardiologists and cardiac surgeons. The decision process should take account of the patient's expectations and the short- and long-term advantages and disadvantages of the potential treatments. Either the cardiologist or the cardiac surgeon then discusses the decision with the patient. It is imperative to involve the patient's primary care physician.

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The DHS is one of the largest patients' organizations in the field of cardiovascular disease, and its efforts towards prevention and information are centered on the cardiac patient. The following review supports the aims of the DHS in an exemplary fashion and documents a milestone in cooperation between cardiac surgery and cardiology, with the goal of achieving optimal information and treatment of the patient with chronic CAD. The article shows that the apparently competing procedures CABG and PCI can be meaningfully integrated in a complementary treatment approach.

The authors and other individuals involved are to be most heartily congratulated on coming to an interdisciplinary consensus on interventional/surgical treatment for chronic CAD, on the basis of both study results and also discussions and expert meetings. Our thanks go to them all.

The authors' remarks constitute an appeal to those in positions of responsibility in the health system to devote

even more effort to the implementation of interdisciplinary decision making in the treatment of patients with chronic CAD.

Conflict of interest statement

The authors declare that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.

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