Letters to the Editor

Viagra®, the Latest Cardio-VASCULAR Drug

C.R. CONTI: *Clin Cardiol* 1998;21:616

To the Editor:

I read with interest the editorial of Dr. Conti entitled "Viagra®, the Latest Cardio-VASCULAR Drug." It is a first from a cardiologist explaining the danger in the concomitant use of all forms of nitrate preparations and sildenafil (Viagra).

In my opinion, based on their pharmacologic action, peripherally-acting vasodilators—namely, alpha-1-selective antagonists such as terazosin and doxazosin, which are commonly used to treat hypertension and prostatic bladder outflow obstruction—present the same danger when sildenafil is prescribed to such problematic patients.

On theoretical grounds, caution may have to be exercised also with prescribing sildenafil to patients who are taking calcium channel blockers such as nifedipine. The same caution could be applied to patients taking direct-acting vasodilators such as hydralazine, or minoxidil.

The above mentioned medications alone have potential side effects, not to mention their effects in combination or with the addition of sildenafil.

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Coronary Bypass Surgery after an Acute Myocardial Infarction: Will Delaying Surgery Decrease Cardiac Events?

C.R. CONTI: *Clin Cardiol* 1998;21:793–794

To the Editor:

I read with great interest the editorial by Dr. Conti on coronary bypass surgery (CABG) and myocardial infarction.¹ He raised a very good question concerning the optimal timing of CABG after an uncomplicated acute myocardial infarction (AMI). So far, there is no prospective randomized trial to support delaying the surgery or early surgery. Although the retrospective study by Svensson *et al.*² did not show that the timing of CABG in itself had a significant effect on hospital mortality of symptomatic patients within 3 weeks of AMI, the 9.1–17.4% operative mortality (within the first 24 hours) was still alarming compared with the 4.0% operative mortality (1 to 7 days). Certainly, one could argue that those who were operated during the early hours were much sicker and probably had worse left ventricular function. As a cardiologist in pri-

vate practice managing AMI patients mostly with primary angioplasty and/or early cardiac catheterization, I find in my interaction with cardiovascular surgeons that most surgeons are reluctant to operate the patients within the first 24 to 48 hours. Some highly skilled surgeons are willing to operate on patients who present within the first 4 to 6 hours, when the infarct is still evolving and is not yet completed. Realistically, that window period is very short, since patients who will undergo CABG usually also undergo cardiac catheterization and other necessary preparations that may easily take up two hours. Their feelings are that after that 4- to 6-hour window period no myocardial salvage can be achieved, and the operative mortality may increase secondary to the potential dreadful complication of cardiac rupture. After the first 24 to 48 hours, the decision to proceed to CABG is by and large arbitrary. The timing is decided mainly according to the clinical stability and other comorbid conditions of the patient; *it becomes more of an art than a science*. A wait period of 5 to 7 days is not unreasonable. (With modern techniques, a wait period of more than 1 to 2 weeks is probably unnecessary.) Of course, exceptions do exist. If the patient has a very high grade left main coronary artery lesion, or thrombus in the left main coronary artery, or the patient has persistent cardiogenic pump failure despite optimal mechanical and pharmacological support, or if mechanical complications of AMI ensue, then one must attempt to achieve revascularization as soon as possible. We must remember that no matter what clinical studies we have today, they may not apply to our particular patient. Sometimes our clinical decision is based not only on our medical knowledge, but also on our clinical experience and a tight cooperation with our surgical colleagues. If our patient dies because of our poor timing, the mortality is 100% for him or her. I still believe a skillful timing of CABG for patients after an uncomplicated AMI will do more good than harm for them. I am distressed that, nowadays, medical cost containment and third-party payers play such an important role in dictating our decision to subject this group of high-risk patients to potentially horrendous procedures.

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References

1. Conti CR: Coronary bypass surgery after an acute myocardial infarction: Will delaying surgery decrease cardiac events? *Clin Cardiol* 1998;21:793–794
2. Svensson LG, Cruz H, Sun J, Dagostino S, Williamson WA, Shahian DM: Timing of surgery after acute myocardial infarction. *J Cardiovasc Surg* 1996;37:467–470