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Editorial

Joint Statement of the Korean Society for Thoracic and Cardiovascular Surgery and the Korean Society for Coronary Artery Surgery on Chapter 7.1 in the 2021 American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions Guideline for Coronary Artery Revascularization

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The Korean Society for Thoracic and Cardiovascular Surgery and the Korean Society for Coronary Artery Surgery would like to acknowledge the American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACC/AHA/SCAI) Guideline for Coronary Artery Revascularization Committee for their accomplishments in formulating a new guideline for coronary artery revascularization [1]. The guideline has reflected the necessary and relevant issues of coronary artery revascularization. Notwithstanding, the guideline has led to controversies by downgrading coronary artery bypass grafting (CABG) from the class of recommendation (COR) I to COR IIb in patients with stable ischemic heart disease (SIHD), normal left ventricular ejection fraction, and three-vessel coronary artery disease (CAD), as presented in chapter 7.1. The downgrading of the COR for CABG in these patients prompted The American Association for Thoracic Surgery (AATS) and The Society of Thoracic Surgeons (STS) to declare that they do not endorse the 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization [2]. Meanwhile, cardiac surgery societies from around the world have issued docu-

ments that support the AATS/STS statement [3-5].

The Korean Society for Thoracic and Cardiovascular Surgery and The Korean Society for Coronary Artery Surgery hereby express the following concerns with chapter 7.1:

1. The abrupt downgrading of the COR for CABG in the Guideline is predicated on the interpretation of the results from the International Study of Comparative Health Effectiveness with Medical and Invasive Approaches (ISCHEMIA) trial [6] and several meta-analyses [7-11]. However, these are not reasons for downgrading the COR for CABG in patients with SIHD.

(1) In the ISCHEMIA trial, only 20% of enrolled patients who were assigned to the initial invasive treatment group underwent CABG, and a substantial proportion of the patients experienced crossover of the treatment arms. Finally, a median follow-up duration of 3.2 years might be relatively short for elucidating the benefits of CABG.

(2) The majority of studies that constituted the meta-analyses only or mostly included patients who underwent percutaneous coronary intervention (PCI) rather than those who underwent CABG in the invasive treatment arm. Because there are inherent differences between CABG and PCI, these meta-analyses should not be used to justify the downgrading of the COR for CABG in patients with SIHD.

2. The optimal care for CAD patients should be provided through the collaboration of cardiac surgeons and cardiologists in the Heart Team, as suggested in the 2018 European Society of Cardiology/European Association for Cardio-Thoracic Surgery Guidelines on myocardial revascularization [12]. Contrary to previous guidelines, the current guideline was not generated under balanced leadership between cardiac surgeons and cardiologists from North America [13,14].

Again, we support the AATS/STS statement against the 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization, and expect that a new guideline will be developed through the collaboration of cardiac surgeons and cardiologists based on appropriate evidence.

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Conflict of interest

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