AIM: To determine if no cardiac testing is “noninferior” to a strategy of testing before major vascular surgery for preventing cardiac death and nonfatal myocardial infarction. METHODS: 770 intermediate cardiac risk patients in whom open abdominal aortic or infrainguinal arterial reconstruction was planned were randomly to: 1) no preoperative testing or 2) dobutamine stress echocardiography or dipyridamole perfusion scintigraphy testing. All patients were maintained on tight β-blocker therapy so that resting heart rates were maintained at 60-65 beats/min before and after surgery. The primary end point was the composite end point of cardiac death or nonfatal myocardial infarction at 30 days after surgery. The secondary outcome was the composite end point at 2 years by intention-to-treat analysis. RESULTS: Among those with no preoperative cardiac testing, 1.8% experienced cardiac death or nonfatal myocardial infarction compared with 2.3% who had preoperative cardiac testing. Of those who had preoperative cardiac testing 12 of 34 patients with extensive ischemia had revascularization. CONCLUSION: Cardiac testing can safely be omitted in intermediate-risk patients that β-blockers aiming at tight HR control are prescribed.

IMPLICATIONS FOR INTERNAL MEDICINE
These data provide further support for a conclusion that there is no place for routine noninvasive stress testing in patients being considered for noncardiac surgery. It must be noted that there is no evidence that preoperative coronary revascularization reduces risk for subsequent noncardiac surgery in stable patients. Internists who play a key role in determining those patients who need further consultation before noncardiac surgery need to be aware of these data and the bedside classification of risk. The critical importance of medical management of myocardial ischemia by all of those involved in perioperative care of such patients is crucial and is again emphasized for β-blockers in the current study. The accompanying editorial provides an important perspective on this clinical problem. The relevant updated ACC/AHA Guideline is referenced.

REFERENCES


SUGGESTED READING

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Warfarin Prescribing in Atrial Fibrillation: The Impact of Physician, Patient, and Hospital Characteristics
Choudhry NK, Soumerai SB, Normand SL, et al.

AIM: To investigate determinants of warfarin use in patients with atrial fibrillation. METHODS: Linked administrative databases in Ontario, Canada, were utilized to identify patients > age 66 years in the hospital with atrial fibrillation and to analyze factors predicting use of warfarin after discharge. RESULTS: Patients without an identifiable provider were significantly less likely to receive warfarin (odds ratio, 0.37 [95% confidence interval, 0.36-0.38]). Of patients with providers, 50,551 (43.5%) received warfarin within 180 days after hospital discharge. Warfarin use was positively associated with AF-associated stroke risk factors (e.g., prior stroke, congestive heart failure) and negatively associated with warfarin-associated bleeding risk factors (e.g., history of intracerebral hemorrhage). After controlling for patient and hospital factors, patients cared for by noncardiologist physicians with cardiology consultation were more likely to receive warfarin then patients treated in noncollaborative environments. CONCLUSIONS: Warfarin continues to be substantially under prescribed to patients who are at high risk for AF-associated cardioembolic stroke. Our findings highlight the need for targeted quality improvement interventions and suggest preferred models of AF care involving routine collaboration between cardiologists and other physicians.

IMPLICATIONS FOR INTERNAL MEDICINE
The 3 papers above emphasize a continuing problem in implementing evidence-based medicine. These papers serve as a reminder to all of us on the need to establish mechanisms within whatever practice environment to ensure adherence to clearly recommended therapies, such as combined antiplatelet therapy post drug-eluting stenting, β-blockers after MI, and antiocagulation in the setting of atrial fibrillation. In my opinion, one of our greatest challenges in busy clinical practices is a systematic and accurate recording of all medication and dedication of resources to track continuing medication and other supplement usage. When there are clinical reasons for not following well-established therapies, documentation of the basis for such judgment is important. All of this is an old story in relation to the use of β-blockers and chronic anticoagulation for atrial fibrillation.

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