Endovascular repair of intact abdominal aortic aneurysm is safer than open repair


Jackson *et al.* performed a retrospective analysis of 4529 patients over 65 years who underwent isolated repair of intact abdominal aortic aneurysm (AAA) between 2003 and 2007. A total of 703 patients underwent open repair and 3826 endovascular repair, and the mean and median follow-up time was 2.6 years. All-cause mortality and AAA-specific mortality were higher in the open-repair group compared with the endovascular repair group (89 vs 76 and 11.3 vs 2.8 per 1000 person-years; *p* = 0.04 and *p* < 0.001, respectively). After adjusting for emergency admission, age, calendar year, sex, race and comorbidities, open repair was more risky than endovascular repair. Compared with endovascular repair, open-repair patients stayed an average of 6.5 days longer in hospital and had a higher incidence of incisional hernia repair (12 vs 3 per 1000 person-years). Whereas there was no significant difference in rates of repeat AAA repair, incidence of 1-year readmission and lower-extremity amputation.

These data show that among older patients, endovascular repair of isolated intact AAA is safer than open repair and is associated with a decreased risk of all-cause mortality and AAA-related mortality.

Many left ventriculographies can be avoided


Left ventriculography is the first imaging tool to obtain information regarding the left ventricular function and volume. It is still performed in most coronary angiography cases although modern noninvasive imaging techniques have been developed in the last decades with more accuracy and smaller risks. Witteles *et al.* retrospectively analyzed the data from the Aetna healthcare benefits database concerning patients who underwent coronary angiography in 2007. Of 96,235 patients who underwent coronary angiography, 78,705 patients (81.8%) received left ventriculography. They found that in 88% of those cases, the test was not necessary – of 37,149 patients with no reason to expect that their left ventricular volume or ejection fraction had changed had undergone an ejection fraction assessment by another modality within the previous 30 days. As many as 32,798 of those patients (88%) received a left ventriculography providing no additional information for the investigator. Witteles and colleagues conclude that in many cases, the left ventriculography can be avoided because an alternative imaging modality

Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

No writing assistance was utilized in the production of this manuscript.
More and more patients with atrial fibrillation who are at moderate-to-high risk of thromboembolism receive percutaneous coronary intervention under continuing oral anticoagulation. Until now it has been unclear as to whether there is a need for additional administration of periprocedural heparins. Kiviniemi et al. investigated assessed bleeding complications and major adverse cardiac and cerebrovascular events in 414 consecutive patients undergoing percutaneous coronary intervention on long-term warfarin therapy for atrial fibrillation. A total of 196 patients were without any additional anticoagulation other than therapeutic oral anticoagulation (international normalized ratio: 2.0–3.5) and 218 patients received additional unfractionated heparin, low molecular weight heparin bolus or subcutaneous low molecular weight heparin. The study showed no differences in major adverse cardiac and cerebrovascular events (4.1 vs 3.2%; p = 0.79) or major bleeding (1.0 vs 3.7%; p = 0.11). There were fewer access-site complications in the group without the additional administration of heparin (5.1 vs 11.0%; p = 0.032). When adjusted for propensity score, patients with additional heparins had a higher risk of access-site complications (odds ratio: 2.6; 95% CI: 1.1–6.1; p = 0.022) without any increased risk of other adverse events. Kiviniemi et al. come to the conclusion that there is no need for further administration of heparin during percutaneous coronary intervention if sufficient oral anticoagulation is administered. Additional heparins may increase access-site complications in those patients.