To the Director

In general, the articles published in the *Revista* are headed by a quotation related to their topics. This is auspicious, because it shows the physicians' interest in culture beyond medicine. As that great teacher of medicine, Carlos Jiménez Díaz, said: *"Those who read only medicine, do not even know medicine."*

Alfredo Buero heads his opinion article "Brief Essay on the Death" (1) with this quotation: *"Death is something we should not fear because, when we are, death is not come, and, when death is come, we are not"*, which he attributes to the Spanish poet and philosopher Antonio Machado.

Actually, it corresponds to Epicurus (341-270 B.C.), philosopher of the mitigated hedonism, who wrote this quote in *Letter to Meneceo*, where he says, literally: *"Death, the most awful of evils, is nothing to us, seeing that, when we are, death is not come, and, when death is come, we are not."* Antonio Machado puts it in the mouth of a ficticious character, in fact, his alter ego, Juan de Mairena, in the book he edited in 1936, *"Juan de Mairena. Sentencias, donaires, apuntes y recuerdos de un profesor apócrifo"*.

Dr. Antonio F. De Rosa[MTSAC]

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Medical professionalism and practices with the industry create conflicts of interests

To the Director

I have read with great interest the Director's Letter about the conflict of interests, published in Nº 5, Volume 76 of the *Revista* (1), and I would like to make some comments.

Sometimes, when we want to extrapolate world tendencies to our country, we fail to take the socio-cultural and economic differences into account. The contribution of the companies is so rooted in our healthcare system that I find it hard to imagine a world without them.

In our country, these companies provide economic support to entire services –especially public ones–, fund societies, and promote –for their own sake– research and technological progress. In a deficient healthcare system, and with poor economic administration, the companies stand as direct funders of the system and their disappearance would collapse the system in the short or long run.

Does anyone imagine a congress of cardiology in Argentina organized exclusively with the contribution of the SAC members? Does anyone imagine this *Revista* without advertising? Unfortunately, private funding is as necessary in cardiology as in any other areas, and although I agree that sometimes a form of regulation should be implemented, the achievements we may pursue are modest. We must raise critical and collective awareness to handle these conflicts of interest, so that these conflicts do not handle us. But I think we must have our own recommendations based on our reality and our healthcare system, and do not fall into the temptation of imitating other people's recommendations for outside systems. We will ever have to start with this task, and maybe this is the right time; the world economic crisis will bring with itself an investment reduction, and we will have no option but do without some of the services the companies provide, but I think that nowadays this is more like a wish and a theorethical assumption rather than a true intention to finally complete the act.

Dr. Darío Di Toro, M.D.
Director of the SAC Council of Clinics
Dr. Darío Di Toro declares he has no conflicts of interest.

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Author's Answer

I appreciate Dr. Darío Di Toro's interest and comments, which allow me to complete some ideas.

It sounds contradictory to me that he points out the error of extrapolating world tendencies to our country without taking the socio-cultural and economic differences into account, and that then he expresses that *"the contribution of the companies is so rooted in our healthcare system that I find it hard to imagine a world without them"*. Since most of them are transnational companies, they transfer not only the culture but the interests of their countries of origin as well.

Then he argues –in my opinion, with no facts but with certain fear– that without the contribution of pharmaceutical companies, our current healthcare system would almost disappear. Literally, he says: *"In our country, these companies provide economic support to entire services –especially public ones– […] In a deficient healthcare system, and with poor economic administration, the companies stand as direct funders of the system and their disappearance would collapse the system in the short or long run.*

However, the concrete data show the opposite. For instance, according to an estimate from the World Bank, the percentage of the Argentine population with no access to prescribed medications in June 2002 was 34.2% of the total. This percentage was much worse, 40%, for indivuduals with the lowest income. For this

reason, the World Bank designed and drove the plan *"Remediar"* (Remedy), implemented by the government, in order to provide essential medications for free to 15 million people depending mainly from the public sector, 70% of whom are below poverty line.

While in 1960 health costs represented 1.5% of the family budget, it increased six times in a few decades, and its incidence was 9% in 1997. Within the 20% of the poorest people, 78% of those health costs was due to purchasing medications. It was not taken into account the distortion the public system underwent, which was caused by the fact that a group of physicians with a low income for assistance, found it an almost irresistible financial incentive to include and follow up patients for the industry in their time for consultation.

Of course it is possible to "imagine" this *Revista* with no advertising. Actually, it has free access through Internet, and advertising funds its printed version, which is distributed only among the SAC members. And of course members' contribution, registration fees, and other grants not provided by the pharmaceutical industry would also allow for organizing more congresses, perhaps a bit different, without the bias in selecting invitations of foreign lecturers carried out by the industry, with the excuse of selecting lecturers for (un)training courses, within the same congress.

I ratify what I expressed in the letter: *"On the one hand, and as one of the parts in the healthcare system, the pharmaceutical and medical device companies promote the patients' welfare by committing themselves to researching and developing products. […] However, the rationale and ultimate responsibility of the companies are related to their shareholders, who expect reasonable profits out of their investments.*

At the same time, as we have noticed in the charte, the principles of medical professionalism place their primary responsibility in their commitment to the patients' welfare, and this altruism places the patients' interests in the first place, assuming there is lack of any other influence or bias in making medical decisions.

Both responsabilities are basically incompatible, and may be contradictory. Even if confronting responsabilities could be avoided, there would still be the patients' perception and potential."

I do not feel as discouraged as Dr. Di Toro seems to be when he says: *"We will ever have to start with this task, and maybe this is the right time […] but I think that nowadays this is more like a wish and a theorethical assumption rather than a true intention to finally complete the act."* And I say this because the SAC authorities entrusted the Bioethics Committee – as the task for this year– to advance a consensual declaration within the SAC, and then, as able, with other medical organizations, about the principles of medical professionalism that should be considered in our everyday actions.

Dr. Hernán C. Doval, M.D.

To the Director

I have read "Brief Essay on the Death", by Alfredo Buero with intellectual delight, probably because its development is based on poets. Personally, I think art brings wisdom beyond (or closer to...) science. (1) Maybe because of the coincidence that I have recently read Ioana Heath's essay *Help to Die* (with a preface and twelve theses by John Berger), (2) whose reading I dare recommend.

I will summarize this work and its authors' personalities. Ioana Heath is an English physician who worked in a poor suburb of London, and chaired the Ethics Committee of the Royal College of General Practitioners and of the British Medical Journal. John Berger (1926-) is an outstanding contemporary English writer. His books include one of the most extraordinary works about medicine, *"A Fortunate Man"*. Heath's beautiful book begins with a quotation from the Swedish poet Sven Lindqvist (1932-): "Society, art, culture, the whole of the human civilization is not but evasion, a huge collective self-deception whose aim is to make us forget that we incessantly fall through the air, that all the time we are closer to death." (2) Heath says: "The physician plays an important role in connection to death", and she quotes Berger: "The doctor is the familiar of death. When we call for a doctor, we are asking him to cure us and to relieve our suffering, but, if he cannot cure us, we are also asking him to witness our dying. The value of the witness is that he has seen so many others die… He is the living intermediary between us and the multitudinous dead. He belongs to us and he has belonged to them. And the hard but real comfort which they offer through him is still that of fraternity." (2, 3)

After her great development, Heath confirms her priorities about people who are dying:

- "Whenever possible, patients should die at home or in another familiar and loving place.
- People should not die in solitude. Their care should be in charge of those individuals the dying patient knows, preferably people who love him/her.
- The relationship and the constant conversation between the physician and the terminal patient are essential.
- Communication is mediated both for words and physical contact.
- Sometimes it is necessary to feel pain in order to feel alive.
- Hope is related to future, but it exists in the present and can be directed to simple sensory pleasures:

music, physical contact, vision of a loving face, sunlight.
– To revive memories and to share them again make it possible to complete a coherent life story.
– The space to recognize the resolution of a life and the perspective of liberating a declining body should be found.
– The depth of time is more important than its duration." (2)

As an example, I am reproducing the first of Berger's "twelve theses": "The dead surround the living. The living are the core of the dead. In this core are the dimensions of time and space. What surrounds the core is timelessness." (2)

I congratulate Alfredo Buero for his brilliant essay, and to the *Revista Argentina de Cardiología* for receiving articles of such quality, which help us think in things like the ones Iona Heath mentions: "Dying is difficult. To be a physician is also difficult: to witness the agony every day and to become aware of the limits of science once and again." (2)

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Surgery in Patients with Left Main Coronary Artery Disease

To the Director

In 2008 issue N° 6 of the *Revista Argentina de Cardiología,* a relevant study by the group of physicians, Borracci M.D. and Rubio M.D., was published. In this study, the immediate and 5-year outcomes after myocardial revascularization surgery (MRS) in 174 consecutive patients with left main coronary artery disease (MLCA) from 2003 to 2007 are reported. (1) It goes without saying that the work is interesting, because it evidences the positive outcomes of the MLCA performed by a trained and experienced team on high-risk patients, not only because of the MLCA lesion but also because 90% of them had associated lesions in multiple vessels.

In 30 days, the mortality was similar to the one expected by the EuroSCORE. The 5-year follow up revealed a cardiovascular mortality equivalent to the general population of comparable age. In the work conclusions, the authors point out that the outcomes were consistent with the ones reported in the international bibliography.

While the work should be considered closely and constitutes a significant contribution to the knowledge of the MLCA outcomes of these patients in "the real world" of our country, it is evident that the scarce number of patients, as well as the fact that the authors belong to an experienced group of three associated cardiovascular surgery services, prevents generalizing the excellence of the outcomes in our area to form a conceptual basis and the evidence required to expand the paradigm of adopting behaviors in this type of patients.

On the other hand, while the reported data show the group's reliability, they do not represent the average quality standard of surgical outcomes for the treatment of these patients in our country. This evidences the need to individualize not only the patients but also the experience of the attending group, so as to choose the proper revascularization therapy in each case.

On the other hand, the authors point out that no statistically significant differences were found regarding mortality in the group of patients who underwent emergency surgery, as opposed to patients with elective surgery (8.3% versus 2.9%, OR: 3.05, CI 95%: 0.51-17.2; p = 0.156), nor in the incidence of combined events (death, infarction, stroke: 11.1% *versus* 7.2%, OR: 1.60, CI: 0.39-6.06; p = 0.492). This seems to be a beta statistical error, that is, related to the absence of power due to the scarce number of patients. On the other hand, if the tendency is confirmed in a larger group, the differences would evidently get statistical significance, and this would suggest a more rational physiopathologic connection in the sense that the more severe patients usually have more morbimortality in invasive revascularization procedures.

Finally, it is surprising that even though three-quarters of the patients were diagnosed with unstable angina, they did not have higher mortality or combined events than the more stable patients. This would explain why the authors clarified what definition was considered for the unstable angina, what risk classification on admittance and in evolution those patients had, and which was the average time between the beginning of the clinical signs and the CRS.

Above and beyond the raised doubts aiming at enriching the experience data reported in the work, the presentations of the different interventional groups (endovascular and surgical groups) must be encouraged, so that, through a proper and rigorous statistical analysis like this one, they can help the clinical cardiologist understand the contribution of revascularization to selecting the best treatment for this group of high-risk patients.

Dr. Horacio Pomés Iparraguirre[MTSAC]

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Authors' Answer

In response to Dr. H. Pomés Iparraguirre's letter, it is important to point out that other local centers have also reported a similar morbimortality in the treatment of left main coronary artery disease (MLCA). (1) Shortly, we may have a wider picture of the outcomes of this type of surgery in all the country, since the outcomes from the National Registry of Cardiac Surgery (CONAREC XVI) are being analized, which include about 2,500 patients with coronary and/or valve surgery in more than 30 national centers. (2) With regard to the definition of unstable angina, in general it corresponded to the angina present on admittance in the Coronary Care Unit; however, most of the patients were already stabilized at the time of surgery, except for the cases defined as "urgency", for which the EuroSCORE criterium would be applied, that is, rest angina requiring IV nitrates until surgery. Undoubtedly, the absence of statistical difference between the groups undergoing urgent or elective surgery is due to the low power of the sample, which was pointed out in the original article, at the end of the second paragraph of the Discussion, where it is explained that the MLCA emergency surgery may increase two times surgery mortality. We sincerely thank Dr. Pomés Iparraguirre's contribution.

Dr. Raúl A. Borracci[MTSAC] and Dr. Miguel Rubio[MTSAC], by the authors

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To the Director

The article "Acute Myocardial Infarction in Women: Clinical Characteristics and Short-Term and Long-Term Outcomes", published in N° 6, Volume 76 of the *Revista Argentina de Cardiología*, is very interesting to me. Over the past decade, attention has been paid to the international literature on the differences regarding physiotherapy, treatment and outcomes of acute coronary syndromes in women, and it is indeed positive that the reality of our country in this regard can be made known.

Dr. Stella Mancín et al., authors of this publication, show outcomes that globally match what has been reported by other groups: older female patients with more cormobilities than men, higher intrahospital mortality, longer time to reperfusion, a very high heart failure rate as complication of the acute coronary events, and greater incidence of refractory angina. The Argentine Society of Cardiology survey on infarction showed similar outcomes. It was carried out in Coronary Units of our country.

An aspect this group has emphasized –and I think it is important– is the impact of renal dysfunction as prognosis indicator. While the concept of additional risk for kidney failure in patients with ischemic heart disease is widely spread, in this case it is observed that minimum increase in uremia induces worse outcomes, and also that renal dysfunction is more frequent in women than in men, although it is usually underdiagnosed due to considering only the isolated creatinine, instead of calculating its clearance to obtain a more accurate dimension of the problem.

According to the authors, the use of reperfusion strategies, as well as angioplasty, did not show gender based differences. This does differ from the outcomes in the international registries, but I think these data must be taken cautiously, since the sample is very small, and this probably has influence in this regard.

It is surprising that myocardial infarctions with and without ST-segment elevation have been included (percentages of women in each of these subgroups are not mentioned). These two acute coronary syndromes have different physiopathologies, prognosis and therapies. It makes the sample very heterogeneous and the outcomes not so relevant.

Above and beyond these limitations, I find it very positive to become aware of our own reality on a highly prevalent disease and with a high mortality rate.

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Authors' Answer

I thank Dr. Ana Salvati for her the interest in our article "Acute Myocardial Infarction in Women: Clinical Characteristics and Short-Term and Long-Term Outcomes". She is a pioneer in the topic "woman and coronary disease" in the Argentine Society of Cardiology. While data reported in previous essays and registries have been confirmed in this work, this concordance emphazises the *higher morbility in women*; however, the *highest mortality is probably attributed to the older age in women*. (1)

What is most relevant in the article is *the inclusion of Latino patients*, because the racial differences usually make those findings different, as expressed by Shaw et al., who showed a much higher mortality among Latino and white women with acute coronary syndrome. (2)

Another interesting fact, as Dr. Salvati points out, is the importance of the urea on admission, which increased four times the risk of death. This simple fact of measuring these values on admission provides relevant data to stratify high risk patients; not only should they be considered in the ACS with no ST as indicated in the GRACE Registry, but also in those with ST segment elevation. (3) A justification for the major renal dysfunction in women is probably the inclusion of the selection bias of the clinical trials that in general only admit patients with normal renal function and thus reflect data from the real world.

As commented by Dr. Salvati, a weakness in our study has been to include patients with both acute coronary syndrome with ST-segment elevation and without ST-segment elevation. While this turns the population somewhat heterogenic and small and the outcomes not so relevant, these data were included in the limitations of the work; previous registries (2, 4) have already shown data from similar populations. Most of them agree that women receive less therapies, like elective coronary revascularization with angioplasty, aspirin, agents IIb-IIa, heparin, and statins, and that this could contribute to differences in gender. (2, 5)

Dr. Stella Maris Macín, M.D.

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