North Coast Physician

In This Issue:

Cover Photo
"LOG POND"
Stephen Kamelgarn, M.D.

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication. hdncms@sbcglobal.net

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E-Mail: hdncms@sbcglobal.net Web page: *www.hdncms.org*

An Awesome Responsibility

Theodore M. Mazer, M.D.

Leading the California Medical Association (CMA) is an awesome responsibility – one that includes representing physicians in the battles medicine faces in California and nationally; promoting policies that protect our patients, our practices and our ability to care for our communities; and preventing regulations that contribute to the ever-increasing problem of burnout among physicians that is resulting in early retirement or career change, frustrations and even suicide.

I believe all physicians are responsible to protect the profession of medicine in the present and for the future. And no one can do that alone. We can do it as a team, listening to our colleagues, especially where their insights and needs differ from ours. I am so encouraged by talking to our medical students and young physicians, with their fresh ideas and outlooks, dedicated to the future of patient care.

One of those students, Cecelia Bonaduce-Leggett, put it well when asked why busy medical students would get involved with medical politics, saying: "We believe the future of medicine should have a say in the future of medicine." If only those who want to tell us how to practice our profession could take a leaf from her book! Listening to those actually practicing medicine to inform public policies for the future.

Fulfilling our mission "to promote the science and art of medicine, the care and wellbeing of patients, the protection of the public health and the betterment of the medical profession," we must advocate for physicians as professionals, enabling us to do what is right for our patients. To support the supremacy of the physician-patient relationship, which allows the unfettered sharing of intimate information and decision making, aware of but unhindered by purely economic factors. We must support physicians in all specialties and modes of practice, so that patients can choose to receive care in whatever forum best suits them.

Every idea starts with one person. The scholar Hillel said that a single candle can light a thousand other candles without diminishing itself. Each of us is such a candle. Each can inspire others to resist forces that impede our ability to care for patients, and each can promote positive changes. Each of us can encourage our colleagues to join us, whether actively or simply as members supporting our efforts. Our actions are for all physicians, and no one should be a bystander.

I look forward to working hard this year on your behalf. I know that when we work together to find common ground on issues and solutions, regardless of specialty or mode of practice, we build an even stronger CMA, and prove the whole greater than the sum of its parts. ***§***

NEW HEALTH LAWS 2018: ARE YOU READY?

The California Legislature had an active year, passing many new laws affecting health care—with a strong focus on health care coverage, drug prescribing, public health and workers' compensation issues.

The California Medical Association has published a summary of the most significant new health laws of interest to physicians. For more details, see "Significant New California Laws of Interest to Physicians for 2018." *http://www.cmanet.org/files/assets/news/2018/01/new-laws-2018-long.pdf* OR contact the Medical Society for a copy of the report, hdncms@sbcglobal.net

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Like to Write?

Editorial and Publications Committee is looking for members who are interested in writing and helping to develop Medical Society member communications, directories, etc. Meetings are held quarterly at the Medical Society office. PLEASE let us know.

Keep Post-Stent Patients on Aspirin for Noncardiac Surgery

Andrew D. Michaels, MD

Over the past 7.5 seven years in Humboldt County, I have seen half of the STEMI patients in this area who survive to the emergency room. Coronary artery disease, including STEMI, patients cut across all socioeconomic demographics, affecting a wide range of patients with respect to age, gender, and general health status. The vast majority of these patients typically survive their coronary event, and go on to have many, many years of ongoing medical care. What to do with their antiplatelet therapy, around the time of noncardiac surgery, is an important decision regarding their medical care.

Two recent cases highlight the risks of holding aspirin in patients undergoing noncardiac surgery. LC is a 64 year-old man with history of three-vessel percutaneous coronary intervention (PCI) in 2007. He was instructed to hold his aspirin five days prior to elective screening colonoscopy by his surgeon. One day after the colonoscopy, he developed crushing chest pain. He presented to the local emergency room with an acute anterior STEMI. Emergency coronary angiography demonstrated an acute proximal left anterior descending occlusion, not near one of his prior stents. He underwent successful stenting of the vessel, and did well clinically.

JP is a 57 year-old man with left circumflex bare metal stenting in 2015, when he had an acute NSTEMI. He was instructed by his orthopedic surgeon to hold aspirin two weeks prior to elective knee surgery. Post-operatively, he was on Lovenox daily for two-weeks, but not restarted on aspirin. Two weeks after knee surgery, he developed severe chest pain. He was diagnosed with an acute anterior STEMI. Coronary angiography demonstrated acute occlusion of the proximal left anterior descending coronary artery. His prior left circumflex stent looked fine. He did well with left anterior descending coronary artery stenting, and was restarted on dual-antiplatelet therapy.

While holding aspirin is reasonable for patients without established cardiovascular disease, those with a prior history of cardiovascular disease in general should stay on aspirin during the perioperative period for noncardiac surgery.

The POISE-2 (Perioperative Ischemic Evalution) Trial evaluated the role of perioperative aspirin in patients undergoing noncardiac surgery (Devereaux P, et al. NEJM 2014; 370: 1494-503). They randomized 10,010 patients to aspirin (200 mg within four hours of surgery and continued at 100 mg daily for 30 days) versus placebo undergoing noncardiac surgery. There was no benefit with respect to myocardial infarction or death, but it did increase bleeding risk.

The POISE-2 investigators more recently published the substudy results focusing on the 470 patients with prior coronary stenting (Graham MM, et al. Ann Intern Med, epub November 14, 2017). The median duration from PCI to noncardiac surgery was 64 months (range 34-113 months). The 30-day outcome of death or myocardial infarction was 50% higher when aspirin was withheld in the peri-operative period. The absolute risk of major and life-threatening bleeding was 0.8% higher when aspirin was continued perioperatively.

This substudy provides important information on the risks of aspirin discontinuation in the perioperative period in patients with a history of prior stenting. As a patient goes more than 3-6 months out from a stent procedure, withholding aspirin increases the risk of a myocardial infarction. The coronary events invariably involve a different coronary occlusion, and are not related to the prior stent. Patients with a prior coronary stent are at higher risk for future myocardial infactions, and continued antiplatelet and hyperlipidemic therapy significantly reduce that risk.

For every 1,000 patients with a prior history of PCI undergoing noncardiac surgery, perioperative aspirin would prevent 59 myocardial infarctions but cause eight major/life-threatening bleeds, according to this POISE-2 substudy. Aspirin is likely to provide more benefit than harm to these patients.

In the DAPT (Dual Antiplatelet Therapy) Study, there was an increased risk of thienopyridine (i.e., clopidogrel, prasugrel, ticagrelor) discontinuation after PCI, with an early increase in myocardial infarction risk (Stefanescu SAC, et al. Circulation 2017; 135: 1720-32). This risk was unrelated to stent thrombosis. This raises issues when antiplatelet therapy is held prior to a surgical procedure. These issues increase the importance of aspirin continuation if thienopyridine therapy is interrupted for noncardiac surgery.

This issue probably comes up most

"Stent", Continued on Pg. 16

Something on your mind? Want to share your thoughts with your colleagues? Please send those thoughts for publication in the North Coast Physician or if you're insecure about your ability to write - let us help you.

"Stent", Continued From Pg. 5

frequent with colonoscopy. For patients undergoing colonoscopic polypectomy, the overall risk of postpolypectomy bleeding is <0.5%. Risk factors for postpolypectomy bleeding include large polyp size and anticoagulant use, especially warfarin and thienopyridines (P2Y12 platelet inhibitors). For patients who do not stop aspirin or other NSAIDs prior to colonoscopy, the rate of postpolypectomy bleeding is not significantly different from those who do not take those medications (Feagins LA. Am J Med 2017; 130: 786-95). In a meta-analysis, aspirin and NSAIDS were not a risk factor for immediate post-polypectomy bleeding but did increase the risk of delayed post-polypectomy bleeding (Pigo F, et al. Dig Liver Dis 2017; S1590-8658: 31256-2). For patients who continue P2Y12 inhibitors and undergo polypectomy, the risk of delayed postpolypectomy bleeding is approximately 2.4%.

Based on these data, continuing low-dose aspirin uninterrupted during colonoscopy provides the greatest overall risk reduction for patients with prior PCI. It would be reasonable to extrapolate this data to patients with prior bypass surgery as well.

Key Points:

1. For patients without a prior history of coronary stenting, holding antiplatelet therapy five days prior to noncardiac surgery is reasonable (based on the POISE-2 trial results). Holding aspirin more than five days prior to noncardiac surgery is not necessary: these long holds do not change the bleeding risk, but may increase the ischemic risk when off antiplatelet therapy.

2. For those with recent coronary stenting within the prior six months, consult with the treating interventional cardiologist regarding antiplatelet therapy around the time of noncardiac surgery.

3. For patients with prior coronary stenting more than six months earlier, continue aspirin 81mg daily without any interruption around the time of noncardiac surgery. If they are on a P2Y12 platelet antagonist, these can generally be held five days prior to surgery, and restarted post-operatively.

4. For surgeries with a higher risk of bleeding complications, including urologic and neurosurgical procedures, consult the treating interventional cardiologist regarding perioperative antiplatelet therapy. §

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HELP SUPPORT LOCAL EDUCATION - BE A CONSORTIUM MEMBER

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ttaylor_hdncms@sbcglobal.net

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