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Letter to the Editor

Predictive Value of the SYNTAX Score in Culprit and Nonculprit Vessel Disease. Response

Valor predictivo de la puntuación SYNTAX en la lesión vascular culpable y no culpable. Respuesta

To the Editor,

We read with great interest the Letter to the Editor by Levent Cerit regarding the article "Multivessel Versus Culprit-only Percutaneous Coronary Intervention in ST-segment Elevation Acute Myocardial Infarction: Analysis of an 8-year Registry".[1] As the author points out, there are several reasons that might explain the worse prognosis of patients with ST-elevation acute myocardial infarction and multivessel coronary disease, especially when they have a high SYNTAX score. The burden of anatomic coronary atherosclerosis, whether obstructive or nonobstructive, is likely to be associated with more subclinical atherosclerotic lesions that may rupture and cause an adverse clinical outcome.[2,3] In patients with ST-elevation acute myocardial infarction and multivessel disease who undergo primary percutaneous coronary intervention of the culprit artery, quantification of the remaining coronary artery disease by the residual SYNTAX score may help to identify patients who are at increased risk for adverse events.[4] Indeed, in our population, the residual SYNTAX score was an independent predictor of major acute cardiovascular events and all-cause mortality during follow-up; these data have been submitted for publication.

Presently, there is no consensus regarding the management of nonculprit lesions after primary-primary percutaneous coronary intervention. The definition of a score, including anatomic complexity of residual disease, to identify patients who will clearly benefit from multivessel revascularization is desirable, although probably utopic. There are still many questions that need clarification: considering patient, operator and lesion specificities, is standardization possible? Should we treat ischemic lesions, vulnerable plaques or both? Should vulnerable patients (eg, those with left ventricular dysfunction, renal disease, or diabetes) be treated more aggressively?

Until we have an evidence-based strategy, clinical judgement based on Heart Team discussion should be pursued in patients with ST-elevation acute myocardial infarction and complex multivessel disease.

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