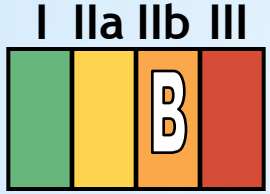
Revascularization to Improve Survival: Left Main CAD Revascularization



PCI to improve survival may be reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD); and 2) clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate-severe chronic obstructive pulmonary disease, disability from previous stroke, or previous cardiac surgery; STS-predicted risk of operative mortality >2%).

Revascularization to Improve Survival: Left Main CAD Revascularization

PCI to improve survival should not be performed in stable patients with significant (≥50% diameter stenosis) unprotected left main CAD who have unfavorable anatomy for PCI and who are good candidates for CABG.

Revascularization to Improve Survival: Non Left Main CAD Revascularization

CABG to improve survival is beneficial in patients with significant (≥70% diameter) stenoses in 3 major coronary arteries (with or without involvement of the proximal LAD artery) or in the proximal LAD plus 1 other major coronary artery.

Revascularization to Improve Survival: Non Left Main CAD Revascularization

CABG

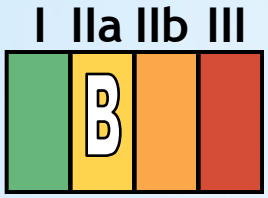
I IIa IIb III

PCI

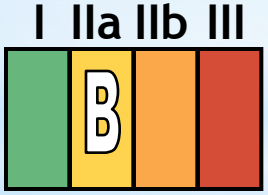
I IIa IIb III

CABG or PCI to improve survival is beneficial in survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia caused by a significant (≥70% diameter) stenosis in a major coronary artery.

Revascularization to Improve Survival: Non-Left Main CAD Revascularization

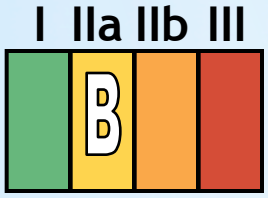


CABG with a LIMA graft to improve survival is reasonable in patients with a significant (≥70% diameter) stenosis in the proximal LAD artery and evidence of extensive ischemia.



It is reasonable to choose CABG over PCI to improve survival in patients with complex 3-vessel CAD (e.g., SYNTAX score >22) with or without involvement of the proximal LAD artery who are good candidates for CABG.

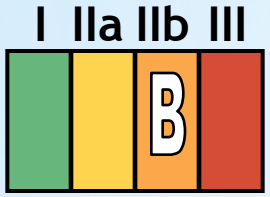
Revascularization to Improve Survival: Non Left Main CAD Revascularization



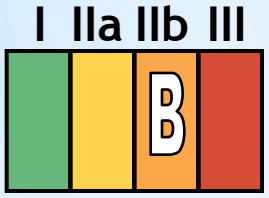
CABG is probably recommended in preference to PCI to improve survival in patients with multivessel CAD and diabetes mellitus, particularly if a LIMA graft can be anastomosed to the LAD artery.

The usefulness of CABG to improve survival is uncertain in patients with significant (≥70%) stenoses in 2 major coronary arteries not involving the proximal LAD artery and without extensive ischemia.

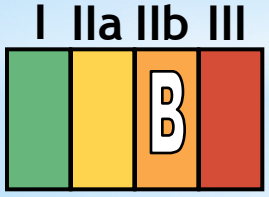
Revascularization to Improve Survival: Non Left Main CAD Revascularization



The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease.



CABG might be considered with the primary or sole intent of improving survival in patients with SIHD with severe LV systolic dysfunction (EF<35%) whether or not viable myocardium is present.

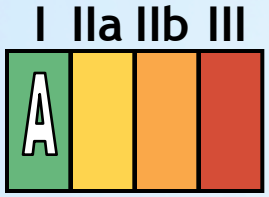


The usefulness of CABG or PCI to improve survival is uncertain in patients with previous CABG and extensive anterior wall ischemia on noninvasive testing.

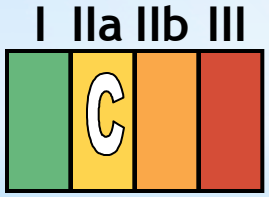
Revascularization to Improve Survival: Non Left Main CAD Revascularization

CABG or PCI should not be performed with the primary or sole intent to improve survival in patients with SIHD with 1 or more coronary stenoses that are not anatomically or functionally significant (e.g., <70% diameter non-left main coronary artery stenosis, fractional flow reserve >0.80, no or only mild ischemia on noninvasive testing), involve only the left circumflex or right coronary artery, or subtend only a small area of viable myocardium.

Revascularization to Improve Symptoms



CABG or PCI to improve symptoms is beneficial in patients with 1 or more significant (≥70% diameter) coronary artery stenoses amenable to revascularization and unacceptable angina despite GDMT.



CABG or PCI to improve symptoms is reasonable in patients with 1 or more significant (≥70% diameter) coronary artery stenoses and unacceptable angina for whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences.