Beta-blocker Use After an Acute Coronary Syndrome. Which One, in Whom, and for How Long? Response

Tras un síndrome coronario agudo, ¿qué bloqueador beta se debería dar, a quién y cuánto tiempo? Respuesta

To the Editor,

We would like to thank Cordero et al. for their comments, because they communicated certain doubts about the compactness of our work, offering the opportunity to clarify them now.

Firstly, the context of stable coronary artery disease is different from acute coronary syndrome. Although they are 2 different stages of the same disease, the clinical and therapeutic implications are different, and therefore the results from one setting cannot be generalised to the other.

Secondly, in the setting of acute coronary syndrome, the time when beta-blockers are introduced and their route of administration must be differentiated. The use of intravenous beta-blockers in the hyperacute phase is a matter of question, particularly for patients with haemodynamic instability. Therefore the meta-analysis referred to in the letter from Cordero et al. must be interpreted with caution, because while it is true that no mortality benefit was found with beta-blockers, this was based on a meta-analysis in which more than 90% of patients were from the COMMIT clinical trial (effect of intravenous metoprolol in the early phase).

Thirdly, based on recent evidence from the era of percutaneous coronary intervention, with the exception from the data from the J-Cypher registry in less than 1000 patients, other clinical trials that evaluated the prescription of oral beta-blockers on discharge from hospital after acute coronary syndrome have demonstrated a prognostic benefit in total mortality with this medication, including in the subgroup of patients with preserved left ventricular systolic function.

Lastly, we must correct a small error in the cited rate of intervention from the DIOICES registry: from the 81% that Cordero et al. referred to, it was 65.6% (60.7% percutaneous coronary intervention and 4.9% aortocoronary revascularisation surgery), figures which are even lower than the CardioCHUS registry (69.7% percutaneous coronary intervention and 4.6% aortocoronary revascularisation surgery), which, if anything, reinforces our results even more.

Therefore, we communicate our defence of the use, unless contraindicated, of oral beta-blockers (in particular carvedilol, bisoprolol, and metoprolol) after acute coronary syndrome in all patients, including those with preserved left ventricular systolic function, knowing that in this group the evidence is limited to observational studies and propensity score analysis.

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