

CABG Star Rating Coming to a Web Site Soon

BY MITCHEL L. ZOLER

FORT LAUDERDALE, FLA. — Later this year, coronary bypass patients will start steering their surgeon choices by the stars. A one-to-three star rating system for cardiac surgeons developed by the Society for Thoracic Surgeons will appear on a Consumer Reports Web site, probably beginning in June.

In a bold step toward getting outcomes-based rankings of surgeons out to the public in a user-friendly format, the society teamed with the Consumers Union, publisher of Consumer Reports, to disseminate rankings of U.S. programs offering coronary artery bypass grafting (CABG). The data come from the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database, which gathers surgery and outcomes data from about 90% of practicing U.S. cardiac surgeons. The ranking will be posted at www.consumerreports.org/health.

The STS leadership is soliciting formal consent from each of its practicing U.S. members; the process requires a physician's consent to place ratings for the practice on the site. The STS leadership first introduced the concept to its members last September, and since then has steadily promoted the idea. As of late January, almost 100 practices had signed releases, nearly 10% of the roughly 1,000 U.S. cardiac surgery practices that perform CABG. The society's immediate goal is to have at least 300 consents on file by mid-March to ensure a robust start. Once that foundation exists, additional participation will likely follow, said Dr. Frederick L. Grover, chairman of the STS council on quality, research, and patient safety and a recent former president of the group.

Each participating practice will receive star ratings in five categories: overall bypass surgery performance, patient survival, avoidance of complications, the extent to which the CABG program fol-

lows recommended surgical practice, and the extent to which recommended medications are used. Performance of each practice in these categories undergoes risk adjustment and assessment as a ratio of observed relative to expected performance. Performance is then ranked relative to all other practices. Grading will be scaled so that most practices fall into the middle range and receive two stars, while high-level performers will get three stars and the bottom tier receives one star, said Dr. Grover, professor and chairman of surgery at the University of Colorado, Denver.

The STS began contemplating public release of its data this way about a year ago, and contacted Consumers Union to flesh out a strategy. The effort shifted into a higher gear last summer when the STS leadership heard from other consumer groups that were planning their own release of CABG outcomes ratings based on administrative claims data, a

source that the STS considers much less reliable than its own database. Those contacts prompted the society to speed development and the timing of the roll-out of its own project, Dr. Grover said in an interview.

In addition to giving the public information it likely wants, a second goal is to further spur surgeons who lag behind the field to improve. "If a program is at one star, hopefully it won't be for more than 1 year. The whole idea is to raise the bar for everyone," he said.

"We think it's in the best interests of patients and our members," Dr. Grover said. "It has risk, no doubt about it. Our members are obviously taking chances" by having the relative performance of their surgical practice and outcomes so openly displayed. "It will be interesting to see if it changes referral patterns."

The society's bottom line is that "the public has the right to know how we're doing," Dr. Grover added. ■

Major Trial of Catheter Ablation for AF Underway

BY BRUCE JANCIN

SNOWMASS, COLO. — The large multicenter CABANA trial, now recruiting, may be the last and best chance to learn if maintaining sinus rhythm confers a survival advantage over rate control in patients with atrial fibrillation.

CABANA (Catheter Ablation Versus Antiarrhythmic Drug Therapy for Atrial Fibrillation) is randomizing roughly 3,000 patients with all types of symptomatic atrial fibrillation—paroxysmal, persistent, and long-standing persistent—to left atrial catheter ablation, antiarrhythmic drug therapy, or rate control medication. The primary end point will be total mortality with at least 2 years of follow-up.

Patients with atrial fibrillation (AF) should be encouraged to enroll in this trial; it's a chance to receive catheter ablation as first-line therapy, should they be randomized to that study arm. In contrast, current clinical practice is generally to reserve ablation therapy for patients who have failed at least one antiarrhythmic drug, Dr. Roger A. Winkle noted at a conference sponsored by the American College of Cardiology.

Catheter ablation as definitive treatment for AF has evolved over a relatively short time from an experimental procedure to an important therapeutic option that provides cure or significant palliation in the majority of patients, with acceptable complication rates at high-volume centers with experienced providers. The results are "vastly superior"

to antiarrhythmic drug therapy in terms of maintenance of sinus rhythm, improvement in quality of life, and reduction of symptoms. That's why CABANA employs ablation as state-of-the-art rhythm control therapy in a showdown against rate control and antiarrhythmic drugs, explained Dr. Winkle, director of electrophysiology at Sequoia Hospital, Redwood City, Calif.

Maintaining sinus rhythm should reduce stroke risk, avoid the side effects of long-term anticoagulation, and improve survival. However, "all of the studies of rate versus rhythm control with the medications we currently have available have been neutral. It's possible that we can't show a beneficial effect of sinus rhythm because we really don't have agents that keep most people in sinus rhythm. Or alternatively, the current antiarrhythmic drugs and warfarin therapy that we use may cause enough harm to offset the benefits of being in sinus rhythm. We just don't have the answer to that," the cardiologist said.

Secondary end points in the CABANA trial include AF recurrence, stroke, quality of life, and cost effectiveness. The principal investigator is Dr. Douglas L. Packer of the Mayo Clinic, Rochester, Minn. Participating sites are well distributed geographically across the United States (www.cabanatrial.org). ■

Disclosures: The trial is funded by St. Jude Medical, Biosense Webster, and the National Heart, Lung, and Blood Institute. Dr. Winkle reported having no relevant financial interests.

Early AF After Cardiac Surgery Predicts Late Recurrence

BY MITCHEL L. ZOLER

ORLANDO — Development of new-onset atrial fibrillation soon after cardiac surgery presents a sharply increased risk for also having atrial fibrillation several years later, as well as significantly worse long-term survival, according to a study of more than 500 patients.

"Aggressive preventive measures should be applied, especially for patients undergoing cardiac surgery who are at high risk for postoperative atrial fibrillation," Dr. Rowlen M. Melduni said at the annual scientific sessions of the American Heart Association.

"Atrial fibrillation is a symptom, not a disease. It's a marker of underlying cardiovascular disease," said Dr. Melduni, a cardiologist at the Mayo Clinic in Rochester, Minn.

To examine the long-term consequences of early AF after cardiac surgery, Dr. Melduni and his associates studied 534 patients from Olmsted County, Minn. The patients, who had no history of AF prior to surgery, underwent coronary bypass surgery, valve surgery, or both between January 2000 and December 2005. Their average age was 66 years, and 70% were men. During the first 30 days after surgery, 37% developed AF, an incidence rate consistent with several prior reports.

During follow-up, which lasted an average of 4 years, the cumulative occurrence of late AF—defined as episodes occurring

more than 30 days following surgery—was 51% in patients who had early AF after cardiac surgery and 13% in patients who did not, a significant difference. The average time from surgery to the appearance of late AF was 2.5 years.

In a multivariate analysis, independent risk factors for developing late AF were having early AF after cardiac surgery, which boosted the risk fivefold; undergoing combined bypass and valve surgery, which raised the risk nearly threefold; and developing postoperative renal dysfunction with a serum creatinine level greater than 2 mg/dL, which doubled the risk. This model adjusted for other potential variables such as age, gender, and treatment with a beta-blocker at hospital discharge.

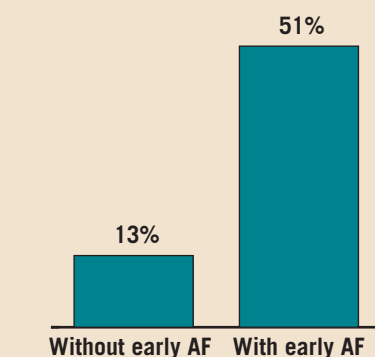
During follow-up, the cumulative survival rate was 60% in patients who had early AF and 78% in those without early AF, a significant difference.

The duration of early AF was also an independent determinant of long-term risk. Patients whose early AF persisted for 3 or more days had twice the risk for late AF as did those with early AF lasting less than 3 days, Dr. Melduni said.

Results from a second study presented by Dr. Melduni in a poster at the meeting documented that patients who developed early postoperative AF often had high left ventricular end diastolic pressure. ■

Disclosures: None.

Later Atrial Fibrillation More Likely in Patients With Early AF



Note: Based on data from a study of 534 cardiac surgery patients.
Source: Dr. Melduni