

Treatment of Coronary Artery Disease using Arteriography alone can result in the introduction of treatment errors.

Richard Fleming, PhD, MD, JD; Matthew R Fleming, BS, NRP | FHHI-OI-Camelot; Eastern Virginia Medical School **Tapan K Chaudhuri, MD (EVMS)**

The decision to treat coronary artery disease (CAD) using PCI, CABG or medical management in many instances is fundamentally determined by the qualitative interpretation of the extent and severity of coronary artery lumen disease [1] present in a given patient.

As previously established, this qualitative interpretation from coronary arteriography results in the over estimation of narrowing of the coronary lumen, when greater than 50%DS is present and the under estimation of the extent of coronary lumen narrowing when less than 50%DS is present [2]. The consequences of this approach results in a biased decision making process yielding less than desired results [2].

The fundamental understanding that CAD is an inflammatory process which builds up in the walls (tissue) of the coronary arteries impairing coronary blood flow long before lumen narrowing occurs demonstrates another concern when treatment decisions are based solely upon anatomic changes within the coronary lumen [3-5].

The trends in characteristics and outcomes discussed [6] reveal the continued misunderstanding of the fundamental pathophysiology of inflammatory CAD, and the failure to quantitatively measure the impact of that inflammatory process [7], thus resulting in continued treatment errors - increasing medical costs without demonstrable improvements in outcomes.

References:

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