Safety and Efficacy of Implementing a Multidisciplinary Heart Team Approach for Revascularization in Patients With Complex Coronary Artery Disease
An Observational Cohort Pilot Study

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**Importance** Since the advent of transcatheter aortic valve replacement, the multidisciplinary heart team (MHT) approach has rapidly become the standard of care for patients undergoing the procedure. However, little is known about the potential effect of MHT on patients with coronary artery disease (CAD).

**Objective** To determine the safety and efficacy of implementing the MHT approach for patients with complex CAD.

**Design, Setting, and Participants** Observational cohort pilot study of 180 patients with CAD involving more than 1 vessel in a single major academic tertiary/quaternary medical center. From May 1, 2012, through May 31, 2013, MHT meetings were convened to discuss evidence-based management of CAD. All cases were reviewed by a team of interventional cardiologists and cardiac surgeons within 72 hours of angiography. All clinical data were reviewed by the team to adjudicate optimal treatment strategies. Final recommendations were based on a consensus decision. Outcome measures were tracked for all patients to determine the safety and efficacy profile of this pilot program.

**Exposures** Multidisciplinary heart team meeting.

**Main Outcomes and Measures** Thirty-day periprocedural mortality and rate of major adverse cardiac events.

**Results** Most of the patients underwent percutaneous coronary intervention (PCI) or coronary artery bypass grafting (CABG); a small percentage of patients underwent a hybrid procedure or medical management. Incidence of 30-day periprocedural mortality was low across all groups of patients (PCI group, 5 of 64 [8%]; CABG group, 1 of 87 [1%]). The rate of major adverse cardiac events during a median follow-up of 12.1 months ranged from 12 of 87 patients (14%) in the CABG group to 15 of 64 (23%) in the PCI group.

**Conclusions and Relevance** Outcomes of patients with complex CAD undergoing the optimal treatment strategy recommended by the MHT were similar to those of published national standards. Implementation of the MHT approach for patients with complex CAD is safe and efficacious.

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The concept of a multidisciplinary care team is not new within the field of medicine. The concept is well established in the fields of oncology and solid-organ transplantation.13 Within cardiovascular medicine, it is an established entity in the management of heart failure3,4 and congenital heart disease5,6 in the pediatric and adult populations and is becoming the standard of care in randomized clinical trials involving complex cardiac conditions.7-9 Within the subspecialty of coronary revascularization, during the conduct of randomized clinical trials, a dedicated multidisciplinary heart team (MHT) has been used successfully.10,11 Despite the successful implementation in randomized clinical trials and the recommendation of the latest practice guidelines that the MHT approach be incorporated into clinical practice, the current literature suggests that decision making regarding treatment modalities in patients with coronary artery disease (CAD) is often not based on empirical evidence and is subject to operator bias. In a review of New York cardiac catheterization registry data for patients who met indications for coronary artery bypass grafting (CABG) and percutaneous coronary intervention (PCI), 93% were referred for PCI, 2% for medical management, and only 5% for CABG.12

With this issue in mind, MHT cooperation should provide a balanced approach toward designing the optimal revascularization strategy for a given patient, taking into account patient preference, coronary anatomy, and clinical comorbidities. Implementation of the MHT approach creates transparency, ensures appropriate adherence to established societal guidelines, and provides the most objective recommendations while minimizing the influence of individual biases. The approach provides a way for cardiac surgeons and cardiologists to share the burden of decision making and outcomes. Such collaboration fosters an environment of teamwork, collegiality, and bidirectional exchange of knowledge that benefits all involved parties but most importantly the patient. Despite these benefits, the exact nature of the safety and benefits of the MHT approach for coronary revascularization requires further study and description.

In an effort to provide an individualized and unbiased approach to complex coronary disease, we instituted an MHT in May 2012 at the Heart and Vascular Institute of the University of Pittsburgh Medical Center, Presbyterian Hospital. Within this structured format, a previous report13 demonstrated successful feasibility of implementing an MHT approach for patients with complex coronary disease. The aims of our present study are to demonstrate the safety and efficacy of the MHT approach for patients with complex CAD and to evaluate the midterm outcomes of these patients in an observational cohort study.

Method

Patient Population

This study was approved by the institutional review board of the University of Pittsburgh Medical Center, and informed consent was waived. From May 1, 2012, to May 31, 2013, all patients who underwent left-sided catheterization and met the following criteria were included in the study: (1) unprotected left main CAD; (2) 3-vessel CAD; (3) 2-vessel CAD involving the proximal left anterior descending artery; (4) CAD in the proximal left anterior descending artery in patients with diabetes mellitus; and (5) any other complex CAD in which the initial treating physician believed that revascularization could be performed reasonably using a percutaneous or a surgical approach.

Exposure

Since May of 2012, MHT meetings were convened each business weekday at 7 AM to include a board-certified attending physician from various specialties. At a minimum, cardiac surgery and intervention cardiology were represented. Details of the MHT structure and its implementation have been described previously13 and include detailed patient history, risk factors, frailty, review of coronary angiograms, and calculation of important risk scores, such as the SYNTAX (Synergy Between PCI With Taxus and Cardiac Surgery) score and the Society of Thoracic Surgeons risk score for mortality and morbidity.14 The MHT recommendation was adjudicated with the appropriateness for coronary revascularization based on the appropriate use criteria for revascularization and individual patient comorbidities.14 Novel innovative approaches to coronary revascularization, such as hybrid procedures involving minimally invasive CABG followed by staged PCI during the same hospitalization, were discussed during the MHT meeting when anatomically feasible and adjudicated on an individual case basis after thorough discussion with the patient regarding the advantages and disadvantages of the hybrid procedure vs other standard therapeutic options.

Outcome Measures

The safety and efficacy of MHT were evaluated by 30-day peri-procedural mortality and midterm major adverse cardiac cerebrovascular events during the median follow-up of 12.1 months. Major adverse cardiac cerebrovascular events were defined as death from any cause, the need for a second myocardial revascularization, myocardial infarction, congestive heart failure, angina, or stroke. Electronic medical records of each patient were reviewed manually.

Results

A total of 180 patients were included in this pilot study. Nearly half of the cohort (87 patients [48%]) underwent CABG, whereas PCI (64 [36%]), a hybrid procedure (3 [2%]), or medical therapy alone (26 [14%]) were recommended for the remainder of the patients (Table). Not surprisingly, patients for whom maximum medical therapy was recommended tended to have more complex coronary artery lesions and lower ejection fractions and to be older. Patients with a significantly elevated predicted pre-operative risk for mortality according to the Society of Thoracic Surgeons criteria15 were usually adjudicated to undergo PCI or medical therapy alone for their complex CAD.

The 30-day mortality rate for the study cohort ranged from 0 to 12% (Figure 1). During the median follow-up of 12.1 months, the incidence of major adverse cardiac cerebrovascular events for the study cohort ranged from 0 to 23% (Figure 2).
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An effective MHT program facilitates access to comprehensive care, while acknowledging the safety and efficacy of direct myocardial protection (DMP) for patients with severe aortic stenosis. Additional limitations include the study's focus on a single institution and the need for prospective randomized trials to confirm these findings. Overall, this study highlights the potential benefits of an MHT program for patients with complex CAD, emphasizing the importance of interdisciplinary collaboration and evidence-based decision-making.