

National Data on Spontaneous Coronary Artery Dissection

Datos nacionales en disección coronaria espontánea

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Ischemic heart disease, particularly acute myocardial infarction, remains one of the leading causes of morbidity and mortality worldwide. Although atherosclerosis is the most common underlying etiology, other less prevalent conditions may also trigger acute coronary syndrome (ACS). Among these, spontaneous coronary artery dissection (SCAD) represents a significant cause, especially in certain patient populations. (1)

Although coronary angiography remains the gold standard diagnostic method, the development and increasing availability of intracoronary imaging techniques, such as intravascular ultrasound (IVUS) and optical coherence tomography (OCT), have significantly improved diagnostic accuracy and enabled more appropriate treatment guidance. (2) However, given that these intracoronary imaging techniques are not always available or routinely used, SCAD remains a potentially underdiagnosed condition, with heterogeneous epidemiological registries. (3)

In our country, multicenter registries allowing adequate characterization of this condition have not been available to date, and the national literature mainly consists of isolated clinical case reports. (4) In this context, the registry published by Rodríguez Arias et al. represents a particularly relevant initiative, as it constitutes the first multicenter registry including both public and private centers. (5)

Consistent with international registries, this cohort shows a higher frequency of SCAD in young women, generally with few or no traditional cardiovascular risk factors. Likewise, the most common clinical presentation was non-ST-segment elevation acute coronary syndrome (NSTEMI-ACS), with the left anterior descending artery being the most frequently affected vessel.

Regarding treatment, the available evidence suggests that the therapeutic approach should be customized according to the patient's clinical presentation and coronary anatomy. A conservative approach is generally recommended, with revascularization

reserved for specific situations such as persistent ischemia, hemodynamic instability, malignant ventricular arrhythmias, or involvement of the left main coronary artery (LMCA). In these scenarios, percutaneous coronary intervention is the primary revascularization approach, whereas coronary artery bypass grafting is reserved for specific cases such as LMCA dissection or extensive multivessel disease. Consistent with these recommendations, most cases derived from the registry were managed conservatively, with percutaneous coronary intervention involving stent implantation being performed in 46.1% of cases.

Although this registry includes a limited number of patients, its findings are consistent with international reports and represent a starting point for further advancing the understanding of this condition in our setting. Several clinical questions remain, particularly regarding the optimal duration of dual antiplatelet therapy, the potential role of anticoagulation, the indications for statin therapy and their therapeutic targets, as well as the strategies for clinical and imaging follow-up and the recommendations regarding physical activity.

In conclusion, this study is a valuable initiative for clinical and interventional cardiology in our country, as it not only allows our experience to be contextualized in relation to international registries but also represents an important step in further characterizing an uncommon but clinically relevant condition.

Ethical considerations

Not applicable.

Conflicts of interest

None declared.

(See authors' conflict of interests forms on the web).

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AUTHORS' REPLY

Dear Dr. Llano

Thank you for your interest in the article by Rodríguez Arias et al. This work represents an initial effort by independent researchers to understand the characteristics of this condition in our country and the incidence of spontaneous coronary artery dissection (SCAD) in acute coronary syndromes. (1)

The pilot registry revealed a significant variation in the understanding of SCAD pathophysiology among cardiologists. This variation was reflected in the lack

of consensus on SCAD diagnosis and management, as well as in the variability of antiplatelet therapy types and duration for these patients.

This pilot study enabled the development of the Argentine Registry of Spontaneous Coronary Dissection (DISCAR), which will begin in 2026 and will collect nationwide data on this condition. The DISCAR registry will use the support tools provided by the Research Area of the Argentine Society of Cardiology, and all public and private institutions in Argentina will be eligible to participate.

Likewise, we expect that the DISCAR registry will allow us to evaluate the use of intravascular imaging in uncertain cases to guide treatment. This will undoubtedly improve outcomes and provide a deeper understanding of the potential mechanisms responsible for SCAD.

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DISCAR Registry

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When the Brain Also Enters the Operating Room

Cuando el cerebro también entra en quirófano

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Postoperative delirium is one of the most frequent and complex complications and, paradoxically, one of the least integrated into routine clinical reasoning. Far from representing a transient or merely behavioral phenomenon, its occurrence is consistently associated with increased mortality, longer hospital stays, higher healthcare costs, persistent functional impairment, and long-term cognitive decline. (1) Despite this, it is still frequently interpreted as an epiphenomenon of surgical stress, more tolerated than anticipated and more treated than prevented.

In this context, the study by Crippa et al., based on data from the ARGENT-CCV national registry, provides robust local evidence on the incidence of postoperative delirium and its independent predictors in patients undergoing cardiovascular surgery. (2) The identification of variables such as prior coronary artery disease, postoperative sepsis, atrial fibrillation, and prolonged mechanical ventilation enables a shift from epidemiological description to clinically meaningful risk stratification, with direct implications for routine clinical practice.

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Beyond its specific findings, the conceptual value of the study lies in reinforcing an integrative view of delirium as an expression of systemic vulnerability. The brain, like the heart or the kidney, responds to surgical trauma through biological mechanisms that include systemic inflammation, endothelial dysfunction, alterations in cerebral perfusion, neurohormonal activation, and loss of cognitive reserve. (3) In this sense, cardiovascular surgery may be understood as a true “biological stress test” capable of revealing previously compensated vulnerabilities.

The association among delirium, sepsis, and postoperative atrial fibrillation is not coincidental. These events share a common inflammatory and hemodynamic substrate, with direct effects on cerebral autoregulation. Similarly, the need for prolonged mechanical ventilation not only indicates greater clinical severity but also sustained exposure to sedatives, complex analgesia, and disruption of the sleep-wake cycle, factors which play a central role in the pathophysiology of delirium. (4)

From a clinical perspective, this study challenges the treating team to broaden the focus of perioperative care. Early identification of high-risk patients requires the implementation of multimodal preventive strategies, including hemodynamic optimization, rigorous infection control, protocolized mechanical ventilation management, systematic assessment of frailty, and structured cognitive monitoring. (4)

In short, the study by Crippa et al. reminds us of an uncomfortable but necessary truth. In contemporary cardiovascular surgery, technical success is no longer measured solely by the patency of a graft or the correction of a valve. The brain also enters the operating room. When delirium occurs, it does not represent an isolated accident but rather the intersection of biology, vulnerability, and the limits of the healthcare model. (2,5) Recognizing it early is not merely an academic exercise; it is a deeper way of caring for the patient.

Ethical considerations

Not applicable.

Conflicts of interest

None declared.

(See authors' conflict of interests forms on the web).

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AUTHORS' REPLY

We sincerely appreciate the comments by Drs. Escalada Lesme and Cabral on our article “Postoperative Delirium in Cardiovascular Surgery: Analysis of Predictive Factors Based on The ARGEN-CCV National Registry,” as well as their careful reading and clinical reflections presented in their letter. We fully agree that postoperative delirium is a complication of major relevance in cardiovascular surgery, not only because of its frequency, but also because of its impact on clinical outcomes, functional recovery, length of hospital stay, and mid- and long-term prognosis.

As the authors of the letter point out, one of the key contributions of our study was the identification of factors associated with clear clinical utility, including prior coronary artery disease, postoperative sepsis, atrial fibrillation, and prolonged mechanical ventilation. We believe that these findings, derived from a national registry, contribute to improved risk stratification and reinforce the need for more systematic monitoring in the perioperative period. In this regard, we agree on the importance of promoting multimodal prevention and monitoring strategies, with particular attention to modifiable postoperative factors.

We also share the view that delirium should not be regarded as an isolated phenomenon but rather as an expression of increased biological vulnerability in patients undergoing cardiovascular surgery. In this regard, early recognition and the implementation of multimodal preventive strategies represent key elements of comprehensive patient care.

We once again would like to thank Drs. Escalada Lesme and Cabral for enriching the discussion of our work and for highlighting a clinical problem that deserves increasing attention in routine clinical practice.

The authors

Lessons from the ARGEN-IAM-ST Registry

Lecciones del registro ARGEN-IAM-ST

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The publication of the analysis by Castillo Costa et al. from the ARGEN-IAM-ST registry is a key tool for identifying opportunities for improvement and growth. (1) Documenting that 7.5% of patients with ST-segment elevation myocardial infarction (STEMI) are admitted after cardiac arrest (CA)—approximately one in thirteen cases—is essential for understanding the complexity of this condition.

However, to interpret this data correctly, we must consider selection bias. The registry captures information from centers affiliated with the Argentine Society of Cardiology (SAC) and the Argentine Federation of Cardiology (FAC), both institutions with an academic profile. In terms of volume, the registry included an average of 682 patients per year. When this data is compared with the estimated national incidence for a population of 46 million inhabitants—between 18 000 and 22 000 STEMI cases per year according to Western epidemiological standards—it becomes clear that only a fraction of the national reality is being captured. This is relevant data because, if mortality in the shock and cardiac arrest subgroup reaches 71% in the most complex centers, it is worth asking what happens in the remaining cases.

From the interventional cardiology perspective, the unfavorable course of these cases despite an adequate overall reperfusion rate (85% in the group with CA) suggests that simply opening the culprit artery is insufficient in the setting of hemodynamic collapse. In high-complexity centers in other countries, the use of advanced mechanical circulatory support (MCS) has begun to improve outcomes in this scenario. The DanGer Shock trial demonstrated that microaxial pump support (Impella) reduced mortality in cardiogenic shock to 45.8% versus 58.5% with standard therapy; a substantial difference compared with our setting, where intra-aortic balloon pump is often the only available resource, if any. (2) However, large-scale implementation of these measures is complex and entails considerable costs for the health system.

Therefore, an initial focus within our healthcare system should be to ensure that all patients receive a

reperfusion rate comparable to those reported in this registry as early as possible. To achieve results similar to those reported in registries such as those of the European Society of Cardiology (ESC), (3) with reperfusion rates above 90%, or the SWEDEHEART registry, where primary percutaneous coronary intervention exceeds 90%, (4) it is imperative to further expand initiative such as Stent-Save a Life!. (5) This involves strengthening myocardial infarction reperfusion networks and the door-to-balloon programs but above all prioritizing the pharmaco-invasive strategy as an effective and equivalent alternative in our setting. In cases of ambulance transfers with prolonged delays or unpredictable logistics that threaten optimal reperfusion times, early thrombolysis should be considered a clinical priority, ensuring early arterial patency and reducing total ischemia time.

This registry and its analysis represent important tools to improve patient outcomes in our setting and constitute a step toward transforming fragmented care networks into a system that prioritizes reperfusion and early referral to high-complexity centers.

Ethical considerations

Not applicable.

Conflicts of interest

None declared.

(See authors' conflict of interests forms on the web).

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AUTHORS' REPLY

We thank Drs. Santilli and García Toro for their valuable comments on our work. Although no national registries currently assess out-of-hospital mortality in acute myocardial infarction (AMI), community-based registries (1) suggest that it is approximately 40%, with severe arrhythmias (ventricular tachycardia [VT] / ventricular fibrillation [VF]) representing the leading cause.

We fully agree with Drs. Pablo Santilli and Sol García Toro that the organization and sustainability of myocardial infarction reperfusion networks, tailored to the characteristics of each community, should be a public health priority in our country.

According to the ARGEN-IAM-ST registry, the largest and most continuously maintained registry in our country, the total ischemia time is prolonged, with a median of 310 minutes (interquartile range [IQR] 185-595) among patients undergoing percutaneous coronary intervention (PCI) and 165 minutes (IQR 90-287) among those treated with fibrinolytics. This likely explains the absence of differences in mortality between the strategies used. (2,3)

The opinion of the treating physicians participating in this registry was unequivocal: delays in initiating a reperfusion strategy occurred in approximately half of the cases (60% among patients undergoing PCI and 62% among those undergoing thrombolysis).

Population education is also essential to reduce delays in seeking care. In the ARGEN-IAM-ST registry, the median delay was 130 minutes (IQR 60-305), with the main causes being the patient's delay in seeking medical assistance (60% of cases) and delays in ambulance arrival (25%). (3)

In this context, public awareness of the basic symptoms of myocardial infarction, training in basic cardiopulmonary resuscitation, and greater availability of automated external defibrillators are of fundamental importance.

Any strategic plan aimed at achieving timely reperfusion in myocardial infarction should be carefully designed to reduce ischemia times and decrease both out-of-hospital and in-hospital mortality. This requires coordinated efforts among all stakeholders involved in the logistics of care, as well as the participation of scientific societies to provide a framework for a comprehensive care strategy.

Víctor Mauro^{MTSAC},
on behalf of the authors

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Ventricular Arrhythmia Alerts in Remote Monitoring: Prognostic Markers or Triggers for Clinical Decision?

Alertas de arritmias ventriculares en la monitorización remota: ¿marcadores pronósticos o disparadores de decisiones clínicas

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Remote monitoring (RM) of cardiac implantable electronic devices has become established as a standard of

care over the past decade. This system enables early detection of arrhythmic events and optimizes follow-

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up of patients with implantable cardioverter-defibrillator (ICD) and cardiac resynchronization therapy with defibrillator (CRT-D). However, debate persists regarding its impact on "hard" clinical outcomes, particularly mortality.

In this context, the study by Guzmán et al., published in the Argentine Journal of Cardiology (RAC), provides relevant real-world evidence by analyzing the prognostic value of ventricular arrhythmia alerts detected through RM in a cohort of patients with ICD and CRT-D. (1) The authors demonstrated that alerts for non-sustained ventricular tachycardia, ventricular tachycardia, or ventricular fibrillation were significantly associated with increased all-cause mortality, with an early and sustained separation of the survival curves. This finding reinforces the concept that remote monitoring provides clinically relevant information, beyond the mere detection of events, reflecting the progression of the underlying heart disease.

A notable aspect of the study is its observational nature and its conduct in a routine clinical practice setting, which allows it to reflect a heterogeneous and complex population, that differs from those typically included in randomized clinical trials. In this regard, the results are consistent with large observational registries, such as the ALTITUDE study, which identified ventricular arrhythmias and defibrillator therapies as adverse prognostic markers. (2) Similarly, previous studies have shown that the occurrence of appropriate shocks is associated with a significant increase in mortality, regardless of the underlying etiology of heart disease. (3)

However, the study also highlights a relevant clinical limitation: in most cases, the detection of ventricular alerts did not lead to substantial changes in therapeutic management. This finding raises a key question for daily practice: is early identification of high-risk patients sufficient if this information is not integrated into a structured intervention strategy?

The true value of RM may lie not only in the generation of alerts, but also in their interpretation within the patient's overall clinical context. Ventricular arrhythmias should act as a trigger for a comprehensive reassessment, including optimization of heart failure therapy, review of device programming, and consideration of advanced strategies such as catheter ablation or multidisciplinary management. (4)

In conclusion, the study by Guzmán et al. reinforces the role of ventricular alerts detected through RM as prognostic markers in patients with ICD and CRT-D. The future challenge is to translate this information into concrete clinical decisions that not only

improve risk stratification but also modify the natural history of the disease, in line with current international consensus recommendations. (5)

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AUTHORS' REPLY

Dear Editor

We thank Drs. Monjes, Zabala, and Camerini for their comments. We agree with their interpretation that the true value of remote monitoring (RM) lies in the clinical response it generates.

Although the alerts were associated with higher mortality, in 60% of cases they did not lead to changes in therapy. This "clinical inertia" does not reflect lack of interest, but rather the absence of structured workflows. While dedicated units exist in many international centers, in our setting RM often relies on individual effort. The disconnection between those who receive the alert (usually the electrophysiologist and fellows in training) and those who manage the underlying disease may hinder timely intervention.

The challenge is to evolve from "technical surveillance" to "proactive clinical management." Alerts should not remain merely prognostic data points, but should instead act as triggers to bridge the gap between remote diagnosis and therapeutic action.

Sincerely,

Juan Pablo Guzmán^{MTSAC}

on behalf of the authors