

2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions

Date Posted:

November 7,
2011

Authors:

Levine GN,
Bates ER,
Blankenship JC,
et al.

Citation:

[*J Am Coll
Cardiol*](#)
[2011;Nov 7](#)

Perspective:

The following are 10 points to remember about these guidelines on percutaneous coronary intervention (PCI):

1. A Heart Team approach to revascularization is recommended in patients with unprotected left main or complex coronary artery disease.
2. PCI to improve survival is reasonable in patients with acute ST-segment elevation myocardial infarction (STEMI) when an unprotected left main coronary artery is the culprit lesion, distal coronary flow is less than TIMI (Thrombolysis In Myocardial Infarction) grade 3, and PCI can be performed more rapidly and safely than coronary artery bypass graft surgery (CABG).
3. PCI with coronary stenting (bare-metal stent [BMS] or drug-eluting stent [DES]) should not be performed if the patient is not likely to be able to tolerate and comply with dual antiplatelet therapy (DAPT) for the appropriate duration of treatment based on the type of stent implanted.
4. Administration of N-acetyl-L-cysteine is not useful for the prevention of contrast-induced acute kidney injury.
5. Primary PCI is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished.
6. The use of radial artery access can be useful to decrease access site complications.
7. An early invasive strategy (i.e., diagnostic angiography with intent to perform revascularization) is indicated in unstable angina/NSTEMI patients who have refractory angina or hemodynamic or electrical instability.

8. Primary PCI should be performed in patients within 12 hours of onset of STEMI and within 90 minutes of first medical contact as a systems goal.

9. DES are useful as an alternative to BMS to reduce the risk of restenosis in cases in which the risk of restenosis is increased and the patient is likely to be able to tolerate and comply with prolonged DAPT.

10. Every PCI program should operate a quality improvement program that routinely: 1) reviews quality and outcomes of the entire program, 2) reviews results of individual operators, 3) includes risk adjustment, 4) provides peer review of difficult or complicated cases, and 5) performs random case reviews and participates in a regional or national PCI registry for the purpose of benchmarking its outcomes against current national norms.

Author(s):

[Debabrata Mukherjee, M.D., F.A.C.C. \(Disclosure\)](#)

Topic(s):

Interventional Cardiology, Cardiovascular Surgery, General Cardiology