In Reply We thank Bates for his interest in our article.1 We agree that despite the separate acronym of STICHES, the 2016 publication is the report of the 10-year results of the Surgical Treatment for Ischemic Heart Failure (STICH) trial.2 In the original 2011 publication,3 at a median follow-up of 4.7 years, 244 patients in the medical therapy arm died compared with 218 patients in the coronary artery bypass grafting (CABG) arm (hazard ratio [HR], 0.86; 95% CI, 0.72-1.04; P = .12). Although the difference in all-cause mortality was not statistically significant in the primary analysis, the reduction in cardiovascular death (HR, 0.81; 95% CI, 0.66-1.00; P = .05) and the reduction in the composite of all-cause mortality or hospitalization for cardiovascular causes (HR, 0.74; 95% CI, 0.64-0.85; P < .001) with CABG were both statistically significant. With extension of follow-up to a median of 9.8 years, the reduction in all-cause mortality with CABG was now statistically significant (HR, 0.84; 95% CI, 0.73-0.97; P = .02). This benefit emerging over longer follow-up has several plausible explanations: extending follow-up leads to accrual of more events, enhancing precision around point estimates and narrowing the CIs. Furthermore, time-varying analyses show an early mortality hazard with CABG. Longer follow-up helps account for this phenomenon and permits the durable and significant benefit of CABG to be shown.

We agree with Bates that results of STICH only apply to patients with an ejection fraction (EF) of 35% or less and not all patients with heart failure (HF). It is for this reason that we listed as 2 of our 4 urgent clinical questions that need answering, “What is the role of revascularization in patients with less severe forms of LVSD [left ventricular systolic dysfunction]?” and “What is the role of revascularization for patients with HF and preserved EF?”

We also agree with Bates that there have been significant advances in medical therapy for systolic HF since the conclusion of enrollment of STICH. Again, it is for this reason that we listed as our fourth urgent unanswered clinical question, “Have advances in contemporary GDMT [guideline-directed medical therapy] altered the value equation for either CABG or PCI [percutaneous coronary intervention]?”

Alongside the editorialist’s support for upgrading recommendations for CABG from class IIb to class IIA on the basis of the longer-term results of STICH, they also stated, “The results of this trial should change our clinical approach to patients with HF.”4 We would contest that, despite class I guideline recommendations, this change in approach has not yet been realized. One potential reason is what the editorialists described as, “an appropriate tension between the durable long-term benefit of CABG and the early mortality associated with the intervention.”4 It is this tension that is spurring international collaborative efforts to generate randomized data to support less invasive therapeutic options. We also endorse Bates’ conclusion, which is similar to that in our original article: that advances in medical therapy, percutaneous coronary intervention, and surgical revascularization all demand new randomized data to establish the appropriate standards for the treatment of patients with ischemic HF.

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CORRECTION

Error in Article: The Original Investigation titled “Outcomes of Patients With Catecholaminergic Polymorphic Ventricular Tachycardia Treated With β-Blockers,” published in the July 2022 issue, was corrected to fix a typographical error in the article. “Overall, all 15 episodes of VT were successfully interrupted...” was changed to “Overall, all 15 episodes of VF were successfully interrupted...” The article was corrected online.


Errors in Table: The Original Investigation titled “Association of Empagliflozin Treatment With Albuminuria Levels in Patients With Heart Failure: A Secondary Analysis of EMPEROR-Pooled” was corrected to fix some rounding and footnote citation errors and add a footnote in the Table.