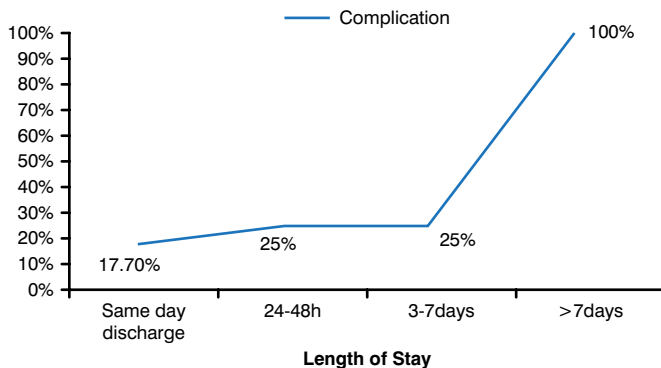


Figure 1. Complication Incidence Increased With Length of Hospital Stay



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This study was limited in that it was a single-center observational study with no controls. There were few events, and it was difficult to confirm information from the records. Despite this, Dr. Joseph concluded that the success rates and outcomes of PCIs done at CHI were acceptable, especially considering the low volume of cases and the recent initiation of the PCI program.

Results of a Stand-Alone PCI Program at Schneider Regional Medical Center

Written by Maria Vinall

Percutaneous coronary intervention (PCI) is a class I recommended therapy for both ST segment elevation myocardial infarction (STEMI) and unstable angina. Traditionally, PCI has been performed in large tertiary centers with on-site coronary bypass surgery programs. Over the past 10 to 15 years, “stand-alone” PCI programs have become more prevalent, particularly in the United States. These programs are imperative for appropriate emergent cardiac care in the Caribbean, where there is a need for expedient treatment that does not require transferring a patient off-island. Geographic, cultural, and financial challenges prohibit routine transfer to tertiary centers in a timely fashion.

The PCI program at Schneider Regional Medical Center (SRMC) consists of a combined cardiac catheterization-interventional radiology laboratory and a single interventional cardiologist. The center services St Thomas and St John, which have a combined population of a little more than 60,000 people. Roy D. Flood Jr, MD, SRMC, St Thomas, USVI, located in the eastern Caribbean, presented results

from a historical cohort of patients treated for STEMI or acute coronary syndrome and those who had abnormal noninvasive screening suggestive of coronary disease at SRMC between January 2006 and June 2013.

SRMC performs percutaneous transluminal coronary angioplasty, coronary stenting, cutting balloon, and thrombectomy. The majority of patients in this review were treated with drug-eluting stents. Most procedures entail guided intravascular ultrasound for diagnostic purposes and evaluation of the stent deployment. Adjunctive pharmacologic agents include clopidogrel, bivalirudin, and eptifibatide. Angio-Seal, which helps cut down on bleeding complications, is used for all closures.

There were 1149 procedures performed during the study period. The types of invasive cardiac procedures are shown in Table 1. There were 337 (97%) acute procedural successes. Complications are shown in Table 2.

SRMC outcome data are similar to those of larger studies. Adverse outcomes, such as myocardial infarction, death, and revascularization, are similar to those of centers where surgery is available on-site. At SMRC, high-risk lesions are generally avoided, but select cases of left main coronary artery PCI and multivessel PCI have been successfully performed.

The program has been largely successful for both acute and elective procedures. Dr. Flood hopes to increase volume and improve his expertise in high-risk procedures.

Table 1. Invasive Cardiac Procedures.

Procedure	No.
Total	1149
Diagnostic only	792
Interventional	347
STEMI	97
Elective PCI	250

PCI=percutaneous coronary intervention; STEMI=ST segment elevation myocardial infarction.

Table 2. Outcomes

Outcome	No. (%)
Acute procedural success	337 (97)
Death	3 (.8)
Acute thrombosis	1 (.2)
Perforation	2 (.6)
Dissection	2 (.6)
Retroperitoneal bleed	1 (.2)