

Table 1  
Patient satisfaction year before and year of cardiology service

Variables	One year before rounding cardiologist (n = 92)	One year during rounding cardiologist (n = 98)	Change	p
Overall patient satisfaction				0.016
Excellent	75%	86%	+11%	
Good	14%	11%	-3%	
Fair	2%	0%	-2%	
Poor	9%	0%	-9%	
Did not answer	0%	3%	+3%	
Level of recommendation				<0.001
Excellent	77%	84%	+7%	
Good	8%	11%	+3%	
Fair	4%	0%	-4%	
Poor	11%	0%	-11%	
Did not answer	0%	5%	+5%	
Comments				0.053
Positive	59%	74%	+15%	
Negative	25%	18%	-7%	
Neutral	4%	5%	+1%	
No comment	12%	3%	-9%	

Note: Positive change indicates an increase in the year during the rounding cardiologist.

comments regarding their stay at the SNF. All patient comments were coded by researchers as “positive” (e.g., “genuine care/interest in resident’s well-being”), “negative” (e.g., “lack of empathy towards patients”), or “neutral” (e.g., “consider an online menu system”). A chi-square analysis was performed to compare patient satisfaction 1 year before versus during the Cardiologist’s first year.

Overall patient satisfaction and level of recommendation increased with access to the cardiologist (Table 1), with a marginally significant increase in the number of positive comments. Increases in “excellent” ratings for patient satisfaction and “level of recommendation” were 11% and 7%, respectively.

These findings suggest that a rounding cardiologist treating patients in a SNF may be an effective strategy to increase patient satisfaction, which indicates a potential increase in quality of care and a decrease in Medicare-issued financial penalties. A large prospective study examining the effect of a rounding cardiologist on patient satisfaction at a SNF using a physician-specific measure of patient satisfaction is needed to confirm the findings of this retrospective pilot study.

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### Strut Thickness and Patients Outcomes in Different End Points After Stent Implantation



We have read the meta-analysis written by Iantorno et al<sup>1</sup> about the impact of strut thickness on outcomes in patients with drug-eluting stents. The investigators through a well-performed analysis of 80,885 patients have clearly demonstrated that strut thickness plays a major role in stent thrombosis and myocardial infarction. However, although we fully agree with the investigators’ conclusions, we would like to point out a comment about the message that might be derived from this study, because it could be easily understood that the lower

the strut thickness will be, the best result will be obtained after percutaneous intervention.

Interventional Cardiology has experimented an impressive progress since the initial era of balloon angioplasty going through the first, second, and third generations of drug-eluting stents and finally the revolutionary concept of the reabsorbable scaffolds, although the latter is the best example that innovation may not always drive to better results. In this way, and despite the optimal performance of the stents with thinner struts in terms of thrombosis and myocardial infarction, we should take into account that with other end points, the thinnest strut may not lead to the best outcome. In the comparison between the Orsiro, a ultrathin-strut sirolimus-eluting stent with biodegradable polymer and Xience, a thin-strut everolimus eluting stent with durable polymer in 330 patients with chronic total occlusions with a length over 50 mm, the primary noninferiority end point, in-segment late lumen loss, was not met for the Orsiro and the binary restenosis was significantly higher (8.0% vs 2.1%;  $p = 0.028$ ).<sup>2</sup> Probably the excellent performance of the Orsiro in studies as the Bioflow V,<sup>3</sup> mainly derived of the lower rate of periprocedural myocardial infarction, comes from its lower profile and a more flexible platform which allow less vessel trauma and also from its

lower strut thickness, which diminishes the risk of side branch occlusion. However, in lesions with high restenosis rate such as long chronic total occlusions, the Xience stent may represent a better choice. Moreover, the recent fourth definition of myocardial infarction<sup>4</sup> has excluded most of the events related with percutaneous intervention, which were simply elevations of troponins without symptoms or changes in the electrocardiogram, which are now considered myocardial damage instead of myocardial infarction and this relevant change will have definitely an influence in the results of future comparisons in stents.

## Disclosures

The authors have no conflicts of interest to disclose.

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