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Commentary

Stable Coronary Artery Disease Patients: Different Practice Patterns in Everyday Clinical Situations

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I read with great interest in the article entitled "Practice patterns for outpatients with stable coronary artery disease: a case vignette-based survey among French cardiologists" presented by Christophe Bauters and colleagues in *EBioMedicine* (Bauters et al., 2015). Authors have assessed the practice patterns for stable coronary artery disease (CAD) outpatients based on an original method of survey among French cardiologists in the Nord-Pas-de-Calais Region (France). As it was underlined by authors of the article background, a number of everyday clinical situations among patients with stable CAD are not specifically covered by current clinical recommendations or the level of obtained evidence is low. Indeed, the lack of tightly adherence and poor perception of specific drugs (β-blockers, anticoagulants, antiplatelets, statins, angiotensin-converting enzyme inhibitors and other renin-angiotensin system blockers), as well as avoid of specific diagnostic procedures (exercise tolerance tests, angiography, other methods of coronary artery visualizations), and possible PCI or coronary artery bypass grafting ion case when clinical decision is not exactly determined by guidelines would probably be associated with poor clinical outcomes or worse of quality of life in the patient population with cardiovascular disease (Murga et al., 2015; Goossens et al., 2015; Rothberg et al., 2015; Sasaki et al., 2014). Authors of the article have investigated responses of cardiologists when stable CAD could be presented. In these cases the decision making based on opinion of cardiologists regarding management of outpatients with stable CAD might be interested to disseminate an experience of cardiologists and induce improving of clinical recommendations in short-term perspective.

Authors of the study conducted a cross-sectional survey of cardiologists using the original survey consisted of six questions pertaining to two clinical scenarios regarding decision making in treatment of stable CAD outpatients. The results of the survey provided by authors have shown that academic cardiologists were more likely to adopt new drug approaches, such as direct oral anticoagulants, or newer attitudes such as prescribing anticoagulants alone rather than dual antithrombotic therapy when anticoagulants were needed. Therefore, there was a frequent decision to go directly to coronary angiography in cases of recurrent angina in known CAD patients. It was found that interventional cardiologists were less likely to discontinue β-blockers before prescribing an exercise test. Overall authors believe that the current health system in France encourages physicians to use tests/procedures rather than simply provide clinical care to their patients.

Because in France there is full reimbursement of all costs, including diagnostic procedures and medications, for chronic CAD individuals, there is requirement to compare current practice patterns for outpatients with CAD that are suitable for Nord-Pas-de-Calais Region (France) with other France regions and other countries. As one can see in article, Dr. Christophe Bauters and colleagues compared the results with data received from France register affected similar patients with CAD. However, cross-sectional survey of cardiologists reflects particularities of decision making in France medical care system based on full reimbursement of all costs for stable CAD subjects. I think that this factor may be a determinant of practice patterns in other medical care systems, especially for low income countries. In this context, international comparisons in practice patterns would be of interest, and novel clinical trials to "close" gaps in the current clinical guidelines are required.

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