

within the first 24 hours of PCI-treated STEMI.³ Current recommendations for sudden death prevention still use the 48-hour cutoff for definition of early VF that is not associated with worse long-term outcome. However, that 48-hour cutoff comes from the pre-PCI era. Whether different and possibly shorter cut-offs should be considered for patients who underwent invasive strategy resulting in immediate restoration of coronary flow is not known. Although VF incidence during the first day of STEMI is sufficiently high for evidence-based decisions, the data on prognostic importance of in-hospital VF occurring beyond the first day of STEMI are scarce and can hardly be used for evidence-based risk stratification. Extremely low prevalence of VF after the first day of STEMI would require collaborative research and prospective evaluation to study its prognostic value.

Marina M. Demidova, MD
Pyotr G. Platonov, MD, PhD

Lund, Sweden
10 February 2015

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**Responses to the Editor RE:
McCullough PA, Roberts
WC. Peter Andrew McCullough,
MD, MPH: An Interview With
the Editor. *Am J Cardiol*
2014;114:1772–1785**



Quotes from AJC Readers:

Peter

“I enjoyed reading your current interview with Bill Roberts in the December issue of the *AJC*! Although I thought I knew a lot about you, I learned a great deal. Well deserved! Thanks so much for

your generous comments about me—and our highly productive working relationship. I’ve thoroughly enjoyed the pioneering cardiology environment and wonderful opportunities I’ve had at Beaumont over the last 30 years, and consider our collaborations among the ‘highlights’ of my professional career. All the best.”

Barry A. Franklin, PhD, Director of Preventive Cardiology and Cardiac Rehabilitation, Oakland University William Beaumont School of Medicine, Royal Oak, MI

Peter

“I got a copy of your interview today. It was read really well, and very informative and personal. Congrats on your move to Dallas. I hope everything is well, and that our paths cross again soon.”

Cindy

Cindy L. Grines, M.D., F.A.C.C., F.S.C.A.I., Vice President of Academic and Clinical Affairs for DMC Cardiovascular Institute, Detroit MI

Peter

I just read your interview with Bob Roberts. As an FYI, I wrote to him first about publishing an article on our first experience with primary PTCA when I was junior faculty at Michigan in 1983. He was incredibly helpful to a young author and ultimately published the Primary Angioplasty Registry in 1989. It was really nice to read the nice words you had to say about the impact Beaumont had on cardiology. I was in the trenches slugging it out and did not realize what an impact it had on our trainees. I will always consider you and other fellows as my professional children and will revel in your success! Please drop me a line periodically as your career progresses. I can add to Ward Kennedy’s acclaim, he told me you were the best resident he had seen in 20 years. I can say the same thing now about you as a cardiology fellow! Have a happy and healthy New Year and please write!

Bill

William W. O’Neill, MD, FACC, Medical Director for the Henry Ford Center for Structural Heart Disease, Detroit, MI

4 February 2015

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Should the Price for Cardiac Rehabilitation Programs be Increased?



Sochor et al.¹ must be commended for their concerns about the evolution of smoking prevalence in patients with coronary artery disease who underwent their first percutaneous coronary intervention. Their findings deserve comment.

The 12-month quit rate did not change significantly from 1999 to 2010.¹ This is not surprising. First, this reflects the lack of will for effective tobacco control policies: current cigarette smoking in adults in the United States only decreased from 20.9 in 2005 to 17.8 in 2013. Accordingly, the Healthy People 2010 objective of reducing the prevalence of cigarette smoking in adults to 12% by 2010 could be attained only by 2030. Second, similar findings are observed in Europe. EUROASPIRE collates indicators on treatment 1 year after a cardiac event in 22 European countries. From 1995–1996 to 2006–2007, the proportion of patients who smoke has remained nearly the same (20% to 18%), but the proportion of women smokers has increased.²

The strongest predictor of smoking cessation at 6 months was participation in cardiac rehabilitation programs (odds ratio 3.17, confidence interval 2.05 to 4.91).¹ Sadly, in Europe, only 36.5% (from 15.9% to 68.1%) of patients having a coronary event or revascularization before the age of 80 years can benefit from cardiac rehabilitation programs.²

Why is there not enough concern for cardiac rehabilitation programs in countries which can afford them? They may remain too cheap compared to the spiraling cancer drug prices. For example, nab-paclitaxel (Abraxane) improves median survival for metastatic non-small lung cancer by 0.08 years; on a crude metric, this is \$400,000 per year of life gained.³

Should the cost of cardiac rehabilitation programs be raised? Nothing can be too expensive against tobacco, the chief preventable cause of illness and death in our societies.

Alain Braillon, MD, PhD

Amiens, France
12 February 2015

1. Sochor O, Lennon RJ, Rodriguez-Escudero JP. Trends and Predictors of Smoking Cessation After percutaneous coronary intervention (from Olmsted County, Minnesota, 1999 to 2010). *Am J Cardiol* 2015;115:405–410.
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3. Bach PB. Indication-specific pricing for cancer drugs. *JAMA* 2014;312:1629–1630.

<http://dx.doi.org/10.1016/j.amjcard.2015.02.044>

Erratum for Ong et al.
“Effect of Change in
Body Weight on Incident Diabetes
Mellitus in Patients With
Stable Coronary Artery Disease
Treated With Atorvastatin (from
the Treating to New Targets
Study)” *Am J Cardiol*
2014;113:1593–1598



The statement in the Methods section (page 1594): “FBG was measured at

each 6-month visit” should have read “FBG was measured at randomization and each annual visit. Some investigators collected FBG at additional time-points and that data was included in our analysis.”

<http://dx.doi.org/10.1016/j.amjcard.2015.02.019>

Erratum for Nazare et al.
“Usefulness of Measuring
Both Body Mass Index and Waist
Circumference for the Estimation of
Visceral Adiposity and Related
Cardiometabolic Risk Profile (from
the INSPIRE ME IAA Study).” *Am J*
Cardiol 2015;115:307–315



This previously published paper should have included the following “Conflict of Interest” statements for Pr Yuji Matsuzawa (YM) and Pr Takashi Kadowaki (TK):

YM has served as a consultant for Daiichi-Sankyo, Otsuka and Teijin Pharma, and has served on speakers’

bureaus for Bayer, Boehringer Ingelheim, Otsuka, Takeda and Teijin Pharma. TK has served on advisory panels for Boehringer Ingelheim, Daiichi-Sankyo, Novo Nordisk, Taisho, Takeda and Tanabe-Mitsubishi, and has served as a consultant for Boehringer Ingelheim and MSD, and has received research support from Astra Zeneca, Chugai, Daiichi-Sankyo, MSD, Ono, Sanofi, Takeda and Tanabe-Mitsubishi, and has served on speakers’ bureaus for Astellas, Astra Zeneca, Boehringer Ingelheim, Daiichi-Sankyo, Dainippon-Sumitomo, Eli Lilly, Kowa, Kyowahakko Kirin, MSD, Novartis, Ono, Sanofi, Sanwa, Taisho, Takeda and Tanabe-Mitsubishi.

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