Discussion to: Impact of concomitant ablation of nonparoxysmal atrial fibrillation during coronary artery bypass grafting on mortality and readmissions

Presenter: John Treffalls, BS\textsuperscript{a,b}
Invited Discussant: Niv Ad, MD\textsuperscript{c}
Corresponding Author: Subhasis Chatterjee, MD\textsuperscript{a,d}

Dr Ad. But there is one thing that we know, whether we know what happened in the study or not, is that in patients who underwent coronary artery bypass grafting (CABG), see it in the presentation coming for us in a few minutes, the vast majority of patients with nonmitral valve surgery as a concomitant surgery are getting a left-sided only lesion set. And you chose to go with the nonparoxysms in patients, go back to the guidelines you mentioned. The guidelines, at least for mitral, but I assume we could say the same thing for nonmitral, say that it’s a class 3 indication, so it’s not recommended to do left-sided only in patients with advanced atrial fibrillation. So, why did you expect to see any difference when in the back of your mind you know that most of those patients, if not all of them, had left-sided only in a disease, it’s much more advanced? And the second question is, why did you expect to see any difference? Let’s say even you had a lesion set only after 1 year, which in this system it’s not even 1 year because you have about 300 days, give or take, because of the limitation. The clock starts and stops in the calendar year. So those are the two questions. Great job.

Mr Treffalls. Thank you for the great questions, Dr Ad. To answer your first question regarding the left-sided ablation, again, these are data that I think is a question that’s important to address. We don’t really understand how patients undergoing CABG in a large all-payer cohort are being ablated, and I would like to have more specific data on how those ablations were performed. But you’re right. We are limited by the nature of the dataset and that we’re unable to determine truly, and I agree it is most likely the left ablation only and probably not a biatrial technique. But I do think it’s important to assess how these are being done in a nationwide all-payer database that’s separate from the Society of Thoracic Surgeons, more of a real-world setting.

And then to your second question, it would have been really nice to be able to follow these patients 2-3-year, up to 5 years’ postoperatively to see if there were changes and readmissions, and I suspect there probably would be. However, the main purpose of our study, as one of your papers previously alluded to, I think there’s such a problem with adoption, specifically in patients undergoing CABG. And I think some of those concerns, one of those concerns is really an increase in perioperative complications, or they think that maybe these patients may be readmitted more frequently. And I think showing that it was not associated with an increased length of stay and not associated with

Dr Ad. First, I would like to thank the association for the invitation to discuss this paper. I want to emphasize one thing before I start. You are a third-year medical student, so congratulations. I think you did a really great job, and I enjoyed the presentation.

Mr John Treffalls (Houston, Tex). Thank you, sir.

Dr Niv Ad (Silver Springs, Md). So now a few highlights. I think you summarize it very nicely in your limitation. But I don’t want to undermine the study because I think it does tell us something. The data are problematic. They’re administrative data, but it’s basically all going into cost and less of the diagnosis acuity and so on and so forth.

Mr Treffalls. Agreed.

From the \textsuperscript{a}Michael E. DeBakey Department of Surgery, Baylor College of Medicine, Houston, Tex; \textsuperscript{b}Department of Surgery, Long School of Medicine, University of Texas Health San Antonio, San Antonio, Tex; \textsuperscript{c}Department of Surgery, Adventist White Oak Medical Center, Silver Spring, Md; and \textsuperscript{d}Department of Cardiovascular Surgery, The Texas Heart Institute, Houston, Tex.

This discussion occurred at the 103rd AATS Annual Meeting.

Address for reprints: Subhasis Chatterjee, MD, Division of Cardiothoracic Surgery, Michael E. DeBakey Department of Surgery, Baylor College of Medicine, One Baylor Plaza, MC-390, Houston, TX 77030 (E-mail: Subhasis.Chatterjee@bcm.edu).

Received for publication Oct 6, 2023; accepted for publication Oct 6, 2023.

JTCVS Open 2023; ■:1-2 2666-2736

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https://doi.org/10.1016/j.xjon.2023.10.008
increased mortality or readmissions. I think it’s important to increase the use of surgical ablation in this cohort, which is such a large number of patients in the United States. And I think they represent a very important way to increase treatment of arrhythmias because there’s so many more patients undergoing CABG than mitral patients.

Dr Ad. Yeah, I agree. I would just rephrase it a little bit. I would say there is a big barrier for nonmitral patients, and we need to increase surgical ablation, but what I would say differently. I would say we need to increase the appropriate surgical ablation because the last thing we want is to have 100% of patients ablated the wrong way and get into the result that we see from our colleagues in the other procedure where it’s a grim outcome on patients in 10 and 15 years, and then it will undermine the entire field.

Mr Treffalls. That’s a very good point. Thank you.

Dr Vinay Badhwar (Morgantown, WVa). Vinay?

Dr Badhwar. Vinay Badhwar, West Virginia, Morgantown. First, congratulations on your poise and elegance at the presentation.

Mr Treffalls. Thank you, Sir.

Dr Badhwar. Very nicely done, crisp slides, and congratulations, Dr Chatterjee, for his mentorship. I have a singular question. In all large database studies, we tend to find trend to patients who are of socially deprived locations having a less impact on therapy, less access to therapy, and altered outcomes. I was struck by one finding that you have that’s contrarian to that trend in that you have a higher incidence of surgical ablation in rural populations. I’m puzzled by that finding, and do you have an explanation?

Mr Treffalls. That’s a great question, Dr Badhwar. I think we were also surprised by that finding. Our hypothesis is that out of all—it’s a Healthcare Cost and Utilization Project Database, and so rural is defined as a hospital in a nonmetropolitan setting, essentially. And I think that of all of the rural hospitals in the United States. Those that are performing cardiac surgery, which are not very many of them, are most likely large. I get to make centers that are in rural hospitals such as West Virginia or Mayo Clinic or other centers that are technically classified as rural hospitals—the University of Virginia, things like that. And I think that is a potential explanation for why we saw an increase and we couldn’t really control all of those settings. As you saw, the teaching status was not associated with increased surgical ablation, which I figured preemptively may have been. But that’s kind of one of our thoughts.

Dr Badhwar. Great job. Thank you.

Mr Treffalls. Thank you, Sir.

Dr Ameen Basha (Calgary, Canada). Hi. Ameen Basha, University of Calgary, in Calgary, Canada. Excellent presentation, just one question. In your analysis, did you access for proportional hazards and whether or not they hold?

Mr Treffalls. For the 1-year readmission?

Dr Basha. That’s correct, yeah.

Mr Treffalls. We did access for numerous causes for the readmission. We looked at surgical ablation, and we looked at numerous others. Surgical ablation was not associated with readmission up to 1 year. There were numerous other things that were, that were not really the focus of the study, but we chose to stick with the propensity score–matched analysis just so we keep it a little bit cleaner.

Dr Basha. Okay. Thank you.

Mr Treffalls. Thank you so much.

All right. Great job.

Mr Treffalls. Thank you.

[applause].

Conflict of Interest Statement

S.C. has served on advisory boards for Edwards Life sciences, La Jolla Pharmaceutical Company, Eagle Pharmaceuticals, and Baxter Pharmaceuticals. All other authors reported no conflicts of interest.

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