ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention—Summary Article

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)

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The American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACC/AHA/SCAI) 2005 Guideline Update for Percutaneous Coronary Intervention (PCI) contains changes in the recommendations, along with supporting text. For the purpose of comparison, this summary contains a list of the updated recommendations (middle column) alongside a list of the 2001 recommendations (left column), with each set accompanied by a comment (right column) that provides the rationale for the changes, additions, or deletions (see Table 1). References

*Official SCAI representative.
†Former Task Force Member during this writing effort.

Acknowledgment: The ACC and AHA recognize Dr J. Ward Kennedy for his dedicated service on developing ACC/AHA guidelines for PTCA and PCI since their inception in 1986 and for his counsel and advice in the preparation of this guideline.

This document was approved by the American College of Cardiology Foundation Board of Trustees in September 2005, by the American Heart Association Science Advisory and Coordinating Committee in September 2005, and by the Society for Cardiovascular Angiography and Interventions in September 2005.

The ACC/AHA Task Force on Practice Guidelines makes every effort to avoid any actual or potential conflicts of interest that might arise as a result of an outside relationship or personal interest of a member of the writing panel. Specifically, all members of the writing panel are asked to provide disclosure statements of all such relationships that might be perceived as real or potential conflicts of interest. These statements are reviewed by the parent task force, reported orally to all members of the writing panel at the first meeting, and updated as changes occur. The relationship with industry information for writing committee members, as well as peer reviewers of the document, is located in an appendix of the full-text guideline, which is available on the ACC, AHA, and SCAI Web sites.


Copies: This document is available on the World Wide Web sites of the American College of Cardiology (www.acc.org), the American Heart Association (www.americanheart.org), and the Society for Cardiovascular Angiography and Interventions (www.scai.org). Single copies of this document are available by calling 1-800-253-4636 or writing the American College of Cardiology Foundation, Resource Center, at 9111 Old Georgetown Road, Bethesda, MD 20814-1699. Ask for reprint number 71-0346. To obtain a copy of the full text published in the January 3, 2006, issue of the Journal of the American College of Cardiology, the January 3, 2006, issue of Circulation, and the January 2006, issue of Catheterization and Cardiovascular Interventions, ask for reprint number 71-0347. To purchase bulk reprints (specify version and reprint number): Up to 999 copies, call 1-800-611-6083 US only or fax 413-665-2671; 1000 or more copies, call 214-706-1789, fax 214-691-6342, or e-mail pubauth@heart.org.

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that support either the 2001 recommendations that have changed or the new or revised recommendations are cited in parentheses at the end of each recommendation or comment. A list of abbreviations is included in the Appendix. The reader is referred to the full-text guideline posted on the World Wide Web sites of the ACC, the AHA, and the SCAI for a more detailed explanation of the changes discussed here. Please note that we have changed the table of contents headings in the 2001 ACC/AHA Guidelines for Percutaneous Coronary Intervention from roman numerals to unique identifying numbers.

In preparing this update, the committee was guided by the following principles:

1. Changes in recommendations and levels of evidence were made because of the availability of data from new randomized trials, the accumulation of new clinical evidence, and/or the development of clinical consensus.
2. The committee is cognizant of the healthcare, logistic, and financial implications of recent trials and factored in these considerations in arriving at the class level of certain recommendations.
3. All recommendations in the PCI guideline update have been written in full sentences that express a complete thought, such that a recommendation, even if separated and presented apart from the rest of the document, will still convey the full intent of the recommendation.
4. The committee wishes to re-emphasize that the recommendations in the guideline apply to most patients but may require modification by existing situations that only the primary treating healthcare provider can evaluate properly.
5. The committee endeavored to maintain the consistency of recommendations in this and other previously published guidelines, primarily the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction and the ACC/AHA 2002 Guidelines for the Management of Patients With Non–ST-Elevation Myocardial Infarction.

The classification of recommendations and levels of evidence are expressed in the ACC/AHA format as follows:

**Classification of Recommendations**

**Class I:** Conditions for which there is evidence for and/or general agreement that a given procedure or treatment is beneficial, useful, and effective.

**Class II:** Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.

**IIa:** Weight of evidence/opinion is in favor of usefulness/efficacy.

**IIb:** Usefulness/efficacy is less well established by evidence/opinion.

**Class III:** Conditions for which there is evidence and/or general agreement that the procedure/treatment is not useful/effective and in some cases may be harmful.

**Level of Evidence**

**Level of Evidence A:** Data derived from multiple randomized clinical trials or meta-analyses.

**Level of Evidence B:** Data derived from a single randomized trial or nonrandomized studies.

**Level of Evidence C:** Only consensus opinion of experts, case studies, or standard-of-care.
### 3. Outcomes
#### 3.2 Acute Outcome: Procedural Complications

<table>
<thead>
<tr>
<th>Class</th>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td></td>
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<tr>
<td>None</td>
<td>All patients who have signs or symptoms suggestive of MI during or after PCI and those with complicated procedures should have CK-MB and troponin I or T measured after the procedure. <em>(Level of Evidence: B)</em></td>
<td>This recommendation appeared in the text of the 2001 revision for CK-MB only. Troponin I or T measurement has been added, and it is now listed as a class I, level of evidence B recommendation (1–10).</td>
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<tr>
<td>Class IIa</td>
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<tr>
<td>None</td>
<td>Routine measurement of cardiac biomarkers (CK-MB and/or troponin I or T) in all patients undergoing PCI is reasonable 8 to 12 hours after the procedure. <em>(Level of Evidence: C)</em></td>
<td>Routine measurement of CK-MB or troponin I or T is added as a new class IIa, level of evidence C recommendation. The committee did not think that evidence regarding the clinical utility of routine measurement of biomarkers in all patients was strong enough to warrant a class I recommendation.</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Institutional and Operator Competency
#### 4.1 Quality Assurance

| Class I | | | |
| None | 1. An institution that performs PCI should establish an ongoing mechanism for valid peer review of its quality and outcomes. Review should be conducted both at the level of the entire program and at the level of the individual practitioner. Quality-assessment reviews should take risk adjustment, statistical power, and national benchmark statistics into consideration. Quality-assessment reviews should include both tabulation of adverse event rates for comparison with benchmark values and case review of complicated procedures and some uncomplicated procedures. *(Level of Evidence: C)* | Quality assurance is an important responsibility for all institutions in which PCI is performed. Institutions must monitor the PCI program with respect to process, appropriateness, and outcomes and correct any circumstances in which quality falls below accepted norms. The quality assessment should be conducted at the level of both the entire program and the individual practitioner. |
| None | 2. An institution that performs PCI should participate in a recognized PCI data registry for the purpose of benchmarking its outcomes against current national norms. *(Level of Evidence: C)* | Participation in a recognized PCI registry for benchmarking outcomes against current national norms is an important part of the quality-improvement process. The ACC–National Cardiovascular Data Registry® or other databases may serve as a valuable resource in this regard. |

#### 4.2 Operator and Institutional Volume

| Class I | | | |
| PCI done by operators with acceptable volume (greater than or equal to 75) at high-volume centers (greater than 400). *(Level of Evidence: B)* | 1. Elective PCI should be performed by operators with acceptable annual volume (at least 75 procedures) at high-volume centers (more than 400 procedures) with on-site cardiac surgery. *(Level of Evidence: B)* | Wording has been added to clarify this statement and emphasize that it relates to elective PCI performed at centers with on-site cardiac surgery. |
| | | | |
| | 2. Elective PCI should be performed by operators and institutions whose historical and current risk-adjusted outcomes statistics are comparable to those reported in contemporary national data registries. *(Level of Evidence: C)* | This recommendation was added to emphasize that historical and current risk-adjusted outcomes for operators and institutions are an essential part of the quality-improvement process. |
| | 3. Primary PCI for STEMI should be performed by experienced operators who perform more than 75 elective PCI procedures per year and, ideally, at least 11 PCI procedures for STEMI per year. Ideally, these procedures should be performed in institutions that perform more than 400 elective PCI procedures per year and more than 36 primary PCI procedures for STEMI per year. *(Level of Evidence: B)* | This recommendation is expanded based on data from the New York State registry indicating that physicians performing more than 10 primary PCI procedures per year have lower mortality rates (11–13). |
| Class IIa | 1. PCI done by operators with acceptable volume (75 or more) at low-volume centers (200–400). *(Level of Evidence: C)* | 1. It is reasonable that operators with acceptable volume (at least 75 PCI procedures per year) perform PCI at low-volume centers (200 to 400 PCI procedures per year) with on-site cardiac surgery. *(Level of Evidence: B)* | Wording has been changed to comply with current recommended phrasing for class IIa recommendation. The fact that this recommendation applies to centers with on-site cardiac surgery is emphasized. Level of evidence has been changed to B based on accumulated published evidence (14). |
### 2001 Recommendation | 2005 New or Revised Recommendation | Comments
---|---|---
2. PCI done by low-volume operators (fewer than 75) at high-volume centers (more than 400). Note: Ideally operators with an annual procedure volume less than 75 should only work at institutions with an activity level of more than 600 procedures/year.* (Level of Evidence: C)

*Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures per year.

None

Class IIb

Class III

PCI done by low-volume operators (fewer than 75) at low-volume centers (200–400). Note: An institution with a volume of fewer than 200 procedures/year, unless in a region that is underserved because of geography, should carefully consider whether it should continue to offer service.* (Level of Evidence: C)

*Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures per year.

Class III

4.3. Role of On-Site Cardiac Surgical Back-up

| Class I | Class I |
---|---|
1. Patients undergoing elective PCI in facilities with on-site cardiac surgery. *(Level of Evidence: B)*

1. Elective PCI should be performed by operators with an acceptable annual volume (at least 75 procedures/procedure per year) at high-volume centers (more than 400 procedures annually) that provide immediately available on-site emergency cardiac surgical services. *(Level of Evidence: B)*

Phrasing has been changed to reflect current terminology and volume criteria; otherwise, no significant changes.

2. Patients undergoing primary PCI in facilities with on-site cardiac surgery. *(Level of Evidence: B)*

2. Primary PCI for patients with STEMI should be performed in facilities with on-site cardiac surgery. *(Level of Evidence: B)*

Phrasing has been changed to reflect current terminology and to be consistent with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction.

Class III

Patients undergoing elective PCI in facilities without on-site cardiac surgery. *(Level of Evidence: C)*

Elective PCI should not be performed at institutions that do not provide on-site cardiac surgery.* *(Level of Evidence: C)*

*Several centers have reported satisfactory results based on careful case selection with well-defined arrangements for immediate transfer to a surgical program (18–29). A small, but real fraction of patients undergoing elective PCI will experience a life-threatening complication that could be managed with the immediate on-site availability of cardiac surgical support but cannot be managed effectively by urgent transfer. Wennberg et al. found higher mortality in the Medicare database for patients undergoing elective PCI in institutions without onsite cardiac surgery (29). These recommendations may be subject to revision as clinical data and experience increase.

Phrasing has been changed to reflect current terminology. As with many dynamic areas in interventional cardiology, these recommendations may be subject to revision as clinical data and experience increase.

Wording has been changed to comply with current recommended phrasing. Level of evidence has been changed to B based on accumulated published evidence (15).

This recommendation has been added to address the issue of low-volume operators performing primary PCI. It reflects the relative lack of evidence supporting a benefit of primary PCI for low-volume operators.

Wording has been changed to reflect current preferred phrasing. Level of evidence changed to B on the basis of published data indicating poorer outcomes at low-volume centers (15).
### 4.4 Primary PCI for STEMI Without On-Site Cardiac Surgery

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<tr>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Class Ib</strong></td>
<td>Patients undergoing primary PCI in facilities without on-site cardiac surgery, but with a proven plan for rapid access (within 1 h) to a cardiac surgery operating room in a nearby facility with appropriate hemodynamic support capability for transfer. The procedure should be limited to patients with ST-segment elevation MI or new LBBB on ECG, and done in a timely fashion (balloon inflation within 90 plus or minus 30 min of admission) by persons skilled in the procedure (at least 75 PCIs/year) and only at facilities performing a minimum of 36 primary PCI procedures per year. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology. Recommendations have been added that 1) physicians perform at least 11 primary PCIs per year for STEMI, 2) a 24 hours per day, 7 days per week call schedule be maintained, and 3) the catheterization laboratory be well equipped with digital imaging equipment, a full array of interventional equipment, and intra-aortic balloon pump capability. The intent is to ensure optimal experience availability and capability to perform primary PCI in patients with STEMI (16,17).</td>
</tr>
<tr>
<td><strong>Class IIb</strong></td>
<td>Primary PCI for patients with STEMI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished, including appropriately experienced physician operators (more than 75 total PCIs and, ideally, at least 11 primary PCIs per year for STEMI), an experienced catheterization team on a 24 hours per day, 7 days per week call schedule, and a well-equipped catheterization laboratory with digital imaging equipment, a full array of interventional equipment, and intra-aortic balloon pump capability, and provided that there is a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital with appropriate hemodynamic support capability for transfer. The procedure should be limited to patients with STEMI or MI with new or presumably new LBBB on ECG and should be performed in a timely fashion (goal of balloon inflation within 90 minutes of presentation) by persons skilled in the procedure (at least 75 PCIs per year) and at hospitals that perform a minimum of 36 primary PCI procedures per year. <em>(Level of Evidence: B)</em></td>
<td></td>
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<tr>
<td><strong>Class III</strong></td>
<td>Patients undergoing primary PCI in facilities without on-site cardiac surgery and without a proven plan for rapid access (within 1 h) to a cardiac surgery operating room in a nearby facility with appropriate hemodynamic support capability for transfer or when performed by lower-skilled operators (fewer than 75 PCIs per year) in a facility performing fewer than 36 primary PCI procedures per year. <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology and to place emphasis on need for inter-institutional planning and support.</td>
</tr>
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</table>

### 4.5 Elective PCI Without On-Site Surgery

| **Class III**        | Elective PCI should not be performed at institutions that do not provide on-site cardiac surgery. *(Level of Evidence: C)* *Several centers have reported satisfactory results based on careful case selection with well-defined arrangements for immediate transfer to a surgical program (18–28). A small, but real fraction of patients undergoing elective PCI will experience a life-threatening complication that could be managed with the immediate on-site availability of cardiac surgical support but cannot be managed effectively by urgent transfer. Wennberg et al. found higher mortality in the Medicare database for patients undergoing elective PCI in institutions without onsite cardiac surgery (29). These recommendations may be subject to revision as clinical data and experience increase.* | Repeated from previous section for consistency. Phrasing has been changed to reflect current terminology. |

### 5.1. Patients With Asymptomatic Ischemia or Canadian Cardiovascular Society (CCS) Class I or II Angina

| **Class I**          | Patients who do not have treated diabetes with asymptomatic ischemia or mild angina with 1 or more significant lesions in 1 or 2 coronary arteries suitable for PCI with a high likelihood of success and a low risk of morbidity and mortality. The vessels to be dilated must subvert a large area of viable myocardium. *(Level of Evidence: B)* | Phrasing has been changed to reflect current terminology. This recommendation and all of those that follow in Section 5 have been reworded to be consistent with the CCS classification system of angina. This recommendation has been changed to class Ila to reflect the published data and Writing Committee consensus that not all patients in this clinical category must have PCI performed (30,31). |
| **Class Ila**        | 1. PCI is reasonable in patients with asymptomatic ischemia or CCS class I or II angina and with 1 or more significant lesions in 1 or 2 coronary arteries suitable for PCI with a high likelihood of success and a low risk of morbidity and mortality. The vessels to be dilated must subvert a moderate to large area of viable myocardium or be associated with a moderate to severe degree of ischemia on noninvasive testing. *(Level of Evidence: B)* | Phrasing has been changed to reflect current terminology. |

1. The same clinical and anatomic requirements for Class I, except the myocardial area at risk is of moderate size or the patient has treated diabetes. *(Level of Evidence: B)*

*This recommendation has been merged with other class Ila recommendations of this section, and the phrasing has been changed to reflect current terminology.*
### 2001 Recommendation

<table>
<thead>
<tr>
<th>Class IIb</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Patients with asymptomatic ischemia or mild angina who do not meet the criteria as listed under Class I or Class II and who have: a. Only a small area of viable myocardium at risk b. No objective evidence of ischemia c. Lesions that have a low likelihood of successful dilatation d. Mild symptoms that are unlikely to be due to myocardial ischemia e. Factors associated with increased risk of morbidity or mortality f. Left main disease g. Insignificant disease less than 50%</td>
<td>This is a new recommendation dealing with the management of recurrent stenosis after PCI among patients with asymptomatic ischemia or class I or II angina. This recommendation for PCI among patients who are eligible for CABG who have significant left main disease has been added to reflect the favorable results noted by several trials with PCI (32–35).</td>
<td>Phrasing has been changed to reflect current terminology. Among patients who are eligible, CABG with 1 arterial conduit is generally preferred for treatment of multivessel disease with significant proximal LAD obstruction in patients with treated diabetes and/or abnormal LV function (36). Phrasing has been changed to reflect current terminology. PCI might be considered in this clinical setting.</td>
</tr>
</tbody>
</table>

### Class III

| Patients with asymptomatic ischemia or mild angina who do not meet the criteria as listed under Class I or Class II and who have: a. Only a small area of viable myocardium at risk b. No objective evidence of ischemia c. Lesions that have a low likelihood of successful dilatation d. Mild symptoms that are unlikely to be due to myocardial ischemia e. Factors associated with increased risk of morbidity or mortality f. Left main disease g. Insignificant disease less than 50% | PCI is not recommended in patients with asymptomatic ischemia or CCS class I or II angina who do not meet the criteria as listed under the class II recommendations or who have 1 or more of the following: a. Only a small area of viable myocardium at risk (Level of Evidence: C) b. No objective evidence of ischemia (Level of Evidence: C) c. Lesions that have a low likelihood of successful dilatation (Level of Evidence: C) d. Mild symptoms that are unlikely to be due to myocardial ischemia (Level of Evidence: C) e. Factors associated with increased risk of morbidity or mortality (Level of Evidence: C) f. Left main disease and eligibility for CABG (Level of Evidence: C) g. Insignificant disease (less than 50% coronary stenosis) (Level of Evidence: C) | Phrasing has been changed to reflect current terminology. Phrasing has been changed to reflect current terminology. Recommendation has been reworded to be consistent with CCS classification system for angina. Level of evidence has been added for each subgroup. |

#### 5.2 Patients With CCS Class III Angina

<table>
<thead>
<tr>
<th>Class I</th>
<th>Class IIa</th>
<th>Class III</th>
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<tbody>
<tr>
<td>Patients with 1 or more significant lesions in 1 or more coronary arteries suitable for PCI with a high likelihood of success and low risk of morbidity or mortality. The vessels to be dilated must subtend a moderate or large area of viable myocardium and have high risk. (Level of Evidence: B)</td>
<td>1. It is reasonable that PCI be performed in patients with CCS class III angina and single-vessel or multivessel CAD who are undergoing medical therapy and who have 1 or more significant lesions in 1 or more coronary arteries suitable for PCI with a high likelihood of success and low risk of morbidity or mortality. (Level of Evidence: B)</td>
<td>Phrasing has been changed to reflect current terminology. Recommendation has been reworded to be consistent with CCS classification system for angina. The recommendation class has been changed to Ila to reflect published data and Writing Committee consensus. Criteria regarding viable and high-risk myocardium have been deleted from this recommendation (30, 31).</td>
</tr>
</tbody>
</table>
### 2001 Recommendation | 2005 New or Revised Recommendation | Comments
--- | --- | ---
**Class IIa**
Patients with focal saphenous vein graft lesions or multiple stenoses who are poor candidates for reoperative surgery. *(Level of Evidence: C)*

2. It is reasonable that PCI be performed in patients with CCS class III angina with single-vessel or multivessel CAD who are undergoing medical therapy with focal saphenous vein graft lesions or multiple stenoses who are poor candidates for reoperative surgery. *(Level of Evidence: C)*

3. Use of PCI is reasonable in patients with CCS class III angina with significant left main CAD (greater than 50% diameter stenosis) who are candidates for revascularization but are not eligible for CABG. *(Level of Evidence: B)*

**Comments**
- Phrasing has been changed to reflect current terminology.
- This recommendation for PCI among patients with significant left main disease who are not eligible for CABG has been added to reflect the favorable results noted by several trials with PCI (32–35).

**Class IIb**
Patient has 1 or more lesions to be dilated with reduced likelihood of success or the vessel(s) subtend a less than moderate area of viable myocardium. Patients with 2- or 3-vessel disease, with significant proximal LAD CAD and treated diabetes or abnormal LV function. *(Level of Evidence: B)*

1. PCI may be considered in patients with CCS class III angina with single-vessel or multivessel CAD who are undergoing medical therapy and who have 1 or more lesions to be dilated with a reduced likelihood of success. *(Level of Evidence: B)*

2. PCI may be considered in patients with CCS class III angina and no evidence of ischemia on noninvasive testing or who are undergoing medical therapy and have 2- or 3-vessel CAD with significant proximal LAD CAD and treated diabetes or abnormal LV function. *(Level of Evidence: B)*

**Comments**
- Phrasing has been changed to reflect current terminology. The 2001 recommendation has been split into 2 separate recommendations.
- Phrasing has been changed to reflect current terminology. The use of noninvasive testing to evaluate for evidence of ischemia has been added.

**Class III**
Patient has no evidence of myocardial injury or ischemia on objective testing and has not had a trial of medical therapy, or has

1. PCI is not recommended for patients with CCS class III angina with single-vessel or multivessel CAD, no evidence of myocardial injury or ischemia on objective testing, and no trial of medical therapy, or who have 1 of the following:
   - Only a small area of myocardium at risk *(Level of Evidence: C)*
   - All lesions or the culprit lesion to be dilated with morphology that conveys a low likelihood of success *(Level of Evidence: C)*
   - A high risk of procedure-related morbidity or mortality. *(Level of Evidence: C)*

2. Patients with insignificant coronary stenosis (e.g., less than 50% diameter). *(Level of Evidence: C)*

3. Patients with significant left main CAD who are candidates for CABG. *(Level of Evidence: B)*

**3.5 Unstable Angina/Non–ST-Elevation Myocardial Infarction (UA/NSTEMI)**
*(Note: Some of these recommendations have been repeated from above because the sections for the 2005 guideline were revised slightly.)*

**Class I**
An early invasive PCI strategy is indicated for patients with UA/NSTEMI who have no serious comorbidity and who have coronary lesions amenable to PCI. Patients must have any of the following high-risk features:

- Recurrent ischemia despite intensive anti-ischemic therapy *(Level of Evidence: A)*
- Elevated troponin level *(Level of Evidence: A)*
- New ST-segment depression *(Level of Evidence: A)*
- CHF symptoms or new or worsening MR *(Level of Evidence: A)*
- Depressed LV systolic function *(Level of Evidence: A)*
- Hemodynamic instability *(Level of Evidence: A)*
- Sustained ventricular tachycardia *(Level of Evidence: A)*
- PCI within 6 months *(Level of Evidence: A)*
- Prior CABG *(Level of Evidence: A)*

**Comments**
- Added to maintain consistency with the ACC/AHA 2002 Guideline Update for the Management of Patients With Unstable Angina and Non–ST-Segment Myocardial Infarction (37).
<table>
<thead>
<tr>
<th>2001 Recommendation</th>
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<tbody>
<tr>
<td><strong>Class IIa</strong></td>
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<tr>
<td>1. Patients with focal saphenous vein graft lesions or multiple stenoses who are poor candidates for reoperative surgery. <em>(Level of Evidence: C)</em></td>
<td>1. It is reasonable that PCI be performed in patients with UA/NSTEMI and single-vessel or multivessel CAD who are undergoing medical therapy with focal saphenous vein graft lesions or multiple stenoses who are poor candidates for reoperative surgery. <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>2. In the absence of high-risk features associated with UA/NSTEMI, it is reasonable to perform PCI in patients with amenable lesions and no contraindication for PCI with either an early invasive or early conservative strategy. See full-text guidelines. <em>(Level of Evidence: B)</em></td>
<td>2. Use of PCI is reasonable in patients with UA/NSTEMI with significant left main CAD (greater than 50% diameter stenosis) who are candidates for revascularization but are not eligible for CABG. <em>(Level of Evidence: B)</em></td>
<td>Added in accordance with growing evidence regarding PCI for patients with UA/NSTEMI. <em>(30, 37–39)</em>.</td>
</tr>
<tr>
<td><strong>Class IIb</strong></td>
<td></td>
<td></td>
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<tr>
<td>1. In the absence of high-risk features associated with UA/NSTEMI, PCI may be considered in patients with single-vessel or multivessel CAD who are undergoing medical therapy and who have 1 or more lesions to be dilated with reduced likelihood of success. <em>(Level of Evidence: B)</em></td>
<td>2. PCI may be considered in patients with UA/NSTEMI who are undergoing medical therapy who have 2- or 3-vessel disease, significant proximal LAD CAD, and treated diabetes or abnormal LV function. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology. Original recommendation replaced by 2 separate recommendations as noted here and in the following recommendations.</td>
</tr>
<tr>
<td><strong>Class III</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Patient has no evidence of myocardial injury or ischemia on objective testing and has not had a trial of medical therapy, or has a. Only a small area of myocardium at risk b. All lesions or the culprit lesion to be dilated with morphology with a low likelihood of success c. A high risk of procedure-related morbidity or mortality. <em>(Level of Evidence: C)</em></td>
<td>1. In the absence of high-risk features associated with UA/NSTEMI, PCI is not recommended for patients with UA/NSTEMI with single-vessel or multivessel CAD and no trial of medical therapy, or who have 1 or more of the following a. Only a small area of myocardium at risk. <em>(Level of Evidence: C)</em> b. All lesions or the culprit lesion to be dilated with morphology that conveys a low likelihood of success <em>(Level of Evidence: C)</em> c. A high risk of procedure-related morbidity or mortality <em>(Level of Evidence: C)</em> d. Insignificant disease (less than 50% coronary stenosis) <em>(Level of Evidence: C)</em> e. Significant left main CAD and candidacy for CABG <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology and level of evidence for each subgroup. Class III recommendations #2 and #3 from the 2001 guidelines have been merged into this recommendation.</td>
</tr>
<tr>
<td>2. All patients after a non–Q-wave MI. <em>(Level of Evidence: C)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5.4. Patients With STEMI</strong></td>
<td>The phrasing has been changed to reflect current terminology as needed for all recommendations in this section and to be consistent with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction.</td>
<td></td>
</tr>
</tbody>
</table>
5.4.1. General and Specific Considerations

Class I

1. As an alternative to thrombolytic therapy in patients with AMI and ST-segment elevation or new or presumed new left bundle-branch block who can undergo angioplasty of the infarct artery less than or equal to 12 h from the onset of ischemic symptoms or more than 12 h if symptoms persist, if performed in a timely fashion* by individuals skilled in the procedure† and supported by experienced personnel in an appropriate laboratory environment.‡ (Level of Evidence: A)

Specific considerations:

2. Primary PCI should be performed for patients less than 75 years old with ST elevation or presumably new LBBB who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock, unless further support is futile because of the patient’s wishes or contraindications/unsuitability for further invasive care. (Level of Evidence: A)

3. Primary PCI should be performed in patients with severe HF and/or pulmonary edema (Killip class 3) and onset of symptoms within 12 hours. The medical contact-to-balloon or door-to-balloon time should be as short as possible (i.e., goal within 90 minutes). (Level of Evidence: B)

4. PCI in patients at least 75 years of age with shock, is reasonable. (Level of Evidence: B)

Class IIa

1. Primary PCI is reasonable for selected patients 75 years or older with ST elevation or LBBB or who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock. Patients with good prior functional status who are suitable for revascularization and agree to invasive care may be selected for such an invasive strategy. (Level of Evidence: B)

2. It is reasonable to perform primary PCI for patients with onset of symptoms within the prior 12 to 24 hours and 1 or more of the following:
   a. Severe HF (Level of Evidence: C)
   b. Hemodynamic or electrical instability (Level of Evidence: C)
   c. Evidence of persistent ischemia (Level of Evidence: C)

Class IIb

1. If immediately available, primary PCI should be performed in patients with STEMI (including true posterior MI) or MI with new or presumably new LBBB who can undergo PCI of the infarct artery within 12 hours of symptom onset, if performed in a timely fashion (balloon inflation goal within 90 minutes of presentation) by persons skilled in the procedure (individuals who perform more than 75 PCI procedures per year, ideally at least 11 PCIs per year for STEMI). The procedure should be supported by experienced personnel in an appropriate laboratory environment (one that performs more than 200 PCI procedures per year, of which at least 36 are primary PCI for STEMI, and that has cardiac surgery capability). (Level of Evidence: A)

Specific considerations:

2. Primary PCI should be performed for patients less than 75 years old with ST elevation or LBBB or who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock, unless further support is futile because of the patient’s wishes or contraindications/unsuitability for further invasive care. (Level of Evidence: A)

3. PCI should be performed in patients with severe HF and/or pulmonary edema (Killip class 3) and onset of symptoms within 12 hours. The medical contact-to-balloon or door-to-balloon time should be as short as possible (i.e., goal within 90 minutes). (Level of Evidence: B)

4. PCI in patients at least 75 years of age with shock, is reasonable. (Level of Evidence: B)

Class IIc

1. Individuals who perform 75 or more PCI procedures per year.

Specific considerations:

2. PCI should be performed for patients less than 75 years old with ST elevation or LBBB or who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock, unless further support is futile because of the patient’s wishes or contraindications/unsuitability for further invasive care. (Level of Evidence: A)

3. PCI should be performed in patients with severe HF and/or pulmonary edema (Killip class 3) and onset of symptoms within 12 hours. The medical contact-to-balloon or door-to-balloon time should be as short as possible (i.e., goal within 90 minutes). (Level of Evidence: B)

4. PCI in patients at least 75 years of age with shock, is reasonable. (Level of Evidence: B)
2001 Recommendation | 2005 New or Revised Recommendation | Comments
---|---|---
Class III | Class III | Phrasing has been changed to reflect current terminology. Important phrasing has been added to address the issue of PCI of the non-infarct-related coronary artery at the time of primary PCI.

1. Elective PCI of a non–infarct-related artery at the time of acute MI. *(Level of Evidence: C)*

2. In patients with acute MI who:
   a. have received fibrinolytic therapy within 12 h and have no symptoms of myocardial ischemia
   b. are eligible for thrombolytic therapy and are undergoing primary angioplasty by an inexperienced operator (individual who performs fewer than 75 PCI procedures per year)
   c. are beyond 12 h after onset of symptoms and have no evidence of myocardial ischemia. *(Level of Evidence: C)*

Class III | Class III | Revised recommendation reflects the committee's opinion that primary PCI should be a class I recommendation for fibrinolytic-ineligible patients within 12 hours of symptom onset. Phrasing has been changed to reflect current terminology and to be consistent with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction.

2. Primary PCI should not be performed in asymptomatic patients more than 12 hours after onset of STEMI who are hemodynamically and electrically stable. *(Level of Evidence: C)*

Class IIb | Class IIb | New recommendation from the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction that addresses conditions under which primary PCI is reasonable for fibrinolytic-ineligible patients with onset of symptoms within the prior 12 to 24 hours.

1. The benefit of primary PCI for STEMI patients eligible for fibrinolysis when performed by an operator who performs fewer than 75 PCI procedures per year (or fewer than 11 PCIs for STEMI per year) is not well established. *(Level of Evidence: C)*

5.4.2. PCI in Fibrinolytic-Ineligible Patients

Class IIa | Class I | Revised recommendation reflects the committee's opinion that primary PCI should be a class I recommendation for fibrinolytic-ineligible patients within 12 hours of symptom onset. Phrasing has been changed to reflect current terminology and to be consistent with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction.

As a reperfusion strategy in candidates who have a contraindication to thrombolytic therapy. *(Level of Evidence: C)*

Primary PCI should be performed in fibrinolytic-ineligible patients who present with STEMI within 12 hours of symptom onset. *(Level of Evidence: C)*

Class IIa | Class IIa | New recommendation from the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction that addresses conditions under which primary PCI is reasonable for fibrinolytic-ineligible patients with onset of symptoms within the prior 12 to 24 hours.

It is reasonable to perform primary PCI for fibrinolytic-ineligible patients with onset of symptoms within the prior 12 to 24 hours and 1 or more of the following:
   a. Severe HF *(Level of Evidence: C)*
   b. Hemodynamic or electrical instability *(Level of Evidence: C)*
   c. Evidence of persistent ischemia *(Level of Evidence: C)*

5.4.3. Facilitated PCI

Class IIb | Class IIb | New recommendation from the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction addressing conditions for which facilitated PCI might be considered. Important randomized trials are under way, and more data are needed regarding outcomes resulting from this treatment strategy (57–63).

Facilitated PCI might be performed as a reperfusion strategy in higher-risk patients when PCI is not immediately available and bleeding risk is low. *(Level of Evidence: B)*

5.4.4. PCI After Failed Fibrinolysis (Rescue PCI)

Class I | Class I | See above (49,51).

None | 1. Rescue PCI should be performed in patients less than 75 years old with ST elevation or LBBB who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock, unless further support is futile because of the patient’s wishes or contraindications/unsuitability for further invasive care. *(Level of Evidence: B)*

2. Rescue PCI should be performed in patients with severe HF and/or pulmonary edema (Killip class 3) and onset of symptoms within 12 hours. *(Level of Evidence: B)*

See above (54–56).
### 5.4.5. PCI After Successful Fibrinolysis or for Patients Not Undergoing Primary Reperfusion

#### Class I

1. Objective evidence for recurrent infarction or ischemia (rescue PCI).  
   (Level of Evidence: B)
2. Spontaneous or provocable myocardial ischemia during recovery from infarction.  
   (Level of Evidence: C)
3. Persistent hemodynamic instability.  
   (Level of Evidence: C)

1. In patients whose anatomy is suitable, PCI should be performed when there is objective evidence of recurrent MI.  
   (Level of Evidence: C)
2. In patients whose anatomy is suitable, PCI should be performed for moderate or severe spontaneous or provocable myocardial ischemia during recovery from STEMI.  
   (Level of Evidence: B)
3. In patients whose anatomy is suitable, PCI should be performed for cardiogenic shock or hemodynamic instability. See also Section 5.4.6 of the full-text guidelines.  
   (Level of Evidence: B)

#### Class IIa

Patients with LV ejection fraction less than or equal to 0.4, CHF, or serious ventricular arrhythmias.  
(Level of Evidence: C)

1. It is reasonable to perform routine PCI in patients with LV ejection fraction less than or equal to 0.40, CHF, or serious ventricular arrhythmias.  
   (Level of Evidence: C)

#### Class IIb

1. Coronary angiography and angioplasty for an occluded infarct-related artery in an otherwise stable patient to revascularize that artery (open artery hypothesis).  
   (Level of Evidence: C)
2. Angioplasty of the infarct-related artery stenosis within hours to days (48 h) following successful thrombolytic therapy in asymptomatic patients without clinical and/or inducible evidence of ischemia.  
   (Level of Evidence: B)

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**2001 Recommendation** | **2005 New or Revised Recommendation** | **Comments**
--- | --- | ---
**Class IIa** | None | None

- 1. Rescue PCI is reasonable for selected patients 75 years or older with ST elevation or LBBB or who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock. Patients with good prior functional status who are suitable for revascularization and agree to invasive care may be selected for such an invasive strategy.  
  (Level of Evidence: B)
- 2. It is reasonable to perform rescue PCI for patients with 1 or more of the following:
  - a. Hemodynamic or electrical instability  
    (Level of Evidence: C)
  - b. Evidence of persistent ischemia.  
    (Level of Evidence: C)

See above (49).

**Class IIb**

- Recurrent angina without objective evidence of ischemia/infarction.  
  (Level of Evidence: C)

Deleted. Recurrent angina is not applicable to rescue angioplasty. Recurrent symptoms are discussed elsewhere.

**Class III**

- Routine PTCA within 48 h following failed thrombolysis.  
  (Level of Evidence: B)

Rescue PCI in the absence of 1 or more of the above class I or IIa indications is not recommended.  
(Level of Evidence: C)

Evidence obtained from studies of PTCA during the fibrinolytic era before the use of stents failed to show a benefit for reperfusion under these conditions. Current trials are under way to investigate the outcome of PCI with stent placement among patients with occluded arteries days after presentation with STEMI.

---

**Class I**

- 1. Objective evidence for recurrent infarction or ischemia (rescue PCI).  
  (Level of Evidence: B)
- 2. Spontaneous or provocable myocardial ischemia during recovery from infarction.  
  (Level of Evidence: C)
- 3. Persistent hemodynamic instability.  
  (Level of Evidence: C)

Phrasing has been changed to reflect current terminology. Revised to a level of evidence C.

Phrasing has been changed to reflect current terminology. Level of evidence revised on the basis of review by the Writing Committee (64).

Phrasing has been changed to reflect current terminology. Level of evidence was revised on the basis of review by the Writing Committee, and cardiogenic shock has been added (cardiogenic shock is discussed in Section 5.4.6 and is a class I, level of evidence A recommendation for patients younger than 75 years old and a class IIa, level of evidence B recommendation for those aged 75 years and older) (49).

**Class IIa**

- Patients with LV ejection fraction less than or equal to 0.4, CHF, or serious ventricular arrhythmias.  
  (Level of Evidence: C)

Phrasing has been changed to reflect current terminology.

Recommendation deleted. Important trials are under way to provide evidence regarding outcomes associated with or resulting from this therapy.

**Class IIb**

1. Coronary angiography and angioplasty for an occluded infarct-related artery in an otherwise stable patient to revascularize that artery (open artery hypothesis).  
   (Level of Evidence: C)
2. Angioplasty of the infarct-related artery stenosis within hours to days (48 h) following successful thrombolytic therapy in asymptomatic patients without clinical and/or inducible evidence of ischemia.  
   (Level of Evidence: B)

This recommendation has been merged into the upgraded class IIb recommendation for PCI after fibrinolytic therapy below.
### 5.4.6. PCI for Cardiogenic Shock

<table>
<thead>
<tr>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Clinical HF during the acute episode, but subsequent demonstration of preserved LV function (LV ejection fraction greater than 0.4). <em>(Level of Evidence: C)</em></td>
<td>2. It is reasonable to perform PCI when there is documented clinical heart failure during the acute episode, even though subsequent evaluation shows preserved LV function (LV ejection fraction greater than 0.40). <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology. Recommendation was upgraded to class IIa by the Writing Committee.</td>
</tr>
<tr>
<td><strong>Class III</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. PCI of the infarct-related artery within 48 to 72 h after thrombolytic therapy without evidence of spontaneous or provokable ischemia. <em>(Level of Evidence: C)</em></td>
<td></td>
<td>This recommendation has been upgraded and merged into the IIb recommendation for PCI after fibrinolytic therapy below.</td>
</tr>
<tr>
<td>2. Routine PCI of the infarct-artery stenosis immediately after thrombolytic therapy. <em>(Level of Evidence: A)</em></td>
<td>1. PCI might be considered as part of an invasive strategy after fibrinolytic therapy. <em>(Level of Evidence: C)</em></td>
<td>This recommendation has been upgraded to class IIb to reflect a possible benefit from improved technology. The Committee recognizes the potential benefit of this therapy but believes more data are needed to define outcomes of PCI after fibrinolytic therapy in the current era of improved antiplatelet, anticoagulant, and drug-eluting stent therapies.</td>
</tr>
</tbody>
</table>

### 5.5. Percutaneous Intervention in Patients With Prior Coronary Bypass Surgery

<table>
<thead>
<tr>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients with ischemia occurring 1 to 3 years postoperatively and preserved LV function with discrete lesions in graft conduits. <em>(Level of Evidence: B)</em></td>
<td>1. When technically feasible, PCI should be performed in patients with early ischemia (usually within 30 days) after CABG. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology. New recommendation is based on several studies demonstrating efficacy of distal embolic protection devices in PCI to saphenous vein grafts (65,66).</td>
</tr>
<tr>
<td>2. Disabling angina secondary to new disease in a native coronary circulation. <em>(If angina is not typical, the objective evidence of ischemia should be obtained.)</em> <em>(Level of Evidence: B)</em></td>
<td>2. It is recommended that distal embolic protection devices be used when technically feasible in patients undergoing PCI to saphenous vein grafts. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>3. Patients with diseased vein grafts more than 3 years following CABG. <em>(Level of Evidence: B)</em></td>
<td>1. PCI is reasonable in patients with ischemia that occurs 1 to 3 years after CABG and who have preserved LV function with discrete lesions in graft conduits. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>2. PCI is reasonable in patients with disabling angina secondary to new disease in a native coronary circulation after CABG. <em>(If angina is not typical, objective evidence of ischemia should be obtained.)</em> <em>(Level of Evidence: B)</em></td>
<td>2. PCI is reasonable in patients with disabling angina secondary to new disease in a native coronary circulation after CABG. <em>(If angina is not typical, objective evidence of ischemia should be obtained.)</em> <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>3. Patients with diseased vein grafts more than 3 years after CABG. <em>(Level of Evidence: B)</em></td>
<td>3. PCI is reasonable in patients with diseased vein grafts more than 3 years after CABG. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>4. PCI is reasonable when technically feasible in patients with a patent left internal mammary artery graft who have clinically significant obstructions in other vessels. <em>(Level of Evidence: C)</em></td>
<td>4. PCI is reasonable when technically feasible in patients with a patent left internal mammary artery graft who have clinically significant obstructions in other vessels. <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
</tbody>
</table>

This new recommendation addresses the feasibility of PCI to native circulation in the presence of a patent left internal mammary artery graft.
<table>
<thead>
<tr>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class III</strong></td>
<td><strong>Class III</strong></td>
<td><strong>Class III</strong></td>
</tr>
<tr>
<td>1. PCI to chronic total vein graft occlusions. <em>(Level of Evidence: B)</em></td>
<td>1. PCI is not recommended in patients with prior CABG for chronic total vein graft occlusions. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>2. Patients with multivessel disease, failure or multiple SVGs, and impaired function. <em>(Level of Evidence: B)</em></td>
<td>2. PCI is not recommended in patients who have multiple target lesions with prior CABG and who have multivessel disease, failure of multiple SVGs, and impaired LV function unless repeat CABG poses excessive risk due to severe comorbid conditions. <em>(Level of Evidence: B)</em></td>
<td></td>
</tr>
<tr>
<td><strong>5.6.1. Intravascular Ultrasound Imaging (IVUS)</strong></td>
<td><strong>Class IIa</strong></td>
<td><strong>Class III</strong></td>
</tr>
<tr>
<td>1. Assessment of the adequacy of deployment of coronary stents, including the extent of stent apposition and determination of the minimum luminal diameter within the stent. <em>(Level of Evidence: B)</em></td>
<td>1. IVUS is reasonable for the following: a. Assessment of the adequacy of deployment of coronary stents, including the extent of stent apposition and determination of the minimum luminal diameter within the stent. <em>(Level of Evidence: B)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>2. Determination of the mechanism of stent restenosis (inadequate expansion vs. neointimal proliferation) and to enable selection of appropriate therapy (plaque ablation vs. repeat balloon expansion). <em>(Level of Evidence: B)</em></td>
<td>b. Determination of the mechanism of stent restenosis (inadequate expansion versus neointimal proliferation) and to enable selection of appropriate therapy (vascular brachytherapy versus repeat balloon expansion). <em>(Level of Evidence: B)</em></td>
<td></td>
</tr>
<tr>
<td>3. Evaluation of coronary obstruction at a location difficult to image by angiography in a patient with a suspected flow-limiting stenosis. <em>(Level of Evidence: C)</em></td>
<td>c. Evaluation of coronary obstruction at a location difficult to image by angiography in a patient with a suspected flow-limiting stenosis. <em>(Level of Evidence: C)</em></td>
<td></td>
</tr>
<tr>
<td>4. Assessment of a suboptimal angiographic result following PCI. <em>(Level of Evidence: C)</em></td>
<td>d. Assessment of a suboptimal angiographic result after PCI. <em>(Level of Evidence: C)</em></td>
<td></td>
</tr>
<tr>
<td>5. Diagnosis and management of coronary disease following cardiac transplantation. <em>(Level of Evidence: C)</em></td>
<td>e. Establishment of the presence and distribution of coronary calcium in patients for whom adjunctive rotational atherectomy is contemplated. <em>(Level of Evidence: C)</em></td>
<td></td>
</tr>
<tr>
<td>7. Determination of plaque location and circumferential distribution for guidance of directional coronary atherectomy. <em>(Level of Evidence: B)</em></td>
<td><strong>Class IIb</strong></td>
<td><strong>Class III</strong></td>
</tr>
<tr>
<td>1. Determine extent of atherosclerosis in patients with characteristic anginal symptoms and a positive functional study with no focal stenoses or mild CAD on angiography. <em>(Level of Evidence: C)</em></td>
<td>IVUS may be considered for the following: a. Determination of the extent of atherosclerosis in patients with characteristic anginal symptoms and a positive functional study with no focal stenoses or mild CAD on angiography. <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology. The previous class IIb recommendations for IVUS have been listed together in this recommendation rather than separately. The use of IVUS to evaluate coronary disease in transplant patients is now a class IIb recommendation.</td>
</tr>
<tr>
<td>2. Preinterventional assessment of lesion characteristics and vessel dimensions as a means to select an optimal revascularization device. <em>(Level of Evidence: C)</em></td>
<td>b. Preinterventional assessment of lesion characteristics and vessel dimensions as a means to select an optimal revascularization device. <em>(Level of Evidence: C)</em></td>
<td></td>
</tr>
<tr>
<td>3. When angiographic diagnosis is clear and no interventional treatment is planned. <em>(Level of Evidence: C)</em></td>
<td>c. Diagnosis of coronary disease after cardiac transplantation. <em>(Level of Evidence: C)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Class III</strong></td>
<td><strong>Class III</strong></td>
<td><strong>Class III</strong></td>
</tr>
<tr>
<td>1. PCI is not recommended in patients with prior CABG for chronic total vein graft occlusions. <em>(Level of Evidence: B)</em></td>
<td>IVUS is not recommended when the angiographic diagnosis is clear and no interventional treatment is planned. <em>(Level of Evidence: C)</em></td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
</tbody>
</table>
### 5.6.2. Coronary Artery Pressure and Flow: Use of Fractional Flow Reserve and Coronary Vasodilatory Reserve

<table>
<thead>
<tr>
<th>Class Ila</th>
<th>Class Iib</th>
<th>Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment of the physiological effects of intermediate coronary stenoses (30 to 70% luminal narrowing) in patients with anginal symptoms.</strong> Coronary pressure or Doppler velocimetry may also be useful as an alternative to performing noninvasive functional testing (e.g., when the functional study is absent or ambiguous) to determine whether an intervention is warranted. <em>(Level of Evidence: B)</em></td>
<td><strong>It is reasonable to use intracoronary physiologic measurements (Doppler ultrasound, fractional flow reserve) in the assessment of the effects of intermediate coronary stenoses (30% to 70% luminal narrowing) in patients with anginal symptoms. Coronary pressure or Doppler velocimetry may also be useful as an alternative to performing noninvasive functional testing (e.g., when the functional study is absent or ambiguous) to determine whether an intervention is warranted. <em>(Level of Evidence: B)</em></strong></td>
<td><strong>Routine assessment with intracoronary physiologic measurements (Doppler ultrasound, fractional flow reserve) to assess the severity of angiographic disease in patients with a positive, unequivocal noninvasive functional study. <em>(Level of Evidence: C)</em></strong></td>
</tr>
<tr>
<td><strong>1. Evaluation of the success of percutaneous coronary revascularization in restoring flow reserve and to predict the risk of restenosis.</strong> <em>(Level of Evidence: C)</em></td>
<td><strong>1. Intracoronary physiologic measurements may be considered for the evaluation of the success of PCI in restoring flow reserve and to predict the risk of restenosis. <em>(Level of Evidence: C)</em></strong></td>
<td><strong>Routine assessment with intracoronary physiologic measurements such as Doppler ultrasound or fractional flow reserve to assess the severity of angiographic disease in patients with a positive, unequivocal noninvasive functional study is not recommended. <em>(Level of Evidence: C)</em></strong></td>
</tr>
<tr>
<td><strong>2. Evaluation of patients with anginal symptoms without an apparent angiographic culprit lesion.</strong> <em>(Level of Evidence: C)</em></td>
<td><strong>2. Intracoronary physiologic measurements may be considered for the evaluation of patients with anginal symptoms without an apparent angiographic culprit lesion. <em>(Level of Evidence: C)</em></strong></td>
<td><strong>Published clinical trials using distal embolic protection devices confirm their benefit in improving cardiovascular outcomes among patients undergoing PCI to saphenous vein grafts. <em>(Level of Evidence: B)</em></strong></td>
</tr>
</tbody>
</table>

### 6. Management of Patients Undergoing PCI

#### 6.1. Evolution of Technologies

##### 6.1.1. Acute Results

<table>
<thead>
<tr>
<th>Class I</th>
<th>Class Ila</th>
<th>Class Iib</th>
<th>Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>It is recommended that distal embolic protection devices be used when technically feasible in patients undergoing PCI to saphenous vein grafts. <em>(Level of Evidence: B)</em></strong></td>
<td><strong>It is reasonable to use intracoronary physiologic measurements (Doppler ultrasound, fractional flow reserve) in the assessment of the effects of intermediate coronary stenoses (30% to 70% luminal narrowing) in patients with anginal symptoms. Coronary pressure or Doppler velocimetry may also be useful as an alternative to performing noninvasive functional testing (e.g., when the functional study is absent or ambiguous) to determine whether an intervention is warranted. <em>(Level of Evidence: B)</em></strong></td>
<td><strong>Routine assessment with intracoronary physiologic measurements such as Doppler ultrasound or fractional flow reserve to assess the severity of angiographic disease in patients with a positive, unequivocal noninvasive functional study is not recommended. <em>(Level of Evidence: C)</em></strong></td>
<td><strong>Routine assessment with intracoronary physiologic measurements such as Doppler ultrasound or fractional flow reserve to assess the severity of angiographic disease in patients with a positive, unequivocal noninvasive functional study is not recommended. <em>(Level of Evidence: C)</em></strong></td>
</tr>
</tbody>
</table>

### 6.2. Antiplatelet and Antithrombotic Adjunctive Therapies for PCI

#### 6.2.1. Oral Antiplatelet Therapy

<table>
<thead>
<tr>
<th>Class I</th>
<th>Class Ila</th>
<th>Class Iib</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The recommendations in this section appeared in table format in the 2001 guideline (see 2001 Table). The phrasing has been changed to reflect current terminology and to be consistent with new evidence and/or recommendations in the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction and the ACC/AHA 2002 Guideline Update for Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction.</strong></td>
<td><strong>It is reasonable to use intracoronary physiologic measurements (Doppler ultrasound, fractional flow reserve) in the assessment of the effects of intermediate coronary stenoses (30% to 70% luminal narrowing) in patients with anginal symptoms. Coronary pressure or Doppler velocimetry may also be useful as an alternative to performing noninvasive functional testing (e.g., when the functional study is absent or ambiguous) to determine whether an intervention is warranted. <em>(Level of Evidence: B)</em></strong></td>
<td><strong>Phrasing has been changed to reflect current terminology.</strong></td>
<td><strong>Published clinical trials using distal embolic protection devices confirm their benefit in improving cardiovascular outcomes among patients undergoing PCI to saphenous vein grafts. <em>(Level of Evidence: B)</em></strong></td>
</tr>
<tr>
<td><strong>1. Patients already taking daily chronic aspirin therapy should take 75 to 325 mg of aspirin before the PCI procedure is performed. <em>(Level of Evidence: A)</em></strong></td>
<td><strong>2. Patients not already taking daily chronic aspirin therapy should be given 300 to 325 mg of aspirin at least 2 hours and preferably 24 hours before the PCI procedure is performed. <em>(Level of Evidence: C)</em></strong></td>
<td><strong>A daily dose of 75 mg of aspirin has been shown to result in improved cardiovascular outcomes similar to daily doses of 325 mg but with fewer bleeding complications (67–69).</strong></td>
<td><strong>Higher doses of aspirin are recommended for patients not already taking aspirin therapy immediately before PCI procedures.</strong></td>
</tr>
<tr>
<td>3. After the PCI procedure, in patients with neither aspirin resistance, allergy, nor increased risk of bleeding, aspirin 325 mg daily should be given for at least 1 month after bare-metal stent implantation, 3 months after sirolimus-eluting stent implantation, and 6 months after paclitaxel-eluting stent implantation, after which daily chronic aspirin use should be continued indefinitely at a dose of 75 to 162 mg. <em>(Level of Evidence: B)</em>**</td>
<td><strong>The doses and duration of aspirin therapy recommended herein are derived from those used for US Food and Drug Administration approval of the specific stent types noted in the recommendation. Daily chronic aspirin therapy is based on recommendations in the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction and evidence indicating that aspirin therapy in dosages as low as 75 mg per day yields outcomes similar to those achieved with 325 mg per day but with fewer side effects (67–69).</strong></td>
<td><strong>Phrasing has been changed to reflect current terminology.</strong></td>
<td><strong>Published clinical trials using distal embolic protection devices confirm their benefit in improving cardiovascular outcomes among patients undergoing PCI to saphenous vein grafts. <em>(Level of Evidence: B)</em></strong></td>
</tr>
</tbody>
</table>
4. A loading dose of clopidogrel should be administered before PCI is performed. (Level of Evidence: A) An oral loading dose of 300 mg, administered at least 6 hours before the procedure, has the best established evidence of efficacy. (Level of Evidence: B)

5. In patients who have undergone PCI, clopidogrel 75 mg daily should be given for at least 1 month after bare-metal stent implantation (unless the patient is at increased risk for bleeding; then it should be given for a minimum of 2 weeks), 3 months after sirolimus stent implantation, and 6 months after paclitaxel stent implantation, and ideally up to 12 months in patients who are not at high risk of bleeding. (Level of Evidence: B)

Class IIa

1. If clopidogrel is given at the time of procedure, supplementation with GP IIb/IIIa receptor antagonists can be beneficial to facilitate earlier platelet inhibition than with clopidogrel alone. (Level of Evidence: B)

2. For patients with an absolute contraindication to aspirin, it is reasonable to give a 300-mg loading dose of clopidogrel, administered at least 6 hours before PCI, and/or GP IIb/IIIa antagonists, administered at the time of PCI. (Level of Evidence: C)

3. When a loading dose of clopidogrel is administered, a regimen of greater than 300 mg is reasonable to achieve higher levels of antiplatelet activity more rapidly, but the efficacy and safety compared with a 300-mg loading dose are less established. (Level of Evidence: C)

4. It is reasonable that patients undergoing brachytherapy be given daily clopidogrel 75 mg indefinitely and daily aspirin 75 to 325 mg indefinitely unless there is significant risk for bleeding. (Level of Evidence: C)

Class IIb

In patients in whom subacute thrombosis may be catastrophic or lethal (unprotected left main, bifurcating left main, or last patent coronary vessel), platelet aggregation studies may be considered and the dose of clopidogrel increased to 150 mg per day if less than 50% inhibition of platelet aggregation is demonstrated. (Level of Evidence: C)

6.2.2 Glycoprotein IIb/IIIa Inhibitors

The recommendations in this section appeared in table format in the 2001 guideline (see 2001 Table). The phrasing has been changed to reflect current terminology and to be consistent with new evidence and/or recommendations in the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction and the ACC/AHA 2002 Guideline Update for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction.

Class I

In patients with UA/NSTEMI undergoing PCI without clopidogrel administration, a GP IIb/IIIa inhibitor (abciximab, eptifibatide, or tirofiban) should be administered. (Level of Evidence: A)

§ It is acceptable to administer the GP IIb/IIIa inhibitor before performance of the diagnostic angiogram (“upstream treatment”) or just before PCI (“in-lab treatment”).

This recommendation and phrasing are compatible with the ACC/AHA 2002 Guideline Update for the Management of Patients With Unstable Angina and Non–ST-Segment Myocardial Infarction and current evidence from randomized clinical trials. The benefits of GP IIb/IIIa inhibition are especially efficacious when clopidogrel is not given (37).

Class IIa

1. In patients with UA/NSTEMI undergoing PCI with clopidogrel administration, it is reasonable to administer a GP IIb/IIIa inhibitor (abciximab, eptifibatide, or tirofiban). (Level of Evidence: B)

§ It is acceptable to administer the GP IIb/IIIa inhibitor before performance of the diagnostic angiogram (“upstream treatment”) or just before PCI (“in-lab treatment”).

2. In patients with STEMI undergoing PCI, it is reasonable to administer abciximab as early as possible. (Level of Evidence: B)

Recommendation has been added for consistency with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (57,75–78).
<table>
<thead>
<tr>
<th>2001 Recommendation</th>
<th>2005 New or Revised Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. In patients undergoing elective PCI with stent placement, it is reasonable to administer a GP IIb/IIIa inhibitor (abciximab, eptifibatide, or tirofiban). (Level of Evidence: B)</td>
<td>Phrasing has been changed to reflect current terminology, especially in a high-risk patient (79,80).</td>
<td></td>
</tr>
<tr>
<td>Class Iib</td>
<td>In patients with STEMI undergoing PCI, treatment with eptifibatide or tirofiban may be considered. (Level of Evidence: C)</td>
<td>Recommendation has been added for consistency with the ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction.</td>
</tr>
<tr>
<td>6.3.4. Left Main CAD</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Class Iia</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Class Ila</td>
<td>It is reasonable to use bivalirudin as an alternative to unfractionated heparin and glycoprotein IIb/IIIa antagonists in low-risk patients undergoing elective PCI. (Level of Evidence: B)</td>
<td>Phrasing has been changed to reflect current terminology.</td>
</tr>
<tr>
<td>Class Iib</td>
<td>Low-molecular-weight heparin may be considered as an alternative to unfractionated heparin in patients with STEMI undergoing PCI. (Level of Evidence: B)</td>
<td>Bivalirudin and argatroban are established therapies in place of heparin among patients with heparin-induced thrombocytopenia (81, 82).</td>
</tr>
<tr>
<td>6.3.3. Management Strategies for Restenosis After PTCA</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Class Ila</td>
<td>It is reasonable that patients who develop restenosis after PTCA or PTCA with atheroablative devices are candidates for repeat coronary intervention with intracoronary stents if anatomic factors are appropriate. (Level of Evidence: B)</td>
<td>Patients undergoing PCI to an unprotected left main coronary artery are at higher risk for adverse events and should be monitored carefully. On the basis of experience and opinion in the available reports, the Writing Committee recommends angiography be performed between 2 and 6 months after PCI.</td>
</tr>
<tr>
<td>7.3.5. Drug-Eluting Stents</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Class I</td>
<td>A drug-eluting stent should be considered as an alternative to the bare-metal stent in subsets of patients in whom trial data suggest efficacy. (Level of Evidence: A)</td>
<td>New recommendation since the 2001 ACC/AHA Guidelines for Percutaneous Coronary Intervention. Evidence continues to accumulate that supports the use of drug-eluting stents (DES) versus bare-metal stents in certain subsets in which DES results and outcomes are better (70, 71, 85–97).</td>
</tr>
<tr>
<td>Class Iib</td>
<td>A drug-eluting stent may be considered for use in anatomic settings in which the usefulness, effectiveness, and safety have not been fully documented in published trials. (Level of Evidence: C)</td>
<td>The data that a DES can improve clinical outcomes for PCI are generally situations and anatomic settings.</td>
</tr>
</tbody>
</table>
Appendix. Abbreviations

CABG coronary artery bypass graft surgery
CAD coronary artery disease
CK creatine kinase
DES drug-eluting stent
ECG electrocardiogram
GP glycoprotein
HF heart failure
IVUS intravascular ultrasound
LAD left anterior descending artery

2001 TABLE. Recommendations for Pharmacological Management of Patients Undergoing PCI—For Comparison Purposes Only (Deleted From 2005 Guideline)

<table>
<thead>
<tr>
<th>Clinical Status</th>
<th>Transmural Myocardial Infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>Class I - Angina</td>
</tr>
<tr>
<td>Aspirin</td>
<td>I*</td>
</tr>
<tr>
<td>Ticlopidine,</td>
<td>I‡</td>
</tr>
<tr>
<td>Clopidogrel†</td>
<td>III</td>
</tr>
<tr>
<td>Warfarin</td>
<td>I</td>
</tr>
<tr>
<td>GP blockers#</td>
<td>II</td>
</tr>
<tr>
<td>Abciximab</td>
<td></td>
</tr>
<tr>
<td>Tirofiban</td>
<td></td>
</tr>
<tr>
<td>Eptifibatide</td>
<td></td>
</tr>
<tr>
<td>Unfractionated heparin**</td>
<td>I</td>
</tr>
</tbody>
</table>

Note: This table has been deleted from the 2005 PCI Guideline Update. The recommendations in this table were updated or deleted, as determined by the writing committee, and included in the 2005 PCI Guideline Update in the recommendation list.

*Roman numerals indicate ACC/AHA class indication I, II, or III.
†In conjunction with stenting.
‡To be given 24–48 h before planned stenting, if possible.
§For 2 to 4 weeks after stent placement.
¶For patients with atrial fibrillation or other pre-existing clinical indications.
#For patients with anterior myocardial wall motion abnormalities or LV thrombus.
Every indication may not apply to all individual agents.
**Low-molecular-weight heparin is under investigation to replace unfractionated heparin.
††Other noncoronary thrombotic complications (eg, thrombophlebitis).

2001 Recommendation    2005 New or Revised Recommendation    Comments

7.3.6.2 Drug-Eluting Stents for the Management of In-Stent Restenosis

Class IIa

None

Class IIa

It is reasonable to perform repeat PCI for in-stent restenosis with a DES or a new DES for patients who develop in-stent restenosis if anatomic factors are appropriate. (Level of Evidence: B)

This is a new recommendation. Clinical trials comparing sirolimus and paclitaxel DESs with PTCA for in-stent restenosis demonstrate improved outcomes for the DESs (97–101).

7.3.6.3. Radiation for Restenosis

Class IIa

None

Class IIa

Brachytherapy can be useful as a safe and effective treatment for in-stent restenosis. (Level of Evidence: A)

This is a new recommendation since the 2001 ACC/AHA Guidelines for Percutaneous Coronary Intervention based on evidence supporting the efficacy of brachytherapy in the treatment of in-stent restenosis (102–109).
References


ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention—
Summary Article: A Report of the American College of Cardiology/American Heart
Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to
Update the 2001 Guidelines for Percutaneous Coronary Intervention)

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