



SDI Review Form 1.6

Journal Name:	Cardiology and Angiology: An International Journal
Manuscript Number:	2014_CA_10483
Title of the Manuscript:	Early or selective invasive strategy in patients with non-ST-segment elevation acute coronary syndrome according to the risk factors at presentation? An outcome study
Type of the Article	Original Research Article

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This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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PART 1: Review Comments

	Reviewer's comment	Author's comment <i>(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)</i>
<u>Compulsory</u> REVISION comments	<p>Thank you for the invitation. I have read the paper and have few comments to share with you:</p> <p>I congratulate the authors for their hard work and their review of the literature. Their research is definitely worth publishing in your journal. But before they get to this final step, there are few comments / questions that need to be answered or clarified for the readers.</p> <p>1. There two similarly designed trials that tried to address the issue of Early Invasive versus Selectively Invasive Management for Acute Coronary Syndromes published in NEJM 2005 & 2009. Only the latter was referenced int his article despite the fact that both of them reached the same conclusion. I think it should be clearer that the current consensus about early intervention is NOT contradictory with regards to the general population of NSTEMI-ACS.</p> <p>2. What was the method of randomization? (76 in</p>	<ul style="list-style-type: none"> - The second study from NEJM about management strategy in acute coronary syndrome was added to the reference list - This study is not randomized. The enrolment in each arm was not based on randomization, but more on a geographical basis and according to the



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	<p>the early invasive group and 102 in the delayed group)</p> <p>3. There were only 28 patients with GRACE score > 140. What were the results for this sub-group with regards to the primary and secondary outcomes?</p> <p>4. What were the criteria to refer the patients in the selective group to cardiac angiography? In the script, the authors stated that they were referred only if they had positive stress test (32 / 102) or recurrent angina? This need to be elaborated: clear definition of angina - how was it graded - angina despite medical therapy? Previous studies used the Canadian Society of Cardiology Classification or if the patients required recurrent admissions for chest pain evaluation as secondary end-points.</p> <p>5. How can the authors explain the low number of PCI's in both group? How can they draw a conclusion with such a small number? Isn't the main point from early strategy is to rescue the ischemic myocardium with re-vascularization instead of medical therapy to prevent irreversible myocardial damage? Also time to intervention need to be cited for both groups in the table.</p>	<p>current situation in our country. We have tried to explain this in the text.</p> <ul style="list-style-type: none"> - The results for the subgroup of 28 patients with GRACE score >140 are presented in section 3.5 - Criteria to refer patients in the selective invasive strategy group to coronary angiography were described in more details in the Methods section. We defined recurrent angina as angina despite medical therapy. At this early stage of hospitalization for ACS patients did not have intense physical activity and CSC classification was not applicable - In early invasive strategy arm coronary angiography was done in all of the patients and PCI in almost all of them (except for 1 patient); in selective invasive strategy arm 2/3 of the patients underwent coronary angiography and almost all of them (except for one) proceeded to PCI. We consider that the number of coronary interventions in this UA/NSTEMI group is not low, at least not for our country. - Time to intervention was added in table 2 - About troponin values: most of the
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	<p>6. Please explain the relatively low levels of troponin in both groups?? The EKG criteria need to be clarified in the tables for both groups. Troponin was considered as one of the criteria for early invasive strategy and advanced anti-thrombotic therapy as per the ACC/AHA guidelines.</p> <p>7. How is this study different from the previous trials??</p> <p>[Comments received from mail]</p>	<p>patients have indeed low troponin values, but there are of course patients with significantly higher values. That makes the distribution uneven and therefore we have used median and interquartile range. And while the median for the whole group is 0.02, the mean troponin value is 0.56 with a standard deviation of 1.96.</p> <ul style="list-style-type: none"> - ECG criteria were added to table 2 - Of course a study comparing early versus selective invasive strategy in UA/NSTEMI patients could not be very different from other studies comparing such strategies in similar cohorts. Our results strongly support the adoption of early invasive strategy in UA/NSTEMI patients and particularly so in higher risk subgroups. And it was the first study of this kind performed in our country.
<u>Minor</u> REVISION comments		
<u>Optional/General</u> comments		