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ORIGINAL ARTICLE

Safety and outcome of same day discharge after elective PCI (Percutaneous Coronary Intervention) in patients with stable coronary artery disease.

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ABSTRACT… Objective: To determine the outcome in patients on same day discharge after elective PCI in patients with stable CAD. **Study Design:** Descriptive, Case Series study. **Setting:** Department of Cardiology, Faisalabad Institute of Cardiology. **Period:** 10th April 2021 to 9th October 2021. **Methods:** A total of 241 patients with stable coronary artery disease as per operational definition undergoing PCI of age 40-80 years and both genders were included. In each patient procedure was done by a consultant cardiologist (at least 3 years' post-fellowship experience). All patients were discharged from ward if remain stable for 6 hours. Patients were followed by researcher for 2 weeks and complications i.e. hematoma formation, allergic reaction and re-hospitalization (yes/no) were noted. **Results:** The age of the participants in this research was between 40 and 80 years with an average age of 61.15 years and SD of 8.27. Majority of the patients 125 (51.87%) were between 40 to 60 years of age. Out of 241 patients, 130 (53.94%) were female and 111 (46.06%) were males with female to male ratio 1.2:1. In my study, outcome in patients on same day discharge after elective PCI in patients with stable CAD was found to be hematoma in 13.28%, allergic reaction in 10.79% and re-hospitalization in 9.13% patients. **Conclusion:** This study concluded that same day discharge after elective PCI in patients with stable CAD is a safe practice.

Key words: Percutaneous Coronary Intervention, Stable CAD, Same Day Discharge.

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INTRODUCTION

Coronary artery disease (CAD) results from the formation of atherosclerotic plaques within the epicardial coronary arteries, leading to myocardial ischemia. It is a major global public health problem and a leading cause of morbidity and mortality in both developing and developed countries.[1] In both developed and developing nations, cardiovascular disease is becoming a problem to millions of people. Despite the fact that, the rate of mortality due to the disease has decreased over the last few decades in developed nations; it remains the top cause of mortality and has a huge social and economic burden on society the world over. The cardiovascular disease has been on the rise in both the low and the middle income countries. It is estimated that the disease will become the leading cause of morbidity and mortality in the majority of the developing countries by 2030.[2] CAD is a disorder that is typical among the aged. But nowadays it is frequently experienced by young adults. It is approximated that approximately 4-10 percent of people who have recorded CAD are below 45 years.[3] The burden of CAD is expected to increase further due to rapid urbanization and lifestyle changes in terms of dietary and sedentary habits, drug and alcohol use and the rise in the prevalence of the risk factors.[4] The number of the risk factors among the people predetermines the burden on the healthcare facilities in the future and the wasted working years of a person. Risk factors pose a health threat to the person, and they give a general strain to the economy.[5] Some of the most significant innovations in the field of percutaneous coronary interventions (PCIs) in the last several decades are as follows: the stent technology, the usage of radial access, the vascular closure devices of the femoral artery, and the more effective strategies of periprocedural antithrombotic.[6] These developments have resulted in a significant decrease in the rates of periprocedural complication with PCI with more recent statistics indicating less than 1.5% rates of major bleeding at 72 hours, and less than 1% rates of in-hospital mortality and acute kidney injury.[7]

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With the progress of PCI safety, it is demonstrated that not all safety measures are required nowadays, including the compulsory cardiac surgery on-site in the cases of elective PCI.[8] Same-day discharge (SDD) of elective PCI is a possible intervention to enhance the value of PCI because it is characterized by higher patient satisfaction and lower costs at the same time.[9,10] Although there are observational studies and randomized studies that prove the safety of SDD, previous research carried out between the years 2004 and 2008 and 2009 to 2013 indicates that uptake of this practice is fairly small in United States.[11] The past researches have indicated that immediate observation following PCI is safe. The patients might be sufficiently chosen to continue to be observed to foresee the post-procedural complications.[12] Moreover, it was demonstrated that the early ambulation following the employment of the femoral approach to PCI did not increase the number of complications and could be safely performed. Hematoma occurrence, allergic reaction and re-hospitalization due to chest pain were observed in 6.0, 10.0 and 10.0 percent of the same day discharge patients respectively following elective PCI in patients without acute coronary syndrome (stable CAD).[13]

This study was aimed at establishing the rate of complications in same day discharge patients undergoing elective PCI in stable CAD patients. Then according to these findings, the one with the shortest time of hospitalization may be chosen in our standard management protocols when handling these specific patients which would save them time and money by discharging early out of the hospital. Since this is the sole tertiary care institute in this region that has been siphoning a significant population, this research will also assist in addressing the burden of the patient by releasing him/her early and releasing him/her to other patients.

METHODS

This descriptive case series study was conducted at the Department of Cardiology, Faisalabad Institute of Cardiology, from April 10, 2021, to October 9, 2021. After obtaining approval from the institutional ethical review committee (32/DME/FIC/FSD, dated: 23.12.2020), a total of 241 patients with stable coronary artery disease (CAD), as per the operational definition, undergoing elective percutaneous coronary intervention (PCI) were included via non-probability consecutive sampling. Inclusion criteria comprised patients aged 40-80 years of both genders. Key exclusion criteria were multi-vessel disease, bifurcation or left main disease, saphenous vein graft or internal mammary artery interventions, immediate adverse cardiac events (ventricular tachycardia, ventricular fibrillation, cardiogenic shock, severe chest pain), immediate adverse cerebral events, bleeding disorders, anticoagulation therapy, hematoma at sheath removal, chronic renal failure (serum creatinine >1.5 mg/dl), and chronic liver disease (serum bilirubin >2 mg/dl) (Bundhun et al., 2017; Amin et al., 2018). All procedures were performed by a consultant cardiologist with at least three years of post-fellowship experience. Patients who remained clinically stable for 6 hours post-procedure were discharged on the same day. The researcher followed each patient for two weeks to document complications, including hematoma formation, allergic reaction, and re-hospitalization. Informed consent was obtained from all participants. An age, gender information, BMI, hypertension, diabetes mellitus, smoking status and the outcomes mentioned above were charted on a structured proforma. The SPSS version 25.0 was used to analyze the data. Expressed frequencies and percentages showed the quantitative variables, and frequencies and percentages showed the qualitative variables in the form of mean plus standard deviation. Stratification was used to control effect modifiers which were age, gender, BMI, hypertension, diabetes and smoking. Post stratification Chi-square test was used and the p-value of less than 0.05 was deemed to be statistically significant.

RESULTS

The study cohort of 241 patients had a mean age of 61.15 ± 8.27 years, with a near-even split between the 40-60 and 61-80 age groups. There was a slight female predominance (53.94%). The majority of patients (78.42%) had a Body Mass Index (BMI) within the non-obese range (≤30 kg/m^2). Comorbidities were highly prevalent, with diabetes mellitus (DM) present in 47.30%, hypertension (HTN) in 51.04%, and a history of smoking in 35.27% of patients. This profile is representative of a typical CAD population with significant metabolic

and cardiovascular risk factors, similar to cohorts described in other SDD studies (Bundhun et al., 2017; Amin et al., 2018). Table-I

The primary outcomes indicate that SDD after elective PCI is associated with a low rate of major complications. Hematoma formation was the most frequent complication (13.28%), followed by allergic reaction (10.79%) and re-hospitalization within two weeks (9.13%). The re-hospitalization rate of 9.13% is comparable to the 10% rate reported in a prior randomized control trial (Malik et al., 2019), while the hematoma rate in this study (13.28%) is higher than the 6% reported in that trial. This discrepancy may be related to differences in vascular access site management or patient selection. Importantly, the absence of reports for catastrophic events like acute stent thrombosis, major bleeding, or mortality aligns with the established safety profile of SDD in carefully selected, low-risk stable CAD patients. Table-II

The analysis reveals important associations between demographic factors and complications:

Age
No statistically significant differences were found in any of the three outcomes between the younger (40-60 years) and older (61-80 years) age groups (p-values: 0.196, 0.840, 0.792). This suggests that age, within the studied range, is not a decisive risk factor for complications post-SDD, supporting the inclusion of older patients in SDD protocols if they are otherwise low-risk. Table-III

Gender
A statistically significant association was found between gender and hematoma formation (p=0.029). Male patients had a notably higher incidence of hematoma (20.72%) compared to females (6.92%). This is consistent with literature suggesting potential anatomical or technical differences in vascular access or hemostasis between genders. No significant gender-based differences were observed for allergic reactions or re-hospitalization. Table-III

Body Mass Index (BMI)
A trend towards significance was observed between BMI and re-hospitalization (p=0.035). Notably, none of the 52 patients with a BMI >30 (obese) required re-hospitalization, whereas 11.64% of patients with a BMI ≤30 did. While counterintuitive, this may reflect a more cautious selection or post-procedural management strategy for obese patients, or it may be a chance finding in this sample. No significant association was found between BMI and hematoma or allergic reaction. Table-III

Comorbidities showed strong and significant associations with specific outcomes:

Diabetes Mellitus (DM)
DM was a significant effect modifier for all three outcomes. Non-diabetic patients had a significantly higher incidence of hematoma (20.47% vs. 5.26%, p=0.0001) and allergic reaction (15.75% vs. 5.26%, p=0.008). Conversely, diabetic patients had a significantly higher rate of re-hospitalization (14.04% vs. 4.72%, p=0.012). The elevated re-hospitalization risk in diabetics is clinically plausible, potentially due to a higher burden of diffuse coronary disease, microvascular dysfunction, or non-cardiac comorbidities leading to post-procedural issues. Table-IV

Hypertension (HTN)
HTN was significantly associated only with a higher incidence of allergic reactions (15.45% in hypertensives vs. 5.93% in non-hypertensives, p=0.017). This unexpected association warrants further investigation but could be related to concomitant medications. No significant link was found between HTN and hematoma or re-hospitalization. Table-IV

Smoking
Smoking status yielded highly significant associations. Non-smokers had substantially higher rates of hematoma (18.59% vs. 3.53%, p=0.0001) and allergic reaction (15.38% vs. 2.35%, p=0.0003). Smokers, however, showed a strong trend towards higher re-hospitalization (15.29% vs. 5.77%, p=0.059). The protective effect of smoking against access site issues like hematoma is a paradoxical finding often observed in cardiovascular studies, potentially related to differences in platelet function or vascular reactivity, but should not be interpreted as a beneficial effect of smoking. Table-IV

DISCUSSION

TABLE-I

Demographic and clinical characteristics details (n=241)

Characteristic	Category	Frequency	Percentage
Age (years)	40-60	125	51.87%
	61-80	116	48.13%
Mean ± SD	61.15 ± 8.27		
Gender	Male	111	46.06%
	Female	130	53.94%
Body Mass Index (kg/m²)	≤30	189	78.42%
	>30	52	21.58%
Mean ± SD	27.41 ± 3.03		
Diabetes Mellitus	Yes	114	47.30%
	No	127	52.70%
Hypertension	Yes	123	51.04%
	No	118	48.96%
Smoking	Yes	85	35.27%
	No	156	64.73%

TABLE-II

The general effect of the same-day discharge on patients who undergo elective interventional cardiology procedural intervention (ICI) (n=241)

Outcome	Frequency	Percentage
Hematoma	32	13.28%
Allergic Reaction	26	10.79%
Re-hospitalization	22	9.13%

TABLE-III

Stratification of outcomes by demographic factors

Factor (Category)	Hematoma Yes (%)	Allergic Reaction Yes (%)	Re-hospitalization Yes (%)	P-Value
Age: 40-60 (n=125)	20 (16.00%)	13 (10.40%)	12 (9.60%)	0.196
Age: 61-80 (n=116)	12 (10.34%)	13 (11.21%)	10 (8.62%)	
Gender: Male (n=111)	23 (20.72%)	13 (11.71%)	15 (13.51%)	0.029
Gender: Female (n=130)	9 (6.92%)	13 (10.00%)	7 (5.38%)	
BMI: ≤30 (n=189)	21 (11.11%)	22 (11.64%)	22 (11.64%)	0.059
BMI: >30 (n=52)	11 (21.15%)	4 (7.69%)	0 (0.00%)	

TABLE-IV

Stratification of outcomes by comorbidities

Factor (Category)	Hematoma Yes (%)	Allergic Reaction Yes (%)	Re-hospitalization Yes (%)	P-Value
DM: Yes (n=114)	6 (5.26%)	6 (5.26%)	16 (14.04%)	0.0001
DM: No (n=127)	26 (20.47%)	20 (15.75%)	6 (4.72%)	
HTN: Yes (n=123)	15 (12.20%)	19 (15.45%)	11 (8.94%)	0.613
HTN: No (n=118)	17 (14.41%)	7 (5.93%)	11 (9.32%)	
Smoking: Yes (n=85)	3 (3.53%)	2 (2.35%)	13 (15.29%)	0.0001
Smoking: No (n=156)	29 (18.59%)	24 (15.38%)	9 (5.77%)	

An increasing trend of percutaneous coronary intervention (PCI) and the escalating cost of healthcare has resulted in the major logistic and financial burden on overwhelmed healthcare resources, across the globe.[14] Numerous attempts have been made in order to reduce medical care spending and still achieve clinical effectiveness and patient safety. Post PCI patients are kept overnight as a routine to evaluate the risk of acute stent thrombosis and complications of vascular access

site.[14] The same-day discharge (SDD), whereby discharge day is the same calendar day of the PCI, has resulted in lower healthcare expenses and higher patient satisfaction.[15] On-patient PCI which has been done in the patients and early ambulation with discharge has led to improved comfort and satisfaction of the patient. The SDD objective can only be achieved when the best practices are undertaken to reduce the risk of developing cardiac and vascular access site complications. The SDD could be performed depending on the adequate estimation of the danger of the acute target vessel blockage, clinical outcomes, and elimination of access site problems in the aftermath of the premature ambulation in the patient, who has experienced PCI.[15] Most of the complications occur too early (within 6 hours) or too late (after 24 hours) following PCI. Reduction of the length of stay in the post-PCI hospital will likely reduce the costs and maximize the use of healthcare resources.[14-18] This study was conducted to evaluate the result of same day discharge in patients who undergone elective PCI in patients with stable CAD. The outcome in patients on same day discharge following elective PCI in patients with stable CAD was observed to be hematoma in 13.28, allergic reaction in 10.79 and re-hospitalization in 9.13 patients in this study. In a research, Hematoma was experienced by 6.0% of patients, allergy reaction by 10.0% and re-hospitalization of chest pain by 10.0% patients of same day discharge following elective PCI in patients with stable CAD.[13] Previous studies that have investigated SDD following PCI have involved both randomized and observational studies[20-28], as well as meta analyses and systematic reviews.[29-31] These articles focus primarily on the elective PCI in patients with stable coronary artery disease, but Abdelaal et al also included some of the low-risk ACS patients in the observational study conducted by Khater et al.[32] The same adverse event post-discharge rates in SDD and non-SDD patients have been in line with our results. There exist studies which involve ACS patients. The lowest adverse events were very low (1 event) in the first 6 hours and no adverse events at the 6 to 24 hours reported in one-third of the patients in a single-center study of 1059 patients with one-third of them having ACS.[33] EASY trial was randomized among 1005 patients who had undergone successful transradial PCI to SDD compared to the overnight stay. They failed to find any negative outcomes at 30 days and 1 year and this guaranteed the safety of SDD used in such patients following straightforward transradial PCI. Abdelaal et al.[35] conducted a study to assess the outcomes of same day discharge or overnight hospitalization following PCI and it must be noted that they were capable of analyzing the results of 110,000 patients (acquired via observational studies and randomized trials). Brayton et al.[36] tested the same results too by saying that same day discharge was not related to an increased risk of major adverse event with the strategy applied in selected patients with PCI and was as safe as the overnight follow-up to the coronary angioplasty. They also had an opportunity to show that patients who did not receive same day discharge following the PCI had low short and long term outcomes. Similarly, this plan was secure and dependable in a one first-time experience of center focused on same day discharge after angioplasty on a contingent of patients who did not suffer complications in the future. Furthermore, one additional single centered registry was done that demonstrated the safety of same day discharge in low-angiographic and clinical risk patients, and no post-procedural complications were reported. The reason behind the small number of serious adverse cardiac cerebral events may lie in the fact that there were no patients with acute coronary syndrome and once again may be used to support the appropriateness of the selection criteria applied to the current study. The careful selection principles on the appropriateness of same day discharge in a heterogeneous population of patients are supported by our research that revealed that the in-hospital resources could be predicted. The available evidence shows that the practice security could be guaranteed without any adverse impact on the quality-of-care or safety of the group of patients having higher-risk profile.

CONCLUSION

Same-day discharge after elective PCI in carefully selected patients with stable CAD is safe and cost-effective, and should be considered in routine clinical practice.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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1	**Faisal Abbas:** Study design.
2	**Muhammad Yasir:** Data analysis.
3	**Muhammad Akram Asi:** Data entry.
4	**Munir Ahmad:** Data collection.