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IN THIS ISSUE OF EUROINTERVENTION

A EuroIntervention State of the Art on the management of cardiogenic shock; intravascular hypothermia as adjunctive therapy for primary PCI; dual therapy with dabigatran plus a $P2Y_{12}$ inhibitor in STEMI patients with atrial fibrillation; a trial of balloon-based techniques for severely calcified coronary lesions; neoatherosclerosis after PCI for in-stent restenosis; antithrombotic therapy for coronary erosions; a mini focus on spontaneous coronary artery dissection, and more…

Davide Capodanno, *Editor-in-Chief*

When it comes to submitting your own original study to a scientific journal, most of your chances for success lie in the choice of the journal itself. At least that's what I tell my fellows when they set publication goals that I find too ambitious or unrealistic.

In reality, when I say this, many doubts assail me: am I clipping their wings? Am I hindering dreams or legitimate aspirations? What if they were right, and my suggestions are just those of a person who – immodestly – has great experience in…his own articles being rejected?

Let's face it, after a few years we all have this experience: sometimes the submission goes well, but most of the time it goes wrong and growing academically

essentially means becoming better at directing your efforts towards more realistic and sustainable goals. This basically means becoming more efficient – writing less but writing better.

To do this, it is necessary to start from a crucial consideration, i.e., the relationship between the value of the article you are planning to submit and the impact factor of the journal. The lower this ratio is, the lower the chances of hitting the target on your first try. If you understand this in advance, with some intellectual honesty, and if your article is suitable for the particular journal you are targeting, the possibilities of acceptance grow substantially. It is difficult to be disappointed in the face of a negative result, if you are good at recognising that the goal was disproportionate.

These reflections frequently come to mind when I think of which articles are suitable for EuroIntervention. What do our submitting authors think when they try to decide if one of their articles is suitable for this journal or not?

Things have changed considerably over the last year, although it's not for me to say whether that's for the better or for the worse. However, there is certainly a whole variety of items that no longer match our standard. We need to be good at communicating about these changes, making clear what our new standard is so that those who send us articles are aware of what to expect in advance before they submit.

Actually, there are no secrets. Our table of contents is there, every month, trying to attract your attention as both readers and authors, so let's see what we've prepared for you in this issue.

We begin with a EuroIntervention State of the Art on the management of cardiogenic shock. Authors **Holger Thiele, Sean Fitzgerald and colleagues** concentrate primarily on cardiogenic shock after acute myocardial infarction, outlining the latest treatments. At the same time, they cite the difficulty in designing trials for the management of this condition, resulting in the minimal amount of evidence-based clinical data existing today. This should change soon, and the authors look forward to the near future when a series of more robust trials in pharmacology and mechanical circulatory support should offer more critical, and much needed, information in this area.

Turning to coronary interventions, **Marko Noc, Thomas R. Keeble and colleagues** present the COOL AMI EU trial in which the safety and efficacy of rapid systemic intravascular hypothermia as an adjunctive therapy to primary percutaneous interventions in patients with ST-elevation myocardial infarction (STEMI) was evaluated. While the device used, the ZOLL® Proteus™, was seen to reduce temperatures, the trial was discontinued due to inconsistencies in patient logistics, with the hypothermia protocol resulting in longer ischaemic delays and no reduction in infarct size. It was also associated with an increase in adverse events. However, the authors note that future trials should be able to build on the negative experiences seen here.

Uwe Zeymer, Christopher P. Cannon and colleagues present a subgroup analysis of the RE-DUAL PCI trial in which the safety and efficacy of dabigatran dual therapy plus a $P2Y_{12}$ inhibitor was evaluated against warfarin triple therapy in patients with atrial fibrillation undergoing a percutaneous coronary intervention for ST-elevation myocardial infarction. In these patients, the results support the use of dabigatran dual therapy,

which was seen to have a lower risk of bleeding and a similar risk of thromboembolic events, and which could thus be considered as a standard of care in these cases. This article is accompanied by an editorial by **Dominick J. Angiolillo and Mattia Galli**.

What is the efficacy of balloon-based techniques in preparing severely calcified coronary lesions before stenting? This is the subject of the ISAR-CALC trial presented by authors **Tobias Rheude, Salvatore Cassese and colleagues**. In this trial, patients were randomised to predilation with either a super high-pressure balloon or a scoring balloon. On intravascular imaging, both of these balloon device techniques were associated with comparable stent expansion as well as a trend towards improved angiographic performance in the severely calcified coronary lesions. This article is accompanied by an editorial by **Emanuele Barbato and Konstantinos Bermpeis**.

In the next article, **Daisuke Nakamura, Yasushi Sakata and colleagues** studied the impact of neoatherosclerosis on prognosis after percutaneous coronary interventions for in-stent restenosis. Using a multicentre registry, the authors determined that the estimated glomerular filtration rate, the time from an intervention to in-stent restenosis, and in-stent restenosis in drug-eluting stents were independent predictors of neoatherosclerosis, which was seen to have a negative impact on clinically driven target lesion revascularisation.

The EROSION study was designed to investigate whether an antithrombotic therapy without stenting could be effective in treating acute coronary syndromes caused by erosion. In this article, **Luping He, Bo Yu and colleagues** present the four-year outcomes of the trial which confirmed the safety and feasibility of this approach. Those patients who had a better response to antithrombotic therapy during the first month were seen to be less likely to require stent implantation during the four-year follow-up period.

Last but not least, our mini focus in this issue looks at our current understanding of spontaneous coronary artery dissection (SCAD), with an introductory editorial by **Jacqueline Saw and Cameron McAlister**.

In the first article in this series, authors **Nicolas Combaret, Pascal Motreff and colleagues** examined data from a national French registry of spontaneous coronary artery dissections. They found a relationship between SCAD and fibromuscular dysplasia as well as a genetic association for SCAD linked to the PHACTR1 locus, with or without the presence of the fibromuscular dysplasia. In this disease, which mainly affects middle-aged women with few or no cardiovascular risk factors, conservative management was seen to be safe.

SCAD angiographic classifications exist, but their clinical impact is unknown. **Ricardo Mori, Javier Escaned and colleagues** look at the relationship between these classifications and the development of adverse clinical events in order to understand their clinical impact better. The authors observed that SCAD was present in a variety of angiographic patterns or angiotypes with certain – specifically angiographically circumscribed and contained haematoma – being seen to have an increased risk of adverse clinical events early in SCAD treatment, as well as in the long-term follow-up.

And now, why don't we let the articles speak for themselves?