

3. Cold exposure and winter mortality from ischaemic heart disease, cerebrovascular disease, respiratory disease, and all causes in warm and cold regions of Europe. The Eurowinter Group. *Lancet* 1997;**349**:1341–1346.
4. Cuspidi C, Ochoa JE, Parati G. Seasonal variations in blood pressure: a complex phenomenon. *J Hypertens* 2012;**30**:1315–1320.
5. Modesti PA. Season, temperature and blood pressure: a complex interaction. *Eur J Intern Med* 2013;**24**:604–607.
6. Rostand SG. Ultraviolet light may contribute to geographic and racial blood pressure differences. *Hypertension* 1997;**30**:150–156.
7. Modesti PA, Morabito M, Massetti L, Rapi S, Orlandini S, Mancia G, Gensini GF, Parati G. Seasonal blood pressure changes: an independent relationship with temperature and daylight hours. *Hypertension* 2013;**61**:908–914.
8. Gavhed D, Makinen T, Holmer I, Rintamaki H. Face temperature and cardiorespiratory responses to wind in thermoneutral and cool subjects exposed to –10 degrees C. *Eur J Appl Physiol* 2000;**83**:449–456.
9. Cassol CM, Martinez D, da Silva FA, Fischer MK, Lenz Mdo C, Bos AJ. Is sleep apnea a winter disease?: meteorologic and sleep laboratory evidence collected over 1 decade. *Chest* 2012;**142**:1499–1507.
10. Alperovitch A, Lacombe JM, Hanon O, Dartigues JF, Ritchie K, Ducimetiere P, Tzourio C. Relationship between blood pressure and outdoor temperature in a large sample of elderly individuals: the Three-City study. *Arch Intern Med* 2009;**169**:75–80.
11. Smith GD, Hart C, Blane D, Gillis C, Hawthorne V. Lifetime socioeconomic position and mortality: prospective observational study. *BMJ* 1997;**314**:547–552.
12. World Health Organization. Commission on Social Determinants of Health: Final Report. http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
13. McManus RJ, Mant J, Haque MS, Bray EP, Bryan S, Greenfield SM, Jones MI, Jowett S, Little P, Penaloza C, Schwartz C, Shackelford H, Shovelton C, Varghese J, Williams B, Hobbs FD, Gooding T, Morrey I, Fisher C, Buckley D. Effect of self-monitoring and medication self-titration on systolic blood pressure in hypertensive patients at high risk of cardiovascular disease: the TASMIN-SR randomized clinical trial. *JAMA* 2014;**312**:799–808.

CARDIOVASCULAR FLASHLIGHT

doi:10.1093/eurheartj/ehu512

Online publish-ahead-of-print 13 January 2015

The world's longest follow-up after percutaneous coronary intervention, 37 years and still going strong

Bernhard Meier*

Swiss Cardiovascular Center Bern, Bern University Hospital, Bern 3010, Switzerland

* Corresponding author. Tel: +41 31 632 30 77; Fax: +41 31 382 10 69, Email: bernhard.meier@insel.ch

When in 1977 a 38-year-old man presented with unrelenting unstable angina to the University Hospital of Zurich, Switzerland, an exception was made to the rule to reserve coronary angiography to patients refractory to extended medical treatment. A single lesion of the left anterior descending artery (LAD) was found (Panel A). Andreas Roland Grüntzig (ARG) had been successfully performing peripheral artery balloon angioplasty for almost 4 years at that time and had been looking for over a year for a suitable patient to perform the first in-man coronary procedure with a miniaturized balloon, dedicated for coronary artery disease. On 16 September 1977 the world's first percutaneous coronary intervention (PCI) remedied the stenosis in the LAD successfully. The patient remained symptom-free for 23 years when a new lesion just proximal to the initial one required a stent. Again he remained asymptomatic for 14 years when a coronary angiogram performed for recurrent exertional angina revealed a stenosis in the distal part of the stent placed in 2000, again just proximal to the historically initial lesion (Panel B). There was also a new stenosis in the proximal part of the right coronary artery (RCA, Panel C). Left ventricular function was normal (Panel D). A drug-eluting stent was placed in each the LAD (Panel E) and the RCA (Panel F). The exercise stress test the next day was normal. The patient was discharged on prasugrel 10 mg, rosuvastatin 10 mg and ramipril 2.5 mg (for hypertension).

This patient had formed a team with ARG to lay the ground for PCI, to date the most common therapeutic intervention in cardiovascular medicine if not in medicine in general. The outcome is remarkable with a 37-year course with just 2 short box-stops after 23 and 37 years, respectively. And the prognosis is excellent for this man, currently 75 years old and still professionally and socially very active.

Published on behalf of the European Society of Cardiology. All rights reserved. © The Author 2015. For permissions please email: journals.permissions@oup.com.

