2. Jager AJ, Tutty MA, Kao AC. Association between physician burnout and identification with medicine as a calling. *Mayo Clin Proc*. 2017;92(3):415-422.
3. Ahola K, Hakanen J, Perhoniemi R, Mutanen P. Relationship between burnout and depressive symptoms: a study using the person-centered approach. *Burnout Res*. 2014;1(1):29-37.
4. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA*. 2011; 306(9):952-960.
5. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377-1385.
6. Mousa OY, Dhamoon MS, Lander S, Dhamoon AS. The MD blues: under-recognized depression and anxiety in medical trainees. *PLoS One*. 2016;11(6): e0156554.
7. Mayo Clinic. Sharing Mayo Clinic. http://sharing.mayoclinic.org/mayo-brothers-wisdom/. Accessed May 18, 2017.

http://dx.doi.org/10.1016/j.mayocp.2017.05.017

In Reply—Physicians in the 21st Century: Between Identification With Medicine as a Calling and Self-Diagnosing Burnout, Depression, and Anxiety

To the Editor: I thank Mousa et al[1] for submitting a letter to the editor in response to our article titled "Association Between Physician Burnout and Identification With Medicine as a Calling."[2] Although our study assessed the relationship between burnout and calling only among practicing physicians, I would support the premise that Mousa et al posit: that is, this inverse calling-burnout association is likely to be found among medical trainees.

However, given the focus of our study, I am reluctant to claim that "lacking the sense of calling can be a critical marker of mental health illnesses."[1] Whether lacking a sense of calling is associated with psychiatric diagnoses such as major depressive or general anxiety disorder, it would seem that there are ways of assessing for such disorders more directly (eg, through the use of formal, validated screening tools as used in the Mousa et al study of medical trainees[3]) or indirectly (eg, measures of burnout) without having to invoke a lack of calling as a critical marker of such disorders.

Audiey C. Kao, MD, PhD
American Medical Association
Chicago, Ill

1. Mousa OY, Dhamoon MS, Dhamoon AS. Physicians in the 21st century: between identification with medicine as a calling and self-diagnosing burnout, depression, and anxiety. *Mayo Clin Proc*. 2017.
2. Jager AJ, Tutty MA, Kao AC. Association between physician burnout and identification with medicine as a calling. *Mayo Clin Proc*. 2017;92(3):415-422.
3. Mousa OY, Dhamoon MS, Lander S, Dhamoon AS. The MD blues: under-recognized depression and anxiety in medical trainees. *PLoS One*. 2016;11(6): e0156554.

http://dx.doi.org/10.1016/j.mayocp.2017.05.016

A Differing Opinion on Primary Percutaneous Coronary Intervention in Patients Who Have Had Cancer: Stent Choice in Onco-cardiology Revisited

To The Editor: We are writing in reference to the report of Wang et al[1] titled "Cancer History Portends Worse Acute and Long-term Noncardiac (but Not Cardiac) Mortality After Primary Percutaneous Coronary Intervention for Acute ST-Segment Elevation Myocardial Infarction," as well as the accompanying editorial by Al-Kindi and Oliveira[2] titled "Onco-Cardiology: A Tale of Interplay Between 2 Families of Diseases," published in the December 2016 issue of *Mayo Clinic Proceedings*. Specifically, we wish to expound upon our differing opinion on the use of coronary artery stents in select onco-cardiology patients.

The study by Wang et al[1] demonstrated the importance of aggressive cardiovascular care in patients with a history of cancer, but also suggested that these patients are less likely to receive drug-eluting stents (DESs) to treat coronary artery disease (CAD), out of concern for high bleeding risk and expectant need for cancer-directed surgery. Although characterized as a "safe" treatment strategy, in our opinion, it might not be optimal for all patients with CAD and a history of cancer.

Many of the clinical risk factors for cancer such as diabetes mellitus, smoking, and a chronic inflammatory state are also risk factors for coronary artery restenosis and thrombosis after stenting. The current generation of DES reduces the risk of restenosis and stent thrombosis as compared with bare-metal stents.[3] It was previously felt that the biggest disadvantage of DESs was the requirement of dual antiplatelet therapy (DAPT) for at least 12 months after stent placement. This interpretation of anticoagulant therapy resulted from the experience with first-generation DESs, in which it was inferred that DES stent failure was more likely because of inhibition of neointimal formation resulting in incomplete endothelialization.[4] However, data on the current generation of DES calls this interpretation of the pathophysiology into question.

A prespecified analysis from the Zatarolimus-Eluting Endeavour Sprint Stent in Uncertain DES Candidates (ZEUS) trial found that patients with high bleeding risk and those receiving stents that slowly eluted zotarolimus (an immunosuppressant) had a lower rate of stent thrombosis, myocardial infarction, and target vessel revascularization compared with those receiving bare-metal stents, despite shorter duration of