

seen in a subgroup of patients with aggressive coronary atherosclerosis. Conversely, the pathophysiologic response⁵ to the presence of an intravascular foreign body (stent) may also adversely affect the fate of the conduits used to graft stented coronary arteries. Stenting can cause prolonged endothelial dysfunction, as well as an acute and chronic inflammatory reaction, even during the late period, with involvement of the distal coronary artery and surrounding myocardium.⁵ This may adversely affect anastomosis sites in patients who subsequently undergo coronary artery bypass grafting.

A vexed question is whether the poor fate of venous conduits used to bypass coronary arteries with in-stent restenosis is due to aggressive atherosclerosis or to an inflammatory reaction involving downstream coronary artery beds. Although we do not know the distribution of occluded conduits with respect to stent locations, we cannot definitively point out the influences on graft patency. We therefore do not support inclusion of these data in meta-analyses.

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Reply to the Editor:

We thank Nezc and colleagues for their interest in our recent article.¹ We regret to point out, however, that Nezc and colleagues misrepresent data reported by Gaudino and associates.² In fact, 2 different analyses were reported in that study. First, Gaudino and associates² reported an angiographic comparison of radial artery (RA) and saphenous vein graft (SVG) conduits randomly assigned to target obtuse marginal coronary arteries (OMs) with previous stenting (study group) versus OMs without previous (control group). The results of this comparison were shown in Gaudino and associates' Table 3,² which compared 20 RA conduits versus 20 SVG conduits from the study group and 20 RA conduits versus 20 SVG conduits from the control group. In addition, they reported angiographic results of other conduits not randomly assigned to complete revascularization in both the study and control groups (see Gaudino and associates' Table 2²).

For the purpose of our meta-analysis of randomized, controlled trials, we included only conduits randomly assigned to target OMs. Therefore, in our study the Gaudino I study included RA versus SVG conduits randomly grafted to previously stented OMs, and the Gaudino II study included RA versus SVG conduits grafted to unstented OMs. The risk that intrastent restenosis would influence the results was exactly the same for all RA and SVG conduits used in the first cohort of patients (Gaudino I). Nezc and colleagues picked up data referring to conduits not randomly assigned to complete revascularization (see Gaudino and associates' Table 2), thus completely misrepresenting the inclusion criteria adopted in our meta-analysis of randomized, controlled trials.

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META-ANALYSIS COVERS THE HORIZON WHEN THE LITERATURE SEARCH IS UNDERTAKEN THROUGH A KEYHOLE

To the Editor:

The meta-analytical review by Benedetto and colleagues¹ comparing failure rates of radial artery (RA) and saphenous vein (SV) conduits in coronary artery bypass grafting has several methodologic flaws that significantly limit its validity. Consequently, we strongly believe that both the data presented and the conclusion that "no definitive evidence supports the superiority of the RA over the SV in terms of graft failure rate"¹ cannot be accepted without challenge.

Benedetto and colleagues' restrictive inclusion criteria¹ may have excluded data from several high-quality studies that considered different target lesions or used definitions of graft failure other than total graft occlusion or severe diffuse graft narrowing (string sign).¹ Angiographic stenosis of more than 50%, 70%, or 75%, for example, may cause symptomatic ischemia and may require repeated angiography. Finally, Benedetto and colleagues¹ appear to have excluded important studies in which assessment of angiographic patency was performed at a fixed interval as a secondary end point. These restrictive inclusion criteria compromise the