CORRESPONDENCE

Re: ‘Long-term Results of a Randomized Controlled Trial Analyzing the Role of Systematic Pre-operative Coronary Angiography Before Elective Carotid Endarterectomy in Patients with Asymptomatic Coronary Artery Disease’

Two meaningful papers by Illuminati et al. have shown real benefits of systematic pre-operative coronary angiography prior to carotid endarterectomy (CEA), suggesting a more aggressive approach to cardiac risk management. However, the high number of inappropriate invasive studies associated with this strategy may be relevant, and the role of prophylactic myocardial revascularization is still under debate. Like Illuminati et al., we routinely performed coronary angiography on a consecutive series of 238 candidates for CEA (January 2005–December 2013), which revealed a prevalence of severe coronary artery disease (CAD; left main trunk stenosis >50%, one-, two-, and three-vessel stenosis >80%) in a subgroup of 64 patients who had diabetes compared with 174 patients without diabetes (n = 35 [54.6%] vs. n = 63 [36.2%]; p < .05). Percutaneous (57.1%) and surgical (42.9%) myocardial revascularization were effective in reducing the post-operative risk in patients with diabetes who usually have a higher peri-procedural myocardial infarction rate than patients without diabetes undergoing CEA. Coexisting CAD in patients scheduled for CEA conveys a peri-operative burden that could offset the long-term benefit of surgery. Routine coronary angiography should be advocated for patients with diabetes who will benefit mainly from prophylactic myocardial revascularization preceding carotid surgery.

REFERENCES


R. Borioni*, F. Tomai, M. Garofalo
Department of Cardiovascular Sciences, European Hospital, Via Portuense 700, Rome 00149, Italy
*Corresponding author.
Email-address: raoulborioni@alice.it (R. Borioni)

Response to ‘Re: Long-term Results of a Randomized Controlled Trial Analyzing the Role of Systematic Pre-operative Coronary Angiography before Elective Carotid Endarterectomy in Patients with Asymptomatic Coronary Artery Disease’

We wish to thank Drs. Borioni, Tomai, and Garofalo, for their kind comments and are pleased to observe that we all strongly recommend inclusion of systematic coronary angiography in the pre-operative workup of diabetic patients without a history or any symptoms of coronary artery disease (CAD) who are nonetheless candidates for carotid endarterectomy (CEA). We are also pleased to learn that the results in this subset of patients are transferrable to those we obtained in our randomized trial, during long-term follow up. It is a matter of great satisfaction to observe that major centers of cardiovascular surgery are providing validation for our initial hypothesis on the value of systematic coronary angiography in the standard workup of CEA candidates. This procedure is meant to detect asymptomatic, significant CAD and to treat it either by percutaneous intervention or by coronary artery bypass grafting, thereby virtually eliminating both post-operative and long-term myocardial ischemic events.

We would like to add that using multivariate analysis, our studies have shown a significant prevalence of myocardial ischemia not only in patients without coronary angiography, but also in smokers versus non-smokers limited to the post-operative period and aged less than 70 years, as well as diabetes during long-term follow up. In fact, if we were to include all of the categories showing a significant correlation with myocardial ischemia, in our indication for pre-operative coronary angiography, we would probably end up by including all CAD asymptomatic CEA candidates; given our randomized results, that is how we have been proceeding.

Nonetheless, Dr. Borioni’s systematic practice of pre-operative coronary angiography in all diabetic patients who are candidates for CEA is absolutely right, as diabetics are the most likely to harbor asymptomatic coronary lesions. As complications of coronary angiography did not appear in our study and are virtually absent from the high caseload hospitals and centers dedicated to the treatment
of cardiovascular diseases, following in the footsteps of Dr. Borioni we would once again like to stress the importance of extending this pre-operative procedure to all CEA candidates without a history of CAD. Hopefully, other centers will achieve results similar to Dr. Borioni’s and ours, thereby contributing to the widespread use of what we presently consider the most reliable tool for diagnosing and simultaneously treating CAD at the time of hospitalization for CEA and other peripheral arterial surgery. Coronary angiography would consequently be dissociated from preconceived ideas pertaining to its mistakenly presupposed danger and invasiveness.

REFERENCES


G. Illuminati
University of Roma, La Sapienza, Roma, Italy

J.-B. Ricco*
University of Poitiers, Medical School, Poitiers, 86000, France

*Corresponding author. Vascular service, University Hospital Jean-Bernard, Poitiers, 86021, France.

Email-address: jeanbaptistericco@gmail.com (J.-B. Ricco)

© 2015 European Society for Vascular Surgery. Published by Elsevier Ltd. All rights reserved.

http://dx.doi.org/10.1016/j.ejvs.2015.06.110
DOI of original article: http://dx.doi.org/10.1016/j.ejvs.2015.05.023

Re: ‘Preferred Strategy for Hemodialysis Access Creation in Elderly Patients’

We praise Tordoir et al. for their comprehensive review of the available evidence for vascular access in the elderly. The recommendation of an early cannulation arteriovenous graft (AVG) as a first access contradicts all published vascular access guidelines and challenges the “one-size-fits-all” approach to vascular access.

Most published outcomes of arteriovenous fistulae (AVFs) are poor, with high primary failure and moderate patency rates. Therefore, the concept of an autologous AVF being the best form of vascular access is only valid if we assume all AVFs work well.

A nonmaturing AVF results in extended catheter use, with its added morbidity and mortality burden. As the dialysis population ages the dogmatic approach recommended by the guidelines must be challenged and emphasis placed on a tailored approach to vascular access. Exhauling vascular access through loss of venous capital is unlikely in elderly patients, and the main priority is to achieve a functional vascular access promptly.

However, age alone should not be a contraindication to AVF creation. Many patients aged >65 years are fully active and may have a lower “physiological age”. Transplantation listing is based more on this concept than prescriptive age, with positive results. The details of the vignette are lacking and while in these patients an AVG may be the best option, the selective use of autologous AVFs may give superior longer term outcomes with less intervention required.

REFERENCES


J. Al Shakarchi*, D. McGrogan, N. Inston
University Hospital Birmingham, Birmingham, UK

*Corresponding author.
Email-address: j.alshakarchi@nhs.net (J. Al Shakarchi)

© 2015 European Society for Vascular Surgery. Published by Elsevier Ltd. All rights reserved.

http://dx.doi.org/10.1016/j.ejvs.2015.05.016
DOI of original article: http://dx.doi.org/10.1016/j.ejvs.2015.05.009

Response to Letter to the Editor ‘Re: Preferred Strategy for Hemodialysis Access Creation in Elderly Patients’

We agree with the comments that most guidelines advise a “fistula first” policy in the incident and prevalent hemodialysis population. However, in concordance with their remarks, autologous arteriovenous fistulae (AVFs) are only valid if all AVFs perform properly and are functional for daily practice. That is precisely the bottleneck of creating vascular