outweighs the selection of the bifurcation stenting technique. As for DCB, it seems useful for ISR after bifurcation stenting, and thus allowing prevention of neointimal hyperplasia and avoiding excessive DES.

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Radial Artery in Breast Cancer Survivors
A Possible Choice but Always With Caution

We read with great interest the article by Yadav et al. (1) and want to congratulate the authors on their extensive experience in this complicated field. Radial access has become the route of default for cardiac catheterization and percutaneous intervention in many centers. However, the fear of a possible lymphedema in breast cancer survivors has always been present and frequently is perceived as a contraindication. The article by Yadav and colleagues represents an important advance demonstrating the safety in a large series of patients. However, we would like to add some information that we consider relevant. Our group has much experience using the radial access (2), and it has been our first choice in diagnostic and therapeutic interventions since 2003. Although a history of breast cancer has never represented a contraindication, we had 1 negative experience with a 78-year-old woman with right mastectomy in 1993 who was admitted with a non-ST-segment elevation myocardial infarction. In 2005, we had already performed a cardiac catheterization through the right radial artery with 6-F catheters without complications. Another angiography was indicated in 2012 through the same right radial artery and in the current procedure a 0.014 Whisper wire (Abbott Vascular, Irvine, California) and a 4-F JR4 catheter were needed to go through a stenosis at the level of the elbow, and later on a 6-F guiding catheter was required to perform an intravascular ultrasound interrogation of the left main artery. During the procedure, a slight resistance was felt in the elbow with the movements of the 6-F catheter. In the next 4 h, a hematoma developed in the patient’s elbow with significant lymphedema of the arm. The perimeter of the right arm reached 34 cm compared with 25 cm in the left arm. Conservative management with elevation of the right arm, cessation of clopidogrel, and maintenance of aspirin were indicated, although 3 weeks were necessary to resolve the complication due to the delayed reabsorption of the edema. Another case with a serious complication was previously described (3). The series described by Yadav et al. demonstrates that the ipsilateral radial artery is one of the possible routes for performing angiography in these patients, but we should keep in mind that in case of complications, there may be a limited capacity to resolve. We believe that probably the most correct procedure should be to approach the contralateral radial or even ulnar arteries first (4) and, in case of failure, then to evaluate the condition of the femoral arteries and the risk of bleeding to choose the most adequate approach between the ipsilateral artery or the femoral access. In addition, as Saito et al. (5) reported that only 71.5% of females have radial arteries with a diameter larger than a 6-F catheter, every effort should be made to reduce the size of the catheter used.

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