IS LOCAL WOUND INFECTION RATE MORE IMPORTANT THAN LONG-TERM GRAFT PATENCY IN CORONARY ARTERY BYPASS GRAFTING?

To the Editor:

Samano and associates¹ have reported their experience on saphenous vein (SV) graft patency after coronary artery bypass grafting (CABG) with yet longer follow-up data. In 1993, a single-center longitudinal randomized trial was initiated by the Örebro group that compared no-touch (NT) and conventional SV graft harvesting.¹ At a mean of 16 years, 27 patients per group, accounting for 72 conventional and 75 NT grafts, underwent computed tomographic angiography to assess graft patency.¹ Of the NT grafts, 83% (62/75) were patent, only slightly lower than the 88% (42/48) patency of the left internal thoracic artery grafts and significantly higher than the 64% (46/72) patency of the conventional SV grafts.¹

In the 1990s, at the same time as the introduction of the NT method, a minimally invasive endoscopic technique was developed for harvesting SV grafts.² The main benefit of the endoscopic approach relates to the decrease in wound morbidity and patient satisfaction, based in part on superior cosmetic outcome, although the technique is of questionable cost-effectiveness because of the higher initial equipment costs.³ The data presented by Samano and associates¹ support SV grafts in the battle for the position of graft of second choice in CABG and call into question the benefit of total arterial revascularization. Despite the benefits shown to date, the use of the NT technique for SV harvesting in CABG is still limited to only a few centers. Considering several reports on inferior patency of SV grafts harvested by means of endoscopy⁴⁻⁷ and the potential clinical benefit behind the improved patency of the NT technique, the question arises as to why surgeons are so reluctant to adopt the NT technique for harvesting SV grafts. Moreover, the adoption of endoscopic vein harvesting has assumed epidemic proportions and is considered the criterion standard for SV harvesting in the majority of centers in the United States⁸ despite those reports revealing inferior patency.

We congratulate Samano and associates¹ on their fine work. It is difficult to understand, given the excellent long-term data with use of the NT technique and increasing reports of poor patency rates in endoscopically harvested SV grafts, why NT harvesting is not used in more centers. In addition, although we are aware of the ongoing Surgical and Pharmacological Novel Interventions to Improve Overall Results of Saphenous Vein Graft Patency in Coronary Artery Bypass Grafting Surgery: An International Multi-Center Randomized Controlled Clinical Trial (SUPERIOR SVG PATENCY CABG, clinicaltrials.gov identifier NCT01047449) comparing NT with conventional SV graft patency and clinical outcome, we hope that the study by Samano and associates,¹ as well as this Letter to the Editor, will reach out to the broader surgical audience and encourage the adoption of the NT technique for harvesting the SV in CABG.

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