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IS BILATERAL INTERNAL THORACIC ARTERY TRULY BETTER FOR OLDER PATIENTS?

To the Editor:

The selection of the second graft conduit remains a matter of debate. To address this point, the Arterial Revascularization Trial (ART) was performed, but this large randomized controlled trial did not prove the benefit of bilateral internal thoracic artery (BITA) graft over single internal thoracic artery (SITA) graft with regard to all-cause mortality, myocardial infarction, or stroke at postoperative 10 years, and a subgroup analysis showed no interaction according to age.¹

Here, Navia and colleagues² report their single-center retrospective observational study comparing the BITA graft with the SITA graft in patients aged 70 years or greater undergoing coronary artery bypass grafting surgery (CABG) from 2001 to 2018. They adopted propensity score-matched technique and found the use of BITA graft improved 10-year survival, with similar postoperative morbidity in patients at this age. They are to be congratulated on the important and meaningful results; however, there are a number of points worth discussing.

First, the assessment workflow for the choice of BITA graft or SITA graft before the operation wasn't mentioned in the study, and it is unclear whether the factors like coronary anatomy and severity of culprit vessel were considered. The latter one has been shown to be an important predictor of the graft patency and survival after CABG.³ Moreover, among their cohort of 1300 patients, patients in the SITA cohort were older with more comorbidities, such as previous renal failure, hypertension, peripheral artery

disease, urgency, and low ejection fraction, suggesting that the SITA graft might be used preferentially in greater-risk patients.

Second, a recent meta-analysis of randomized controlled trials showed the use of radial artery (RA) compared with SVG was associated with a lower risk of a composite of cardiovascular outcomes among patients undergoing CABG.⁴ In addition, a recent publication from Royse and colleagues⁵ reported that postoperative survival was not different between RA and right internal thoracic artery when using as the second arterial conduit joined to the left internal thoracic artery (LITA) via a Y graft for total arterial revascularization. However, in the present study, there was a mixed population in the SITA graft group, which included LITA plus RA with or without saphenous vein (SVG) in 80% of the patients and LITA plus SVG in the remaining patients.² Therefore, we are concerned about the difference of outcomes between the BITA and SITA graft groups was derived from these 20% of patients with LITA plus SVG. If the authors can provide an additional subgroup analysis, it would have better clarified the significance of their findings.

Finally, they matched 243 pairs by propensity score; given that there were only 332 patients in the SITA group, this represents more than a 27% loss from the population of interest that could result in decreased generalizability and accuracy of the results. Furthermore, the propensity-matched patients in the study were more like the SITA group than the BITA group, so external validity for the greater BITA cohort is in question.

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