We thank Dashwood and colleagues\(^1\) for their reply to our commentary regarding the use of the radial artery (RA) and no-touch saphenous vein graft (NT-SVG) in patients undergoing coronary artery bypass grafting surgery.\(^2\) Our commentary was predicated on the recently published 8-year patency results of a single-center randomized controlled trial comparing the RA with the NT-SVG by Dreifaldt and colleagues.\(^3\)

We agree that NT-SVG has excellent potential as evidenced by numerous histologic and some clinical studies,\(^4,7\) and it is encouraging that endoscopic harvesting techniques are being explored for the NT-SVG to address leg infection rates.\(^1\) With regard to endoscopic harvesting, comparative studies have predominantly involved endoscopic conventional saphenous vein graft (SVG) versus open conventional SVG harvesting (Veterans Affairs study by Zenati and colleagues\(^8\)). Clinical trials of NT-SVGs have exclusively used an open approach.\(^4,7\) A higher incidence of vein harvest site complications has been seen with the NT-SVG compared with conventional SVGs\(^4\) and endoscopic SVGs in an observational study.\(^9\) Two studies\(^10,11\) reported a skip incision technique of NT-SVG; however, additional studies are required, including the feasibility of this technique, incidence of wound complications, and impact on graft patency and clinical outcomes.

Furthermore, when comparing the RA with the NT-SVG, we emphasize that the comparison must be performed on a level ground accounting for the known properties of the study conduits. To our knowledge, the study by Dreifaldt and colleagues\(^3\) is the only trial to compare the 2 conduits, and Samano and colleagues\(^6\) used the NT-SVG almost exclusively for a number of years.

It is well known that RAs tend to perform best when grafted to targets with more than 90\% stenosis.\(^12,13\) This is because in situations of competitive flow, RAs are prone to spasm and occlusion.\(^12,14\) In the trial by Dreifaldt and colleagues,\(^3\) more than 60\% of radial targets had less than 90\% stenosis, with approximately 33\% of the RAs targeted to a less than 70\% stenotic vessel.\(^2,3\)

Furthermore, the media of the RA is 1.7-fold thicker than the internal thoracic artery, increasing its propensity for contractility.\(^15\) Thus, it is encouraged to minimize alpha-adrenergic agents perioperatively if possible\(^16\) and use calcium channel blockers (CCBs) at discharge for longitudinal protection.\(^16\) A meta-analysis by Gaudino and colleagues\(^17\) also showed that CCB therapy was protective against major adverse cardiac events (adjusted Cox hazard ratio 0.52, \(P = .02\)) and further supported by the Society of Thoracic Surgeons practice guidelines that states it is reasonable to use RA grafts to targets with severe stenosis and pharmacotherapy to reduce perioperative graft spasm.\(^2,18\) In the study by Dreifaldt and colleagues,\(^3\) only 24\% of patients received a CCB for the indication of hypertension.\(^2\)

Overall, Dreifaldt and colleagues\(^3\) should be congratulated for undertaking a longitudinal RCT, which is a merit on its own. The findings of the study show that there is a role for both conduits, but one could argue that the RAs in the trial were not used in the optimal manner. Data supporting less-invasive harvesting of the NT-SVG are limited so far, but the rationale for less-invasive harvesting is sound. Accordingly, it would be premature for assigning a silver to the NT-SVG and bronze to the RA as Dashwood and colleagues\(^1\) suggest; rather, until a trial that compares these conduits in their optimized environment occurs, The Race for the Second Best Conduit... continues.

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