Review of: "Graft Angiography Through Right Radial Artery: A Retrospective Cohort Study"

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Potential competing interests: No potential competing interests to declare.

Muhammad Omer Hashmi and colleagues retrospectively analyzed their local success rate for coronary graft angiography through the right radial artery. They compared their results with “a control group” for the success rate (of angiography), for procedural parameters (fluoro time, volume of contrast, procedure time), and for the complications of bleeding, hematoma, pseudoaneurysm, radial artery occlusion, and nerve injury. They must be complimented for their commitment to performing graft angiography through radial access.

Moreover, if people want to improve their skills, looking at their performance is an excellent place to start. However, the analysis and the description of their work must be extensive. So, we encourage the authors to expand their communication further.

The manuscript may be easily optimized by feeding the reader.

The local hemostasis protocol should be described.

The “control group” should be described (origin, patient characteristics, etc.) and how the selection of right radial (RR) access versus non-RR was made. The alternative routes should be described (left radial? right versus left femoral? other?).

The study could have looked more deeply at the procedures: for example, what causes failure (puncture? inability to reach aortic arch? other?)? How many procedures were only diagnostic versus interventional? How many grafts were patent? In how many cases was success partial versus complete?

In Table 2, 20 patients in the control group had a problem with radial artery occlusion: explain... (conversion after radial attempts failures?).

One significant benefit of radial access is the ease of controlling any local bleeding, so the rate of bleeding is not the primary concern. However, the consequences of bleeding make the difference: how many blood transfusions and how many local surgeries for bleeding were required in the study population (versus the control group).

“Nerve injury” should be described: is it compartment syndrome?

If yes, the hemostasis protocol should be described (and probably modified).

The discussion could focus on improving the local statistics: why not discuss ways to be less aggressive for the procedure, such as reducing the size of catheters, for example? 5F is large enough for diagnostic purposes. Multipurpose shafts are available, which reduces the number of catheters to be exchanged. Patent hemostasis techniques are well-described and provide excellent results.

Systematic graft control post-surgery is not clinically justified until the surgeon’s statistics are locally known.