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Revascularization strategies for occluded carotid artery

We read with interest the article by Song et al[1] entitled "Long-term outcomes of axillary to carotid bypass for symptomatic patients with chronic common carotid artery occlusion."

Symptomatic chronic common carotid artery atherosclerotic occlusion is a rare entity compared with internal carotid artery occlusive disease.[2] Many surgical procedures are available for treatment of symptomatic chronic common carotid artery atherosclerotic occlusion, such as long endarterectomy beginning at the innominate or left subclavian arteries, long endarterectomy and carotid-to-subclavian transposition, and a bypass grafting procedure. However, the optimal surgical treatment is not yet clear.[3]

We have a few questions regarding their study. First, we wondered whether the authors had excluded those patients who had undergone previous coronary bypass surgery and had a patent internal mammary artery with an anastomosis to the left anterior descending coronary artery. The use of an axillary artery as an inflow artery for carotid bypass can cause a coronary steal problem.

In addition, in their study, the authors preferred to use a ringed 8-mm polytetrafluoroethylene graft as a conduit. The saphenous vein has also been used for these operations with high patency and low infection rates.[4] Thus, we wondered why the authors suggested the use of the polytetrafluoroethylene graft.

Also, the authors performed axillary artery exploration through an infraclavicular incision and performed a graft through the subclavicular tunnel. If the supraclavicular incision has been used, it is not necessary to perform a subclavicular tunnel, and the possible risk of compression could be avoided.[5]

In routine practice, many clinics do not stop antiplatelet therapy (especially, acetylsalicylic acid) before peripheral vascular surgery. However, the authors stopped antiplatelet drugs on the day of bypass surgery. We wondered whether that would have resulted in any differences in the hemorrhagic outcomes.

Finally, the authors prescribed antiplatelet drugs during the follow-up period. However, we wonder whether anticoagulant agents would be a sufficient alternative to antiplatelet therapy during long-term follow-up. We just wonder about the authors' assessment.

We congratulate Song et al[1] for their valuable and safe treatment methods for common carotid artery occlusions. We would like to hear the authors' opinions on these matters.

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Reply

We are sincerely grateful to Professor Aydin and colleagues for their thoughtful comments about our paper.[1] The internal mammary artery (IMA) is used with increasing frequency for myocardial revascularization. There were three patients who had previously undergone coronary bypass surgery with IMA as grafts in