positive tests in 3.6% [5]. The incidence of a positive test is positive. In a study of 2940 arms Hosokawa et al. found positive tests. At our institution 3.5% of Allen tests are harvest [1]. Other series have reported much lower rates of and suggest further investigation prior to radial artery harvesting: Results in 3977 cases. Ann Thorac Surg 2001;72:1557—61.


Keywords: Radial artery; Coronary artery bypass grafting; Allen test

Letter to the Editor

Re: Is the Allen test reliable enough?

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Keywords: Radial artery; Coronary artery bypass grafting; Allen test

We agree with Kohonen et al. [1] that a negative Allen’s test is safe to harvest the radial artery. This is well known. We have harvested the radial artery in 881 patients with a negative Allen’s test without postoperative hand ischaemia [2]. Barner has done the same in 1364 patients [3] and Meharwal and Trehan in 3977 cases [4].

What to do in the event of a positive test is not as straightforward. Kohonen et al. report 23% tests as positive and suggest further investigation prior to radial artery harvest [1]. Other series have reported much lower rates of positive tests. At our institution 3.5% of Allen tests are positive. In a study of 2940 arms Hosokawa et al. found positive tests in 3.6% [5]. The incidence of a positive test is dependent on the time allowed for capillary refill, hyperextension of the hand and the length of the ischaemic interval prior to the release of the ulnar artery. We have previously described our technique in detail [2]. We would suggest in the event of a positive test to immediately repeat it using an alternative technique and taking great care to prevent hyperextension of the hand. This should reduce the number of positive tests and still allow safe harvest of the radial artery reserving more complex investigations for cases with two positive tests with two different techniques.

References


Letter to the Editor

Re: Perivascular tissue of internal thoracic artery releases potent nitric oxide and prostacyclin-independent anticontractile factor

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Keywords: CABG; Perivascular tissue; Nitric oxide; Saphenous vein; Internal thoracic artery

We read with interest the recent article by Malinowski et al. [1] on the release of a soluble anticontractile factor from perivascular tissue (PVT) of the internal thoracic artery (ITA). In this study the authors show that the PVT surrounding the ITA, the ‘gold standard’ graft in coronary artery bypass surgery (CABG), releases a nitric oxide (NO) and prostacyclin-independent anticontractile factor. The authors suggest that the presence of an active PVT might explain the functional difference between skeletonised and non-skeletonised ITA and influence vascular function after graft implantation. Possible drawbacks of removing PVT should be taken into account since preservation of this tissue might be beneficial.

Malinowski et al. suggest that the influence of PVT removal on the function of other vessels used for CABG, such as the saphenous vein, the radial or the gastroepiploic arteries should be analysed. Although we have not performed functional studies, we have recently shown that the PVT surrounding saphenous veins used as grafts in patients undergoing CABG exhibits positive endothelial nitric oxide synthase (eNOS) immunoreactivity, contains eNOS mRNA and