Reply to Dashwood

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Conflict of interest: No

We thank Dr Dashwood [1, 2] for his commentary on our review of external venous bypass surgery. He expressed the view that despite some improvements in conduit function with external stenting, the no-touch technique of venous grafting has demonstrated superior long-term results and should, therefore, be employed instead of external stents.

There is no doubt that the no-touch technique for saphenous vein harvesting is associated with more favourable results than in veins extracted using conventional methods [3, 4]. The no-touch technique involves removing the SV with an outer layer of tissue which, may itself, act like a biological external stent. As Dashwood has described, the no-touch technique results in a number of improved histological appearances, which have been associated with an improvement in the patency of SV conduits. On the other hand, a number of complications of this technique have been described, including larger leg wounds and numbness over the harvesting site [4].

As we discuss in our article, the results of early generation external venous bypass supports were indeed poor and unfavourably compared with those of non-stented SV grafts in the same patient [5]. However, the current generation of external stents has been associated with much better biological and haemodynamic properties, notably the VEST device as discussed in our article [2, 6]. Furthermore, we still await the results of a recent multicentre trial investigating the long-term effects of such stents (the VEST-III Trial, NCT02511834). Although the no-touch technique offers superior patency to conventionally harvested vein grafts, only further research will reveal whether similar results can be obtained with external stenting of vein grafts harvested by an endoscopic technique and avoiding the large wounds and additional leg morbidity associated with the no-touch technique.

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Global cardiac surgery: a wake-up call

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Global cardiac surgery can be defined as an area for study, research, practice and advocacy that places priority on improving health outcomes and achieving health equity for all people worldwide who are affected by cardiac surgical conditions or have the need for cardiac surgical care, as adapted from Dare et al. [4]. This will require addressing the individual interdependent components of a health system and, more broadly, international and transnational relations, with the need for regionalization of cardiac surgical services. Similarly, this urges for investments in and close collaboration between cardiac surgeons, cardiologists, anaesthesiologists, nurses, technicians, perfusionists, biomedical engineers, intensive care personnel, primary health workers and other health services, in addition to infrastructure ranging from preventive measures and early diagnostic systems to in-hospital surgical and interventional care, imaging, catheterization, intensive care units and other supporting services, to postoperative rehabilitative and follow-up systems, addressing anticoagulation and regular cardiovascular screening.

To overcome this gross disparity and neglect of access to cardiac surgical services, strengthening health systems to robust and resilient systems is essential. To do so, there is the need for global collaboration within the cardiac community, overarching with the inclusion of cardiac surgical and interventional stakeholders, to establish a unified voice to effectively advocate for the 4.5 billion people lacking cardiac surgical care when needed [5]. The recent ‘Cape Town Declaration on Access to Cardiac Surgery in the Developing World’ on rheumatic heart disease is a first step in the right direction [6]. However, the entire global cardiac community is urged to act upon the necessity to build consensus to collectively respond to this unmet need and gross inequality, impeding the chance, if not basic human right, to health.

REFERENCES