CABG is more beneficial for survival. Because patients with diabetes have more diffuse coronary disease with a 2-fold higher rate of total occlusions and a tendency towards more distal disease [5], however, revascularization is often more challenging in patients with diabetes and consequently may be less complete (Supplementary material, Reference [E5]). Independent predictors of incomplete-revascularization CABG in the SYNTAX [Synergy between PCI with TAXUS and Cardiac Surgery] trial [6] were unstable angina, diffuse disease or small vessels and the number of lesions, but not diabetes. On the basis of results of the BARI [Bypass Angioplasty Revascularization Investigation] trial (Supplementary material, Reference [E4]), the concept of ‘reasonable’ incomplete-revascularization CABG of the circumflex or right coronary artery territory (Supplementary material, Reference [E1]) has been advocated [7–9]. In the present meta-analysis, however, even including these studies (Supplementary material, Reference [E2], E4) showed a benefit of complete- over incomplete-revascularization CABG with regard to survival. To reduce the effect of treatment-selection bias and potential confounding, we strictly abstracted (then combined in a meta-analysis) adjusted (but not unadjusted) risk estimates from observational studies. However, potential biases are likely to be greater for observational studies compared with randomized trials; so results should always be interpreted with caution when they are included in reviews and meta-analyses [10].

SUPPLEMENTARY MATERIAL

Supplementary material is available at ICVTS online.

Conflict of interest: none declared.

REFERENCES


