



Invited Commentary

Commentary on: Endoscopic vein harvesting for coronary artery bypass grafting in the UK: what we believe and what we do. A Commentary on the article “Use of endoscopic vein harvesting (EVH) during coronary artery bypass grafting in United Kingdom: The EVH survey”, *Int J Surg* 2019;69:146-151



Soni et al. [1] used an online questionnaire to survey the use of endoscopic vein harvesting (EVH) for coronary artery bypass grafting in the UK and the factors influencing surgeons' preference. Their effort is commendable and offers a snapshot of EVH use in the UK. The survey was completed by 52% of the approached surgeons, with 25% responding that they routinely use EVH, and 44% mentioning use in less than 10% of their cases. While a response rate of 52% is understandable for an online survey, the small sample size limits the findings of the study and leaves us with questions.

If the Harefield study is presumed to represent the general opinion, their findings may indicate how recent studies are shaping EVH practice in the UK. Soni et al. report that 90% of their respondents believe EVH to minimize leg wound issues and 25% consider concerns about EVH patency to be genuine. The REGROUP Trial [2] showed EVH to be associated with markedly lower rates of leg-wound complications and put to rest previous concerns about the safety of EVH in terms of cardiovascular events and mortality. However, no data was reported on graft patency [2]. The secondary analyses of the PREVENT-IV and ROOBY trials showed poorer patency with EVH and may explain why many surgeons are still reluctant to adopt EVH [3,4]. It is possible that the higher rates of vein-graft failure associated with endoscopic procedures in the previous trials were, in part, due to lack of experience in EVH. It is also possible that the survey respondents represent only a subset of the general population and more complex modeling could have identified associations between surgeons' characteristics and EVH use.

While majority of the respondents admit benefit of EVH in minimizing leg-wound complications, only 25% routinely practice it. In contrast, EVH has been adopted as the standard of care in United States with approximately 80% CABG procedures utilizing EVH [5]. A considerable personal and institutional learning curve, and cost is associated with adoption of EVH as the standard of care. Judgments on the cost and feasibility of EVH depend on the local context and setting. Issues worth considering include time, staff, surgical skills and training, equipment necessary to carry out the procedure, and the ability of healthcare systems to implement them [5]. It must be emphasized that the REGROUP trial included only experienced saphenous-graft harvesters. To translate the results of the trial broadly, it is essential that only certified experts perform EVH, which may not be always possible.

Consequently, the open approach continues to remain popular in some countries. Where EVH is not practical, outcomes of open vein harvesting can be improved by below-knee harvesting of smaller diameter vein and the use of the no-touch saphenous vein which may improve patency.

Conflicts of interest

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