U.S. Department of Veterans Affairs

Public Access Author manuscript

N Engl J Med. Author manuscript; available in PMC 2020 June 16.

Published in final edited form as:

N Engl J Med. 2019 May 30; 380(22): e43. doi:10.1056/NEJMc1904533.

Endoscopic versus Open Vein-Graft Harvesting for CABG

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The authors reply:

Saffarzadeh et al., Li et al., Bonchek, and Dashwood commented on our trial involving patients undergoing CABG surgery in which endoscopic vein-graft harvesting, performed by experts in the technique, was compared with an open approach and was found to result in similar freedom from major adverse cardiac events and a lower incidence of wound-healing complications.

Generalizability of findings in clinical trials is highly desirable and is best achieved by striking a balance in the selection of participating institutions and providers, especially if the focus is on a technique that is expertise-based, like endoscopic vein harvesting. By including only centers of excellence and excluding community practices, the generalizability of conclusions is likely to be reduced. In the REGROUP trial, we elected to include a mix of providers that would be more representative of the general community precisely in order to improve the generalizability of the findings. In the real world, a wide spectrum of providers is safely practicing vein harvesting. The harvest times and frequency of conversion observed in our trial are in line with our philosophy of aiming to reproduce the real world of vein harvesting while at the same time setting a strict threshold for minimal provider expertise (at least 100 endoscopic harvests in an established program, with conversion occurring in <5% of patients). Of the 33 endoscopic providers who participated in our trial, 81.8% had more than 10 years of experience, and 48.5% had performed more than 1000 endoscopic harvests before the initiation of the trial. As was correctly pointed out by Li et al., a few studies have reported shorter harvest times or less frequent conversion than ours, but these studies do not represent the real world of everyday practice, were not randomized, or were single-center, single-provider uncontrolled series that were at risk for observation bias.

We believe that there is an unmet need for monitoring and quality assessment of endoscopic vein-harvest providers, partially driven by the lack of a dedicated procedural code in the Current Procedural Terminology manual edited by the American Medical Association. In

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Since publication of their article, the authors report no further potential conflict of interest.

our opinion, more effort is needed on the part of hospitals and professional societies to develop and maintain quality-improvement initiatives for endoscopic vein harvesting, especially at institutions that have declining volumes of CABG surgery due to the increasing preference for percutaneous coronary intervention.