LETTERS TO THE EDITOR

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Comparison of operator radiation exposure with optimized radiation protection devices during coronary angiograms and ad hoc percutaneous coronary intervention by radial and femoral routes

We have read with interest the study by Brasselet et al., which evaluates the operator radiation exposure during coronary angiograms and ad hoc percutaneous coronary interventions by radial and femoral approaches. We have some concerns about the paper.

First, according to the authors’ statement, the special feature of this study was that the operators were blinded to the data collection and study purpose; we would like to know how they did not consider the operator radiation exposure in about 50% of procedures that were excluded in the study period, in the light of operator blindness; we also would like to know whether the authors have some data regarding the radiation exposure in the excluded procedures.

Secondly, the authors affirm that, in their experience, radial alone and radial plus femoral approaches were related to an annual radiation exposure close to whole-body limit (20 μSv/year) ‘as assessed using the left-arm dosimeter.’ We think that there is a misinterpretation because the left-arm dosimeter assesses the limb radiation exposure, whose limit is 500 μSv/year, as also the authors reported. Thereafter, in the study that enrolled 420 patients, the authors found that both electronic dosimetry and passive dosimetry assessed under the lead apron, with optimized radiation protection devices, were not significant; how do they explain that, in their annual experience of 800 coronary angiograms and 700 coronary angiograms followed by ad hoc percutaneous coronary interventions, they reported a mean annual operator radiation exposure ranging from 9.77 to 17.96 μSv/year?

Thirdly, procedural durations were significantly higher in the radial group; to our knowledge, both in our registry and in previous studies, the procedural time is lower with the radial approach, also in comparison to the femoral approach followed by closure devices.

Finally, in the study, the radiation exposure levels were higher and fluoroscopy time was lower when compared with other studies; we disagree with the authors about the submitted explanation: if the higher radiation dose is related to high rate of PCIs performed in multiple and complex lesions, why is the fluoroscopy time lower?

References

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Association between hormone replacement therapy and subsequent arterial and venous vascular events: a meta-analysis

A new systematic review regarding this contested women’s health issue is certainly welcome. However, the inclusion of several trials evaluating the effects of menopausal hormone therapies (MHTs) on coronary heart disease (CHD), myocardial infarction, cerebrovascular events, and venous thrombo-embolism events (Figure 3) is debatable. Out of 25 included studies, 11 were conducted to study other outcomes such as bone density, fractures, or surrogate markers for CHD. These studies reported data on CHD as adverse events. Furthermore, studies without placebo control or a double-blind design were included; they may not provide the best possible estimates. This new meta-analysis may be seen as problematic as adverse events differ from pre-specified primary or secondary cardiovascular outcomes regarding the quality to capture events. The latter type of data were exclusively utilized in a previous (not referenced) systematic review on the subject with differing results regarding CHD. Yet, one further prior (not referenced) systematic analysis also included studies with adverse events, some of which were not included in the present publication.

One may argue that these considerations may not matter anyway, given that the overwhelming proportion of data were derived from the Womans’s Health Initiative and the HERS study, placebo-controlled double-blind trials. The association between MHT and vascular is a contested one; therefore, further sensitivity analyses taking into