Author's response to reviews

Title: Contemporary Incidence and Risk Factors for Carotid Artery Disease in Patients Referred for Coronary Artery Bypass Surgery

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Author's response to reviews: see over
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Vipin Zamvar, MD
Editor
Journal of Cardiothoracic Surgery

David Taggart, MD
Editor
Journal of Cardiothoracic Surgery

Dear Dr. Zamvar and Dr. Taggart:

Thank you for reviewing our manuscript entitled: “Contemporary Incidence and Risk Factors for Carotid Artery Disease in Patients Referred for Coronary Artery Bypass Surgery” for your consideration for The Journal of Cardiothoracic Surgery.

We have read the editors comments thoroughly and have modified the manuscript and references as best we could to implement their suggestions as follows:

In response to Reviewer, Susumu Manabe:

(1) Incidences of carotid artery disease presented in Table 2 are not compatible with those presented in Results section, first paragraph. Is the incidence of bilateral moderate stenosis 7% or 9.4%?

The incidence of bilateral moderate stenosis is 9.4%. We have changed the sentence in the Results:

“In the 559 patients who had preoperative carotid duplex ultrasound, as listed in Table 2, 64% had mild to no stenosis and 36% had significant carotid artery stenosis (>50%).”

(2) Are the p values in Table 3 and 4 the results of univariate analysis or multivariate analysis? If they were the results of multivariate analysis, other data such as Odds ratio or 95% CI should be presented here.

The results are by univariate analysis. We have indicated this in the “Statistical Analysis” section.

(3) The recommendation of this study to perform routine carotid screening for patients undergoing CABG is not considered rational. This recommendation is based on the finding that incidence of CAS was high in CABG population.
(moderate CAS: 24%, severe CAS: 8.6%). However, according to Durand et al. (you have referred this study as Ref 17.), the selective carotid screening reduced preoperative testing by 40%, with only a “negligible” impact on surgical management or neurological outcomes, although the incidence of severe CAS was 13.4%. The latest guideline (2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery) recommends to perform preoperative CAS screening in selected patients (i.e., age >65 years, left main coronary stenosis, PAD, history of cerebrovascular disease [transient ischemic attack [TIA], stroke, etc.], hypertension, smoking, and diabetes mellitus). (class IIa, Level C)

If you recommend the routine performance of preoperative CAS screening, you have to clarify the advantage of this approach based on your data. For example, if you follow the recommendation of ACC/AHA guideline or Durand, what percentage of patient with CAS will be overlooked?

We have removed the last sentence (listed below) from the discussion:
“Given the high incidence of CAS in patients with coronary artery disease, we recommend routine use of carotid ultrasound”.

We truly appreciate the efforts put forth by you, the reviewers and editors in helping us prepare this manuscript, and we are quite proud of the final result.

With our very best regards,

Robert J. Moraca MD