

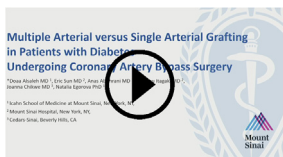
influence on long-term outcomes, but this was not captured in these databases.

CONCLUSIONS

In this retrospective cohort analysis of data from mandatory New Jersey state registry linked with death records and hospital discharge databases, patients with diabetes benefit from receiving MAG over SAG. MAG was associated with improved long-term survival, lower hazards of repeat revascularization and the composite outcome of death from any cause, stroke, postdischarge MI, and/or repeat revascularization. Coordinated efforts are needed to offer MAG to patients with diabetes.

Webcast

You can watch a Webcast of this AATS meeting presentation by going to: <https://www.aats.org/resources/1312>.



Conflicts of Interest Statement

The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

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Key Words: coronary revascularization, multiarterial graft, single arterial graft, diabetes

Discussion

Presenter: Doaa Alsaleh



Dr Rashmi Yadav (London, United Kingdom). I'm happy to speak from here. Thank you very much. Thank you for your invitation, and thank you for your excellent presentation. If I understood your slides correctly, they do show that there was the same level of myocardial infarction and repeat revascularization in the two groups. And if that is the case, then do you think that it is the old chestnut of retrospective observational studies where we are not able to identify hidden confounder? And often, as surgeons, we have an end-of-the-bed test. We see a patient who looks better and better, and they got a multiarterial graft. Do you think that these might be noncardiac reasons why those patients have a better survival over a seven-year period?



Dr Doaa Alsaleh (*New York, USA*). Thank you so much for your question. If I can just ask about the very first you said, about the myocardial infarction?

Dr Yadav. And repeat revascularization. Was it similar in the two groups, or different?

Dr Alsaleh. No. So it was not significant for the MI, but it was significant for the repeat revascularization.

Dr Yadav. Okay. Thank you. So, there is some evidence that it is helping them in the longer term. My other observation, and perhaps this is simply an observation, is that as a total proportion of the group, there were approximately 30% women patients, and only 20% of women received multiple arterial grafts. And this is a trend that we're starting to see now and something that we need to address that will then get less guideline-directed revascularization compared to men. Do you have any comments about that?

Dr Alsaleh. Yeah. That's an excellent observation. There are, in fact, a few papers that looked at multiple arterial vs single arterial by gender, and we're also doing that as an additional analysis and will include it in the manuscript. We're going to look at multiple arterial vs single arterial by gender and look at all the patient characteristics for women and why they're being offered less multiarterial vs in men.

Dr Yadav. Thank you.

Dr Alsaleh. Thank you so much.

Dr Yadav. Thank you. And my final question is, do you know what is the reason for this disturbing trend of less arterial grafts over the time period that you've studied? Would you like to hazard any reasons why this is happening?

Dr Alsaleh. Why is there a decline in the trend? Yeah. So, because the guidelines generally, both the US and the European guidelines, there is no clearcut guideline for the use of multiarterial vs single arterial to use in patients in general. And then each of the patients could carry higher risk of other outcomes. For example, an important risk could be seen as well with the type of the graft used. That's sternal infection. And that is also an important outcome that we're looking to explore. So maybe there is a hesitancy based on the outcomes that could be more troublesome, or also, training in arterial grafting procedures as well.

Dr Yadav. Okay. Thank you very much. Well done.

Dr Alsaleh. Thank you.

Unidentified Speaker 1. Thank you. There's an awful lot of data there to chew over. My question relates to prior percutaneous coronary intervention (PCI). In New York State, it was shown conclusively that if you have PCI first and then coronary artery bypass graft, the results are less good. So I'm asking you, are you able to reflect on this in your database, and may that be the explanation for the poorer outcomes?

Dr Alsaleh. Thank you for your question. If you can just repeat. If I could reflect on the PCI being—

Unidentified Speaker 1. Before CABG. So that it appears to many of us who do surgery that if a patient has had their coronary arteries instrumented before, particularly on multiple occasions, the target vessels are damaged in a way that produces poorer outcomes from surgical revascularization.

Dr Alsaleh. Yeah. We actually included prior PCI and we adjusted for it as part of our data, and it was 1 of the variables that we actually also did propensity match. So it was adjusted for in our data.

Unidentified Speaker 1. Thank you.