

Letter to the Editor

Editöre Mektup

Is distal radial access a “bridge too far” for routine use in acute coronary syndrome?

Dear Editor,

We read with great interest the article by Erdem et al.^[1] presenting their experience regarding distal radial access (DRA) in patients with acute coronary syndrome (ACS). The authors reported a high success rate of DRA, which is 94.2%. We are informed that distal radial pulsations were manually checked; however, it is not clear if patients with inadequate or absent distal radial pulsations were also considered for the DRA. In our experience, almost 5% of patients presenting with ACS have unobtainable DRA pulsations.

Moreover, such a remarkable success rate can be driven by the absence of termination criteria for DRA. In a cohort of 253 DRA procedures (42.1% in patients with ACS), we found lower DRA success rate (90.2%) when number of attempts was limited to five and the time pre-specified for DRA to five minutes.^[2] Yet, this strategy led to shorter sheath insertion times (needle-to-sheath time 1.68±1.29 minutes, failed procedures included), which is of great interest in ACS.

In this study, all the procedures were performed by a single operator, a fact that abolishes inter-operator variability, although it also hinders the extrapolation of data to multi-operator cath-lab scenarios. For example, in our cohort, as much as 25.1% of the DRA procedures were left-sided (only five patients in the mentioned study). For left-side procedures, DRA could be preferred over traditional wrist access (TWA) owing to higher comfort level for both patient and operator.

We found the enthusiasm level for DRA implementation to be inferior, when compared with the one observed during shift from transfemoral to wrist access. Upon presenting the study plan to our interventional cardiologists (all of whom were “fundamental radialists” and high-volume ACS operators), only three out of eight accepted to participate in the study. In addition, throughout the study, there was a considerable level of frustration produced by a declining, but persistent number of DRA failures, occasionally even in patients with adequate DRA pulsations. Such issues

occur less frequently in TWA. Therefore, in our opinion, DRA in ACS should be reserved for selected patients with acceptable anatomy and high anticipated benefit, experienced and eager operators, and should be protocolized with established time-frame limitations. Whether the benefits of DRA over TWA outweigh the additional time spent for each DRA, or the cumulative time and effort spent on the steep part of the learning curve, is, at best, uncertain.

NB: Both authors consider themselves to be eager DRA operators.

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2. Kos N, Nedic M, Zeljkovic I, Pavlov M, Krcmar T, Radeljic V, et al. TCT CONNECT-427: Initial experience with the distal radial (“snuffbox”) access for coronary interventions. *JACC* 2020;76:B183. [\[Crossref\]](#)

Author’s reply

Dear Editor,

We would like to thank the reader for showing interest in our article titled “Is distal radial access a ‘bridge too far’ for routine use in acute coronary syndrome?” and for their valuable comments and suggestions.

The patients’ data were reviewed retrospectively and compared in terms of the procedural characteristics and complications highlighted in the manuscript. The reported success rate was high and in line with the relevant reports in the literature. All the procedures were performed by a single experienced operator (K.E.). Distal radial artery pulsations were present in all the patients included in this study. Cases with weak distal radial artery pulsations and those with insufficient dis-

tal radial artery pulsations were not considered, and the procedure was continued as usual. This condition was not recorded or considered as a necessary fact to be recorded.

The current guidelines about the procedure provide no information regarding the number of attempts and the sheath insertion times. Therefore, the criteria leading to the termination of the procedure by our colleagues could be considered. The lack of standardized termination criteria might have increased the success rate. Yet, any surgeon with experience in traditional radial procedures could be regarded as being more fit to conduct the procedure discussed in this manuscript. As pointed out in the manuscript, “except the com-

fort it provided, no significant differences between the two processes could be derived from our study.”

One underlying reason for the scarce number of operators volunteering for a distal radial intervention could be the necessity of previous experience in conventional transradial procedures. We believe the same as our colleagues; this technique should be used only by experienced operators according to the risk/benefit ratio. Interventional cardiology guidelines should be updated with relevant information for the selection of appropriate patients.

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