

## Coronary-subclavian steal syndrome in a hemodialysis patient with ipsilateral subclavian artery occlusion and contralateral vertebral artery stenosis “Case Report”

To the Editor,

I read the article written by Sağ et al. (1) entitled “Coronary-subclavian steal syndrome in a hemodialysis patient with ipsilateral subclavian artery occlusion and contralateral vertebral artery stenosis “Case Report”” published in *Anatol J Cardiol* 2016; 16: 542-6 with great interest.

It is well known that the use of left internal thoracic artery (LITA) for coronary artery revascularization has been associated with better long-term patency and patient survival than the use of a saphenous venous graft (2). On the other hand, patients with end-stage renal failure (ESRF) are under increased risk of coronary artery disease (3). Unfortunately, patients who need dialysis have been confronted with coronary-subclavian steal syndrome owing to left subclavian artery stenosis or ipsilateral upper extremity arterio-venous fistula (AVF) that gives rise to a low resistance vascular bed (4). Moreover, it is reported that the ipsilateral location of coronary artery bypass with the use of LITA and upper extremity AVF may be associated with an increased risk of cardiac events (5).

In the light of the points mentioned above, would you suggest the three results listed below?

1. In patients with ESRF having upper extremity AVF, ipsilateral LITA should not be used for coronary artery revascularization.
2. Ipsilateral upper extremity should be avoided for AVF if ipsilateral LITA is used for coronary artery revascularization.
3. If there is an obligation regarding the use of ipsilateral LITA, we should use ipsilateral LITA as a free graft rather than in situ.

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