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Radial Access in Primary PCI for Acute Myocardial Infarction

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Abstract

Transradial approach (TRA) is now considered the standard of care in many centers for elective and primary percutaneous coronary intervention (PCI). The use of the radial approach in ST-segment elevation myocardial infarction (STEMI) patients has been associated with a significant reduction in major adverse cardiac events. However, it is still unclear if the side of radial access (right vs. left) has impact on safety and effectiveness of TRA in primary PCI. So this chapter was conducted to summarize the benefits of transradial access over transfemoral access based on the most recent studies and to compare between using either right radial or left radial as an access for transradial procedure.

Keywords: primary PCI, left radial access, right radial approach, AMI

1. Introduction

Primary percutaneous coronary intervention (PPCI) angioplasty saves life and improves outcomes in patients with acute ST-segment elevation myocardial infarction (STEMI). The vascular access in this life-threatening situation has an impact on mortality and morbidity. In this chapter, we will discuss the preferred vascular access in PPCI; radial vs. femoral and review the studies that compared right radial vs. left radial in acute myocardial infarction.

2. Vascular access in acute myocardial infarction; radial or femoral

There is ongoing debate about which of the two commonly used primary percutaneous coronary intervention (PCI) methods, the traditional femoral artery access, or the radial artery access should physicians use. Some physicians support use of the femoral artery method because of concerns on the adequacy of support with the radial route. The claim is that femoral approach can provide stronger support for more complex procedures that require bulkier hardware; kissing balloons, crush techniques, and rotablation. However, most PPCI procedures do not entail densely calcific lesions or complex bifurcations. Most of the trials show that using radial access is feasible in the PPCI procedure and compared with femoral access; can provide a bleeding and mortality advantage.

ST-segment elevation myocardial infarction (STEMI) patients treated with primary percutaneous coronary intervention (PPCI) are likely to benefit from the bleeding reduction by using the radial approach as these patients have more risk for access site bleeding and bleeding-related complications as in primary percutaneous intervention we use aggressive antiplatelet and antithrombotic therapies [1]. Using the radial approach may allow higher doses of anticoagulants to be used for further ischemic reduction with minimal bleeding incidence in comparison with using the femoral approach [2]. In addition, the use of the radial approach in STEMI patients has been associated with a significant reduction in major adverse cardiac events (MACE) during follow-up [3].

3. Trials that compared radial and femoral access in primary PCI

We summarize the most important trials that compared radial and femoral access in primary PCI (**Table 1**).

These trials strongly suggest benefits from the radial approach in terms of reduction of bleeding and possible mortality. There still remain some concerns on the longer door to balloon times with the radial approach.

| Study name | Year | Study design | No. of patients (TRI vs. TFI) | Endpoints | Comments (other outcomes) |
|-------------------|------|------------------------------------|----------------------------------|-----------------------|--|
| | | | | Results (TRI vs. TFI) | |
| | | | | P value | |
| TEMPURA [4] | 2003 | Prospective randomized study | 77 vs. 72 | MACE | Characteristics of coronary intervention were similar in both groups except total procedure time, which was significantly shorter in the TRI group. |
| | | | | 5.2 vs. 8.4% | |
| | | | | $P = 0.444$ | |
| RADIAL-AMI [5] | 2005 | Multicenter pilot trial | 25 vs. 25 | Procedure time | Despite longer procedure time, Contrast use or fluoroscopy time shows no significant difference. |
| | | | | 32 vs. 28 min | |
| | | | | $P = 0.04$ | |

| Study name | Year | Study design | No. of patients (TRI vs. TFI) | Endpoints | Comments (other outcomes) |
|-------------------|------|---|----------------------------------|---|---|
| | | | | Results (TRI vs. TFI) | |
| | | | | P value | |
| FARMI [6] | 2007 | Prospective randomized study | 57 vs. 57 | Bleeding complications 2 vs. 11 <i>P</i> value significant | Coronary angiography duration shorter in TRI than TFI group, but PCI duration was the same. |
| Li et al. [7] | 2007 | Prospective randomized study | 184 vs. 186 | Significantly less Bleeding complications with TRI 2 vs.7 | Time procedure is same in TRI and TFI group. |
| Yan et al. [8] | 2008 | Prospective randomized study | 57 vs. 46 | Local complications 1.8 vs. 13.1% <i>P</i> < 0.05 | All procedure data and MACE show no significant difference between the two groups. |
| RADIAMI [9] | 2009 | Prospective randomized study | 50 vs. 50 | Different procedure data <i>P</i> > 0.05 insignificant. | Time to ambulation in TRI group was significantly shorter then in TFI group (<i>p</i> = 0.003). |
| Gan et al. [10] | 2009 | Prospective randomized study | 90 vs. 105 | Different procedure data were similar. | Puncture-related complications were lower in the TRI group than the TFI group (<i>P</i> < 0.05). |
| Hou et al. [11] | 2010 | Prospective randomized study | 100 vs. 100 | Different procedure data <i>P</i> > 0.05 insignificant. | Vascular complications and total hospital stay were lower in TRI group than TFI group (<i>p</i> < 0.01). |
| RADIAMI II [12] | 2011 | Prospective randomized study | 49 vs. 59 | Different procedure data using star closure device. | D2B is longer in TRI group than TFA group (<i>p</i> = 0.009), but MACE and bleeding complications were the same. |
| RIFLE-STEACS [13] | 2012 | Multicenter randomized parallel group study | 500 vs. 501 | 30-day NACEs 13.6 vs. 21% <i>P</i> = 0.003. | Lower cardiac mortality (<i>p</i> = 0.020), bleeding (<i>p</i> = 0.026), and hospital stay (<i>p</i> = 0.03) in TRI group. |
| RIVAL [14] | 2012 | Multicenter randomized parallel group study | 3507 vs. 3514 | Complications at 30 days. | Large hematoma and Pseudo aneurysm needing closure in TFI group more than TRI (<i>p</i> < 0.0001, <i>p</i> = 0.006). |
| STEMI-RADIAL [15] | 2012 | Prospective randomized study | 348 vs. 359 | Complications at 30 days, 1.4 vs. 7.2%, <i>P</i> = 0.0001. | Contrast utilization were significantly reduced in TRI than TFI (<i>p</i> = 0.01). Mortality shows no difference between two groups. |
| Ocean race [16] | 2014 | Prospective randomized study | 52 vs. 51 | Quality of life. | Radial access is associated with significantly fewer problems with mobility and self-care and better psychological outcome after PCI. |

| Study name | Year | Study design | No. of patients (TRI vs. TFI) | Endpoints | Comments (other outcomes) |
|--------------------------|------|---|----------------------------------|---|--|
| | | | | Results (TRI vs. TFI) | |
| | | | | P value | |
| Kasem et al [17] | 2014 | Retrospective study | 150 vs. 63 | D2B and contrast volume. | TRI is not associated with prolonged door to balloon time or excess contrast utilization. Also TRI is associated with lower mortality, less need for invasive hemodynamic support and fewer local complications. |
| ALKK PCI registry [18] | 2015 | Prospective observational study | 2530 vs. 15,270 | Complications, bleeding and mortality 1.8 vs. 5.1% $P < 0.001$. | TRI group show higher procedural success rate and lower vascular access complications and mortality. |
| Warren J. c. et al. [19] | 2015 | Multicenter prospectively collected study | 2947 patients | Door to balloon time 30 vs. 27 min. $P < 0.001$. | Time to first balloon longer with TRI group than with TFI, but no difference mortality and reinfarction rates between TRI and TFI. |
| Haq et al. [20] | 2015 | Retrospective data | 45 vs. 47 | Demographic and procedure data insignificant except D2B. | D2B is longer in TRI group than TFA group ($p = 0.021$). |
| MATRIX [21] | 2015 | A Randomized, multicenter study | 4197 vs. 4207 | MACE at 30 days 8.8 vs. 10.3% $P = 0.0307$ | NARC and BARC higher in TFI than TRI group ($p = 0.0092$, $p = 0.013$) and all-cause mortality ($p = 0.045$). |
| Graham et al. [22] | 2016 | Prospective randomized study | 338 vs. 1553 | 30-day major bleeding 3.7 vs. 1.2% $P = 0.18$ insignificant. | 30-day death and reinfarction show no significant statistically difference between two groups ($p = 0.11$, $p = 0.56$). |
| Kołtowski et al [23] | 2016 | Prospective randomized study | 52 vs. 51 | The cost between the two access points 3060 vs. 3374 EUR was insignificant. | The indirect costs were lower in the radial group. Introduction of radial access as the default approach in all centers may significantly reduce the overall financial burden from a social perspective. |
| Lee et al. [24] | 2016 | Prospective randomized study | 336 vs. 1609 | procedural success, complications, mortality and MACE $TRI < TFI$. significant better in TRI group | In octogenarians, TRI was more effective than the TFI approach in PPCI. |

| Study name | Year | Study design | No. of patients (TRI vs. TFI) | Endpoints | Comments (other outcomes) |
|--|------|----------------------|----------------------------------|--|--|
| | | | | Results (TRI vs. TFI) | |
| | | | | P value | |
| Kilic et al. [25] | 2017 | Prospective registry | 1310 vs. 2270 | 30-day all-cause mortality 1.7 vs. 4.6% $p < 0.001$. | Radial access is associated with improved outcome in patients with an acute coronary syndrome. |
| TRI, transradial intervention; TFI, transfemoral intervention; D2B, door to balloon; MACE, major adverse cardiac events; NARC, net adverse clinical events; BARC, Bleeding Academic Research Consortium. | | | | | |

Table 1. Trials of (TRI) vs. (TFI) in acute myocardial infarction.

4. Right vs. left radial artery access

Transradial cardiac catheterization can be performed either by using right or left radial access. But the catheterization laboratory setup, patient preparation, and overall techniques are different from using right radial access to left radial access. The transradial operator should be proficient with both right and left radial accesses. The modern cardiac catheterization laboratory and its support staff should also be proficient to handle these differences efficiently in order to maximize the advantages gained by using either right or left radial in transradial procedures.

5. Historical aspects

Transradial catheterization was started by using the left radial artery as an access for the procedure. The original description of transradial catheterization was introduced by Lucien Campeau in 1989. Campeau successfully completed a coronary angiography by utilization of left radial artery as an access for the transradial procedure. Campeau prepared the left wrist in hyperextension position to facilitate the puncturing of the radial artery. Campeau completed the procedure by using 18-gage needle, 5-Fr sheath, and 5-Fr catheters [26]. The right radial approach was utilized by Ferdinand Kiemeneij in the first description of transradial PCI in 1993. Ferdinand Kiemeneij successfully completed a percutaneous coronary intervention by the utilization of right radial artery as an access for the transradial procedure. Kiemeneij completed the procedure by using 22-gage access needles, 6-Fr sheath, and 6-Fr guiding catheters [27].

Since 1993, the right radial approach became the preferable vascular access by the majority of transradial operators. The disruption of the traditional laboratory setup and the relocation of the operator in the left radial approach to the left side of the patient, on the contrary, the right radial approach is more familiar as the femoral approach in the catheter and equipment manipulation from the right side by both the operator and the support staff. However, the

left radial artery access has advantages over the right radial approach in lower incidence of vascular anomalies less than right radial and using the left radial approach mimetic the femoral approach regarding the manipulation of the catheters and support of guiding catheters. **Table 2** summarizes the differences and similarities between right and left transradial accesses based on the most recent studies [28].

| | Right radial access | Left radial access |
|--------------------------|---|---|
| Acceptability | More popular | Less popular (if indicated only) |
| Preparation and setup | More standardized | Less standardized (disrupt traditional setup) |
| Comfort for the operator | More comfortable | Less comfortable |
| Learning curve | Longer | Shorter |
| Catheter manipulation | More challenging (similar with experts) | Better control |
| Radiation dose | Similar (longer with trainees) | Similar (shorter with trainees) |
| Efficacy and safety | Similar | Similar |

Table 2. Comparison between right and left radial access [28].

6. Preprocedural assessment

The choice of right radial vs. left radial is decided by the transradial operator and patient-related factors. Transradial operator may choose the left radial in special conditions as in requiring cannulation of the LIMA or in a presence of a contraindication for using the right radial access. The left radial approach may be preferred in specific patients who have a higher risk for right radial artery (RRA) tortuosity like in female gender, short stature, low body weights, and elderly.

6.1. Right radial access

The patient is positioned supine on the table in the same manner as the transfemoral route. An arm board extension is attached to the right-hand side of the table. Arm boards are available in different shapes and designs. Perhaps best suited for this purpose may be the trapezoid-shaped fiberglass board, with the narrow end tucked under the mattress at shoulder level and the broad area at the wrist.

The patient should be prepared with the wrist exposed, the forearm placed in the supine position and the hand gently taped in position, with the wrist hyper extended and supinated. A pulse oximetry probe is placed on the right index finger or thumb to allow for continuous monitoring of the circulation to the hand throughout the procedure. After the wrist has been appropriately prepared, it will be examined for the radial artery. Infiltrate local anesthetic subcutaneously at least 2 cm proximal to the radial styloid process (in the region where the

radial artery pulse is best appreciated) to form a small wheal. The skin is sterilized with an alcohol-based skin preparation. The groin should also be prepared for access in the event of a failed radial artery insertion. The angiography drape is applied so as to expose the wrist in an area where the radial artery pulse will be palpable.

Radial artery puncture can be done using open needle technique (anterior wall puncture) or trans-fixation technique (posterior wall puncture). After the artery has been successfully punctured, introduce the guide wire through the cannula. Once the guide wire has been smoothly advanced through the device, remove the cannula while leaving the guide wire in place. Introduce the sheath (with the dilator inserted) over the guide wire into the radial artery. A small superficial skin incision may be made where the guide wire enters through the skin to facilitate smooth passage of the sheath and to prevent radial artery spasm.

After the sheath is fully advanced, the guide wire and the dilator assembly may be removed. After the removal of the dilator, the sidearm may be used for administration of compatible medications as antispasmodic agents (e.g., verapamil 2.5–5 mg diluted in blood, nitrates 100–200 mic) through the sheath via the sidearm. And anticoagulants (e.g., heparin 5000 U) may be administered either via the sheath or IV, depending on the procedure performed.

6.2. Left radial access

There are more variations in catheterization laboratory setup, patient preparation, and equipment setup with the left radial compared to the right radial approach. Some operators prefer to perform the left radial procedure from the left side of the patient. In this case, the patient is positioned, prepped, and draped in a similar fashion as that of right radial access, only the arm board is attached to the left side of the table, and the equipment is arranged as a mirror image of the right-sided approach.

The patient is positioned supine on the table in the typical manner as the transfemoral route. A pulse oximeter probe is placed on the left index finger or thumb to allow continuous monitoring throughout the procedure. The operator achieves vascular access either from left side of the patient or from the right side of the patient, as if performing a left femoral artery puncture. After needle puncture and sheath insertion in a typical manner as right radial approach, the left forearm is pronated and adducted, such that the left wrist rests close to the right inguinal area. The operator then performs the catheterization procedure on the right side of the patient with a general setup that closely resembles the transfemoral approach.

7. Trials of right vs. left radial elective PCI

In previously published studies, comparing RRA with left radial artery (LRA) in elective PCI, it has been shown that both approaches are safe, have similar success rates, volume of contrast agent, and similar rate of crossover to different approach [29–32]. On the other hand, controversy between these researches regarding number of catheters used, Fluoroscopy time, and radiation exposure in LRA compared to RRA was obvious. Dominici et al. [29] and Kado et al. [32]

have shown a reduction in fluoroscopy time and number of catheters used in LRA compared to RRA, while Freixa et al. [31] and the “transradial approach (left vs. right) and procedural times during percutaneous coronary procedures (TALENT) study” demonstrated similar procedure and fluoroscopy time between both approaches when performed by well-trained operators [30]. Moreover, decreased radiation exposure with LRA was detected by Kado et al. [32] which is not concordant with the results of sub-study of the “TALENT” trial, which demonstrated no differences in radiation dose between the two approaches [33]. Recently, several studies have shown that the LRA might be associated with shorter procedural time and lower cerebrovascular complications when compared with the RRA in elective PCI [29, 34, 35].

8. Right vs. left radial access in acute myocardial infarction

Data from published studies addressing the best transradial approach (TRA) (right vs. left) in the setting of primary PCI are scarce, while data in the setting of elective PCI are controversial. Although the right radial artery (RRA) approach is usually the first point of access, tortuosity within the brachial and subclavian arteries may result in more radiation exposure, lengthy procedure, or even procedural failure [34, 36, 37]. Alternatively, the left radial artery (LRA) approach, although unflavored and less extensively studied, may offer an advantage from the point-of-view of vascular anatomy [29, 33].

Since delay in the reperfusion, time is considered the main cause of mortality in STEMI patients [38, 39], it is essential to decrease the reperfusion time when undergoing primary PCI. As the choice of transradial access site over the femoral approach is preferred in patients with STEMI because of less bleeding complications, it remains undetermined whether RRA or LRA provides a shorter procedural time in STEMI patients undergoing primary PCI. Up to date, only a few researches have compared the access side (right vs. left) during primary PCI [40–42].

We did a retrospective study on 400 consecutive patients presenting to our hospital with STEMI. Primary PCIs were performed for 202 patients using the right radial approach and 198 using the left radial approach. Results show that there was no significant difference in demographics and clinical characteristics for patients included in both groups with mean age 57 ± 12.8 years, with male predominance (77.2%). There was no significant difference between the right radial and left radial regarding success rate (97.5 for RRA vs. 98.4% for LRA; $P = 0.77$), contrast amount used (151.2 ± 12.4 ml for the RRA vs. 150.8 ± 19.6 ml for the LRA; $P = 0.41$), fluoroscopy time (FT) (13.2 ± 4.3 min for the RRA vs. 12.8 ± 3.5 min for the LRA), needle-to-balloon time (18.2 ± 2.8 min vs. 17.8 ± 6.5 min for RRA & LRA respectively, $P = 0.12$), number of catheters, postprocedure vascular complications, in-hospital reinfarction, and stroke/transient ischemic attack (TIA) or death. We concluded that both right radial access and left radial access are safe and effective in primary PCI, as both approaches have a high success rate and comparable needle-to-balloon time [40].

A recent retrospective study done on 135 patients compared LRA vs. RRA in STEMI patients. Primary PCIs were performed for 85 patients using the right radial approach and 50 using the left radial approach. Results show that there was no significant difference in room procedural

times, success rates, and comparable safety. But the authors attributed these results to the choice of LRA in patients known to be at risk for RRA failure (old age, female gender, lower body weight, and lower BMI). As in the patients of the LRA group, there were more females (40 vs. 20%, $P = 0.02$), significantly older (69.7 ± 14.8 vs. 60.0 ± 12.5 years, $P < 0.0001$), lower body weights (78.0 ± 16.3 vs. 95.1 ± 26.8 kg, $P \leq 0.0158$), shorter stature (169.3 ± 10.8 vs. 173.9 ± 10.3 cm, $P = 0.02$), and lower BMI (27.2 ± 5.1 vs. 31.2 ± 7.7 kg m⁻², $P \leq 0.01$) [41].

A recent prospective study on 200 STEMI Chinese patients compared LRA vs. RRA. Primary PCIs were performed for 100 patients using the right radial approach and 100 using the left radial approach. Results show that there were no significant differences in the demographics and clinical characteristics for patients included in both groups. There was no significant difference between the right radial and left radial regarding procedural success rate (98 for left vs. 94% for right; $P = 0.28$). But there was significant difference between the right radial and left radial regarding needle-to-balloon time (16.0 ± 4.8 LRA vs. 18.0 ± 6.5 min RRA; $P = 0.02$), fluoroscopy time (7.4 ± 3.4 LRA vs. 8.8 ± 3.5 min RRA; $P = 0.01$), and CAK dose area product (51.9 ± 30.4 vs. 65.3 ± 49.1 Gy cm²; $P = 0.04$). Fu and colleagues attributed these results to the anatomical advantage of LRA, which allows for quicker and easier delivery of a PCI device, such as a balloon or aspiration catheter. They also mentioned that all operators participating in this study had been well trained to perform the left radial PCI procedure before the study [42].

Another recent prospective study on 206 patients with acute myocardial infarctions who required emergency percutaneous coronary intervention and were divided into the following two groups: a group that underwent percutaneous coronary intervention through the left radial artery and other group that underwent percutaneous coronary intervention through the femoral artery. The times required for angiographic catheter and guiding catheter placements, the success rate of the procedure, and the incidence of vascular complications in the two groups were observed. Results show that there was no significant difference in catheter placement time or the ultimate success rate of the procedure between the two groups. However, the left radial artery group showed a significantly lower incidence of vascular complications than the femoral artery group ($P < 0.05$) [43].

9. Conclusion

The choice of TRA access site (right vs. left) in primary PCI depends on the experience of performing operator and demographics of treated population. With well-trained operators in both approaches, no significant difference in safety or effectiveness of either approach can be detected, as demonstrated in our study and by the “TALENT” study (senior group) in elective PCI and Larsen et al. in primary PCI [30, 41]. On the other hand, LRA shows better outcomes (compared to RRA) with less trained operators or those trained mainly on LRA, as demonstrated by the results of “TALENT” study (the fellow group) and by Fu et al. [30, 42].

Populations characterized by short stature or low BMI (e.g., Chinese population in Fu et al.) [42] showed better outcomes with LRA in primary PCI. On the other hand, Saito et al. [44] revealed lower success rates via LRA in Japanese patients, which were due to a higher

reported frequency of left subclavian arteries originating too distally and/or tortuosity not permitting catheter advancement to the aortic root.

Similarity between RRA and LRA in safety and effectiveness gives more space for TRA in primary PCI, as more patients can achieve rapid and successful revascularization (similar to TFA) but with the added safety margin that TRA provides.

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References

- [1] Mehta SR, et al. Effects of radial versus femoral artery access in patients with acute coronary syndromes with or without ST-segment elevation. *Journal of the American College of Cardiology*. 2012;**60**(24):2490-2499
- [2] Rao SV, et al. The transradial approach to percutaneous coronary intervention: Historical perspective, current concepts, and future directions. *Journal of the American College of Cardiology*. 2010;**55**(20):2187-2195
- [3] Arzamendi D, et al. Effect on bleeding, time to revascularization, and one-year clinical outcomes of the radial approach during primary percutaneous coronary intervention in patients with ST-segment elevation myocardial infarction. *The American journal of cardiology*. 2010;**106**(2):148-154
- [4] Saito S, et al. Comparative study on transradial approach vs. transfemoral approach in primary stent implantation for patients with acute myocardial infarction: results of the test for myocardial infarction by prospective unicenter randomization for access sites (TEMPURA) trial. *Catheterization and Cardiovascular Interventions*. 2003;**59**(1):26-33.
- [5] Cantor WJ, et al. Radial versus femoral access for emergent percutaneous coronary intervention with adjunct glycoprotein IIb/IIIa inhibition in acute myocardial infarction—the RADIAL-AMI pilot randomized trial. *American Heart Journal*. 2005;**150**(3):543-549
- [6] Brasselet C, et al. Randomised comparison of femoral versus radial approach for percutaneous coronary intervention using abciximab in acute myocardial infarction: Results of the FARMI trial. *Heart*. 2007;**93**(12):1556-1561
- [7] Wei-min L. et al, Safety and feasibility of emergent percutaneous coronary intervention with the transradial access in patients with acute myocardial infarction. *Chinese Medical Journal*. 2007;**120**(7):598-600

- [8] Yan Z-x, et al. Safety and feasibility of transradial approach for primary percutaneous coronary intervention in elderly patients with acute myocardial infarction. *Chinese Medical Journal*. 2008;**121**(9):782-786
- [9] Chodór P, et al. RADial versus femoral approach for percutaneous coronary interventions in patients with acute myocardial infarction (RADIAMI): A prospective, randomized, single-center clinical trial. *Cardiology Journal*. 2009;**16**(4):332-340
- [10] Gan L, et al. Effectiveness and feasibility of transradial approaches for primary percutaneous coronary intervention in patients with acute myocardial infarction. *Journal of Nanjing Medical University*. 2009;**23**(4):270-274
- [11] Hou L, et al. Comparative study on transradial versus transfemoral approach for primary percutaneous coronary intervention in Chinese patients with acute myocardial infarction. *Saudi Medical Journal*. 2010;**31**(2):158-162
- [12] Chodór P, et al. Radial vs femoral approach with StarClose clip placement for primary percutaneous coronary intervention in patients with ST-elevation myocardial infarction. RADIAMI II: A prospective, randomised, single centre trial. *Kardiologia Polska*. 2010;**69**(8):763-771
- [13] Romagnoli E, et al. Radial versus femoral randomized investigation in ST-segment elevation acute coronary syndrome: The RIFLE-STEACS (Radial Versus Femoral Randomized Investigation in ST-Elevation Acute Coronary Syndrome) study. *Journal of the American College of Cardiology*. 2012;**60**(24):2481-2489
- [14] Jolly SS, et al. Radial versus femoral access for coronary angiography and intervention in patients with acute coronary syndromes (RIVAL): A randomised, parallel group, multicentre trial. *The Lancet*. 2011;**377**(9775):1409-1420
- [15] Bernat I, et al. STEMI-RADIAL: A prospective, randomized trial of radial vs. femoral access in patients with ST-segment elevation myocardial infarction. In: *Transcatheter Cardiovascular Therapeutics (TCT) Scientific Symposium*. 2012
- [16] Koltowski L, et al. Quality of life in patients with ST-segment elevation myocardial infarction undergoing percutaneous coronary intervention—radial versus femoral access (from the OCEAN RACE Trial). *The American Journal of Cardiology*. 2014;**114**(4):516-521
- [17] Kasem H, Elteby I, Dashti R, Aljarallah MA. Radial versus femoral access in a newly initiated primary PCI service. *European Heart Journal Acute Cardiovascular Care*. 2014;**3**(2):44
- [18] Bauer T, et al. Use and outcome of radial versus femoral approach for primary PCI in patients with acute ST elevation myocardial infarction without cardiogenic shock: Results from the ALKK PCI registry. *Catheterization and Cardiovascular Interventions*. 2015;**86**(S1):S8-S14
- [19] Cantor WJ, et al. Reperfusion times for radial versus femoral access in patients with ST-Elevation myocardial infarction undergoing primary percutaneous coronary intervention. *Circulation. Cardiovascular Interventions*. 2015;**8**(5):e002097

- [20] Haq M, et al. Transradial versus transfemoral approach for primary percutaneous coronary intervention—single centre experience over a period of two years. *University Heart Journal*. 2017;**11**(2):56-62
- [21] Valgimigli M, et al. Radial versus femoral access in patients with acute coronary syndromes undergoing invasive management: A randomised multicentre trial. *The Lancet*. 2015;**385**(9986):2465-2476
- [22] Graham JJ, et al. Radial versus femoral access for percutaneous coronary intervention in ST-elevation myocardial infarction patients treated with fibrinolysis: Results from the randomized routine early invasive clinical trials. *Cardiovascular Revascularization Medicine*. 2016;**17**(5):295-301
- [23] Koltowski Ł, et al. Cost-effectiveness of radial vs. femoral approach in primary percutaneous coronary intervention in STEMI—Randomized, control trial. *Hellenic Journal of Cardiology*. 2016;**57**(3):198-202
- [24] Lee HW, Cha KS, Ahn J, Choi JC, Oh JH, Choi JH, Lee HC, Yun E, Jang HY, Choi JH, Hong TJ. Comparison of transradial and transfemoral coronary intervention in octogenarians with acute myocardial infarction. *International Journal of Cardiology*. 2016;**202**:419-424
- [25] Kilic S, et al. Effects of radial versus femoral artery access in patients with acute myocardial infarction: A large centre prospective registry. *Netherlands Heart Journal*. 2017;**25**(1):33-39
- [26] Campeau L. Percutaneous radial artery approach for coronary angiography. *Catheterization and Cardiovascular Diagnosis*. 1989;**16**(1):3-7
- [27] Kiemeneij F, Laarman GJ. Percutaneous transradial artery approach for coronary stent implantation. *Catheterization and Cardiovascular Diagnosis*. 1993;**30**(2):173-178
- [28] Shah RM, et al. Comparison of transradial coronary procedures via right radial versus left radial artery approach: A meta-analysis. *Catheterization and Cardiovascular Interventions*. 2016;**88**(7):1027-1033
- [29] Dominici M, et al. Left radial versus right radial approach for coronary artery catheterization: A prospective comparison. *Journal of Interventional Cardiology*. 2012;**25**(2):203-209
- [30] Kanei Y, et al. Randomized comparison of transradial coronary angiography via right or left radial artery approaches. *The American Journal of Cardiology*. 2011;**107**(2):195-197
- [31] Freixa X, et al. Right versus left transradial approach for coronary catheterization in octogenarian patients. *Catheterization and Cardiovascular Interventions*. 2012;**80**(2):267-272
- [32] Kado H, et al. Operator radiation exposure and physical discomfort during a right versus left radial approach for coronary interventions. *JACC: Cardiovascular Interventions*. 2014;**7**(7):810-816
- [33] Sciahbasi A, et al. Transradial approach (left vs right) and procedural times during percutaneous coronary procedures: TALENT study. *American Heart Journal*. 2011;**161**(1):172-179

- [34] Norgaz T, Gorgulu S, Dagdelen S. A randomized study comparing the effectiveness of right and left radial approach for coronary angiography. *Catheterization and Cardiovascular Interventions*. 2012;**80**(2):260-264
- [35] Pristipino C, et al. Prospective registry of vascular access in interventions in lazio region study group. Major improvement of percutaneous cardiovascular procedure outcomes with radial artery catheterisation: Results from the PREVAIL study. *Heart*. 2009;**95**(6):476-482
- [36] Lo TS, et al. Radial artery anomaly and its influence on transradial coronary procedural outcome. *Heart*. 2009;**95**(5):410-415
- [37] Kawashima O, et al. Effectiveness of right or left radial approach for coronary angiography. *Catheterization and Cardiovascular Interventions*. 2004;**61**(3):333-337
- [38] Luca GD, et al. Time delay to treatment and mortality in primary angioplasty for acute myocardial infarction. *Circulation*. 2004;**109**(10):1223-1225
- [39] Cannon CP, et al. Relationship of symptom-onset-to-balloon time and door-to-balloon time with mortality in patients undergoing angioplasty for acute myocardial infarction. *JAMA*. 2000;**283**(22):2941-2947
- [40] Elmahdy MF, ElMaghawry M, Hassan M, Kassem HH, Said K, Elfaramawy AA. Comparison of safety and effectiveness between right versus left radial arterial access in primary percutaneous coronary intervention for acute ST segment elevation myocardial infarction. *Heart, Lung and Circulation*. 2017;**26**(1):35-40
- [41] Larsen P, et al. Comparison of procedural times, success rates, and safety between left versus right radial arterial access in primary percutaneous coronary intervention for acute ST-segment elevation myocardial infarction. *Catheterization and Cardiovascular Interventions*. 2011;**78**(1):38-44
- [42] Fu Q, et al. Randomized comparative study of left versus right radial approach in the setting of primary percutaneous coronary intervention for ST-elevation myocardial infarction. *Clinical Interventions in Aging*. 2015;**10**:1003
- [43] Qi G, et al. Emergency percutaneous coronary intervention through the left radial artery is associated with less vascular complications than emergency percutaneous coronary intervention through the femoral artery. *Clinics*. 2017;**72**(1):1-4
- [44] Saito S, et al. Transradial coronary intervention in Japanese patients. *Catheterization and Cardiovascular Interventions*. 1999;**46**(1):37-41

