

Authors' response to "Is the routine screening for significant atherosclerotic renal artery stenosis during coronary angiography/intervention indispensable?"

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We are grateful for the constructive comments given by Babic *et al.* (2013) on our article recently published in the *Journal of Zhejiang University-SCIENCE B (Biomedicine & Biotechnology)* (Pu *et al.*, 2012). The aim of this study was to generate a logistic regression model to predict the presence of significant atherosclerotic renal artery stenosis (ARAS) defined as luminal diameter stenosis $\geq 70\%$ of uni- or bilateral renal arteries using clinical, biochemical, and angiographic factors. Although others have used less severe stenosis criteria ($< 50\%$ luminal diameter narrowing), we believe that renal intervention may be more likely considered for patients with significant ARAS. Likewise, since the mortality risk depends highly on the severity of ARAS, significant ARAS should not be mis-diagnosed during coronary intervention via transradial access (White and Olin, 2009). We agree with Babic *et al.* (2013) that our regression model may be applied in a particular circumstance, and some patients without all risk factors as indicated in our regression model could be suspected for the presence of significant ARAS.

The classification of significant coronary artery disease as the angiographic percent stenosis $\geq 70\%$ at the site of coronary artery lesions is to some extent arbitrary. However, within the range of angiographically significant coronary artery disease including lesions of $\geq 70\%$, this criterion of stenosis severity has been correlated with physiologic significance, has relevance to commonly applied angiographic standards, and is widely accepted clinical practice (Scanlon *et al.*, 1999). In this study, patients with 0-vessel disease were those without significant coronary disease, including normal coronary artery and mild to moderate coronary stenosis.

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