Valsalva (Figure 2, B). The left coronary artery (anterior descending) was anastomosed as usual.

I agree with the authors that injury or compression of the anomalous coronary artery is a significant hazard during aortic valve replacement with a prosthetic valve. Use of stentless aortic bioprostheses, however, should reduce if not eliminate the risk of compression of the artery by the replacement device. The authors strongly contend that "adequate mobilization of the anomalous coronary artery from the aortic annulus avoids injury by suture ligation." I suggest that mobilization of the anomalous coronary artery may not be required in some cases associated with bicuspid aortic valve, in which rightward displacement of the anomalous circumflex and right coronary artery ostia causes the anomalous coronary artery to take an oblique course over the noncoronary sinus and a shorter relationship with the aortic annulus. Suture placement in the fibrous hinge point of the aortic valve with care not to penetrate the aortic wall should not injure the coronary artery after the precise course of the artery is

known. I would add a further caution—that the anomalous circumflex coronary artery in association with a bicuspid aortic valve could be injured by classic oblique aortotomy into the noncoronary sinus. Transverse aortotomy or division of the aorta above the sinotubular junction should be used in patients with this anomaly.

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Reply to the Editor:

Doty's case lends further credence to our view that coronary angiography should be

strongly considered before aortic valve surgery, even in young patients, so that the precise anatomy is understood before the operation. Even if mobilization of the anomalous left circumflex coronary artery away from the aortic annulus is not needed, as was the situation in Doty's patient, who received a stentless valve, preoperative knowledge of the anatomic course of the artery was likely very helpful in planning that operation. Furthermore, such preoperative knowledge would have been even more critical had a stented bioprosthesis or a mechanical valve been chosen. As Doty points out, the traditional oblique aortotomy may have resulted in injury to the anomalous artery in his patient. I agree with Doty's remarks that the precise course of the artery should at least be known, if not treated (dissecting the artery away from the annulus), so as to avoid coronary artery injury during suture placement into the aortic annulus.

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