remarkable from 1 week after apex-sacrificing VRS but not in apex-sparing VRS. Drs Lunkenheimer and Anderson described in their letter that resection of any part of LV wall, including the septum, is tolerated without impairing LV function when the left ventricle is dilated. However, septal anterior ventricular exclusion or pacoexy reduces the septal and anterior wall without amputating the LV apex and yields good clinical results.^{13,14} We think those results are compatible with our study.

In addition, results of some clinical cases that underwent the apex-sparing VRS in our unit have been excellent so far. Thus we believe that it is important to reduce the LV volume in dilated left ventricle with severe LV dysfunction. Apex-sparing VRS may improve the clinical results.

Although the hypothesis by Dr Torrent-Guasp and colleagues is very interesting,¹⁵ there is no scientific proof so far. Therefore the relationship between cause and result in the improved LV function after the apex-sparing VRS and preservation of single muscle band is still unknown, and further study will be required.

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Study of warm perfusion rather than cardioplegia

To the Editor:

I read the article by Mallidi and colleagues,¹ "The Short-term and Long-term Effects of Warm or Tepid Cardioplegia," and raise the following concern. The title is not descriptive of the protocols. Rather than isolated cold or warm cardioplegia, the article really describes cold and warm total-body and cardiac perfusion strategies. The article states, "In the warm or tepid blood cardioplegia group, the systemic

temperature was maintained at 33°C to 37°C, and the blood cardioplegia was delivered at a temperature of 37°C. In the tepid cardioplegia group, the systemic temperature was permitted to drift passively during the operation to 32°C to 34°C. The temperature of the cardioplegia was 28° to 30°C. In the cold cardioplegia group, the systemic temperature was actively cooled to 25°C to 32°C, and the blood cardioplegia was actively cooled to a temperature of 5°C to 8°C."

Other combinations may have similar results, for example a warm corporeal perfusion strategy (drifting without active cooling) and cold cardioplegia. The data do not preclude such a result.

This group has done a nice job scientifically studying and promoting warm perfusion and protection strategies. I think that describing their technique as "warm blood cardioplegia" does not describe the strategy adequately, and "warm perfusion strategy" might be more accurate.

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Reference

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Reply to the Editor:

Dr Savage correctly points out that the article published in the March issue of the Journal by our group was not simply a comparison of cold versus warm or tepid cardioplegia, but rather a comparison of the strategy of warm or tepid cardioplegia versus cold cardioplegia. The three cardioplegic and systemic perfusion strategies used in patients undergoing isolated coronary artery grafting surgery at our institution were described in detail in the article. Other possible cardioplegic and systemic perfusion strategies (such as warm systemic perfusion with cold cardioplegia, tepid systemic perfusion with cold cardioplegia, systemic hypothermia with warm or tepid cardioplegia, and so on) were not used in our institution.