cantly, only 2% had mild aortic insufficiency. Comparison of these two series is difficult because of the differences in population and etiology, but in the absence of prospective or randomized studies, we must base our decisions on extrapolation from current data. Thus there is no conclusive evidence that valve-sparing operations for patients with MFS have an advantage relative to Freestyle root replacement. Antimineralization treatment and zero-pressure fixation⁸ make this valve more attractive for implantation than a homograft because of the lower rate of calcification with no significant changes in the elastic properties of the elastic wall,^{8,9} and reoperation if needed is simpler with the Freestyle bioprosthesis because of lessened inflammatory reaction in the host tissues. A Freestyle root replacement with graft extension could be a reasonable operation for patients with MFS for whom anticoagulation is contraindicated or not acceptable. Further long term data are needed, however, before any of these operations can be recommended with certainty.

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Amiodarone for postoperative atrial fibrillation

To the Editor:

We read with interest the article by Yagdi and colleagues¹ dealing with the use of amiodarone to prevent of postoperative atrial fibrillation (AF). In this prospective, randomized study, 77 patients (amiodarone group) received intravenous amiodarone during the first 48 hours after the operation followed by declining oral dosing over a 30-day period, and 80 patients (control group) received placebo. The authors observed a statistically significant reduction in the incidence of AF (10% in amiodarone group vs 25% in control group) as well as a significant reduction in the mean duration of AF (12.8 ± 4.8 hours in amiodarone group vs 34.7 ± 28.7 hours in control group).

We recently reported similar results in a prospective, randomized study conducted with 200 consecutive patients undergoing CABG.² The treatment group received oral amiodarone 4 hours after arrival to the intensive care unit and until hospital discharge. The incidence of AF was reduced from 25% to 12%, and its duration was also reduced.

These two prospective randomized trials constitute additional evidence for the efficacy of amiodarone in the prevention of AF after CABG. Interestingly, although in our series only the oral form of amiodarone was used, the results observed were almost identical to those reported by Yagdi and colleagues,¹ suggesting that the intravenous administration of amiodarone may not offer additional beneficial effects in preventing postoperative AF. If these observations were to be confirmed in future studies, the problem of the cost-effectiveness of the use of amiodarone in this setting, as alluded to in the editorial by Saltman,³ would be completely resolved.

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Reply to the Editor:

There is no consensus about the optimal dose and route of amiodarone in prophylaxis against atrial fibrillation after coronary artery bypass grafting. In most of the studies we cited in our article,¹ intravenous amiodarone doses ranged from 10 mg/(kg · d) to 20 mg/(kg · d) through 2 to 8 days. Oral amiodarone doses ranged from 2.8 to 7.0 g through 7 to 20 days. We used relatively short-term, low-dose (10 mg/[kg · d], for 48 hours) intravenous administration, followed by oral tapered doses at a total of 9.0 g through 30 days. We prefer a combination therapy to take the advantage of accelerated loading time with the intravenous amiodarone and to obtain the incremental benefits of the oral amiodarone during the short-term intravenous administration.

We found that the postoperative administration of amiodarone was effective at significantly reducing the incidence of postoperative atrial fibrillation by 14.6%, the duration of atrial fibrillation episodes by 21.9 hours, and the ventricular response rate by 20 beats/min. In addition to the lower incidence of postoperative atrial fibrillation, the amiodarone group had sig-