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Reply to the Editor:

We read with great interest the comments of Dr Pocar and colleagues about the article we recently published in *The Journal of Thoracic and Cardiovascular Surgery*.¹

It is mandatory for everyone involved in cardiac surgery to know everything about the reasons that have been mentioned in the first and second paragraphs of their comments. We have previously reported and underlined our policy regarding internal thoracic artery (ITA) harvesting [. . . In order to optimize the internal thoracic artery length, and avoid the use of the most distal part of internal thoracic artery (often small in diameter and prone to spasm), we try to make the internal thoracic artery graft as short as possible. . .].² According to this policy, it was not a very distal part of the ITA that was used for coronary-coronary bypass grafting (CCBG). A crossclamp time of 41 minutes to perform 4 anastomoses on coronary arteries is not too much, and for the current level of myocardial protection, 10 minutes more means nothing.

As to the third reason, let us suppose that ITA has been used to revascularize the distal third of the left anterior descending coronary artery (LAD), although it did not have enough length as a pedicled graft to reach the anastomotic site. An aggressive form of atherosclerotic disease would progress with time, no matter that the coronary artery was grafted with the ITA, because coronary artery disease progress even if the targeted artery was grafted with an arterial graft (although to a lesser extent than if it was grafted with vein graft).³ A new proximal lesion on the LAD great enough to jeopardize distal flow (through a coronary-coronary bypass graft) would probably be the reason to attempt the revascularization (percutaneous coronary intervention or redo coronary artery by-

pass grafting), even in the absence of a coronary-coronary graft on the LAD, as well as in the case that the ITA (eg, in skeletonized fashion) was used in the first operation.

I absolutely agree with Dr Pocar and associates that anastomoses should ideally be constructed to bypass the most distal lesion, but it is obvious that with CCBG over distal and single stenosis on the LAD, we have done exactly what they have underlined. Free ITA grafts yield excellent patency rates of approximately 90% at 5 years,⁴ as well as at 7 years.⁵ We know that a major problem influencing early free ITA graft patency was related to construction of a proximal anastomosis on the ascending aorta. In the case of CCBG, we have a situation that a segment of the free ITA graft at the site of proximal anastomosis matches better with the lower dp/dt of the LAD artery than the ascending aorta. That is the reason that we can expect an even better patency rate over the years. There have been only 2 cases of late angiography in patients with coronary-coronary free ITA grafts on the LAD (3 and 8 years after surgical intervention) recording patent coronary-coronary grafts.⁶

I agree with Dr Pocar and associates that CCBG might at times be useful, and that was in the reported case. We have performed more than 25,000 cardiac procedures at our institution over 25 years. I was the attending surgeon in more than 2500 cardiac procedures. Of more than 1600 procedures performed per year (70% being coronary artery operations), we have selected only 2 patients for CCBG of a single distal lesion of the large LAD (in the patients with multiple-vessel disease). The other patient's single distal LAD lesion was grafted with a short segment of the radial artery in CCBG fashion.⁷ It means that our candidates for CCBG procedure were selected very carefully.

As to the fourth reason, when you have to perform coronary surgery because of multivessel disease, it does not make sense to increase cost with implantation of a drug-eluting stent, even in the countries with great economic potential.

Finally, our intention was not to challenge the guidelines for coronary revascularization but to underline that once in a

blue moon we can meet the patient who does not fit in a guideline frame.

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Repair of the Ebstein anomaly To the Editor:

I read with great interest the article by Chen and colleagues¹ "Early and Medium-Term Results for Repair of Ebstein Anomaly." The results are superb, without hospital mortality and with improvement of the functional condition. The technique proved to be reproducible.

It seems from previous studies² that the Ebstein anomaly is a combination of ventricular and valvular disease. This concept has led my group to develop the use of an associated bidirectional cavopulmonary shunt in severe cases.³

I was surprised by the preoperative right ventricular ejection function, which was normal in all cases except 1 in Dr Chen's series, without quantified data.

My first concern is to know what is meant by the right ventricle. Is it the effec-