was greater. Similar results have since been reported from the randomized prospective trial by Desai and colleagues.²

Second, Mussa and colleagues probably agree that the ultimate goal of optimizing graft patency is improving survival. In well-matched patients undergoing CABG, all of whom received left ITA to left anterior descending coronary artery pedicle (LITA-LAD) grafts, using the radial artery as a second arterial conduit as opposed to vein resulted in improved late survival, especially after the third postoperative year (Figure 1).³ This benefit is similar to or better than what has been reported with bilateral ITA grafting. We suggest that the radial artery is indeed the arterial conduit of second choice, at least in patients in whom the bilateral ITA is contraindicated.

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Reply to the Editor:

We thank Zacharias and colleagues for their interest in our article concerning current perspectives in radial artery (RA) use as coronary bypass conduits.¹ Their letter raises 2 important issues: (1) comparative patency of RA versus saphenous vein graft conduits and (2) the effect of using RA grafts on survival after coronary bypass surgery.

Concerning the issue of RA versus saphenous vein graft patency, the excellent midterm graft patency rates taken from the symptomatic subgroup reported by Zacharias and colleagues² merely give an indication of graft durability but do not provide definitive information with respect to long-term patency. We are fortunate that prospective, randomized controlled trials specifically are currently addressing this question. Recently, Desai and associates³ reported data from the largest of these trials, the Radial Artery Patency Study (RAPS), and found a significant difference in favor of RA angiographic patency 1 year after the operation. Buxton's group has reported results from a much smaller cohort, part of the Radial Artery Patency and Clinical Outcome (RAPCO) trial,⁴ suggesting no significant difference in angiographic patency between RA and saphenous vein grafts. Forthcoming midterm and long-term patency data from these groups should resolve this important issue.

The effect of RA grafts on survival after CABG has yet to be elucidated in the context of a controlled trial to address the second point. The 8-year time-to-event analysis of propensity-matched groups from Zacharias and colleagues² provides encouraging preliminary support for the thesis that RA conduits might translate to improved clinical outcomes. Again, a definitive answer awaits analysis of long-term clinical outcome data from the ongoing randomized trials.⁴

The best evidence to date, both in terms of conduit patency⁵ and survival,⁶ suggests that the optimal strategy for CABG in most cases is the use of bilateral internal thoracic arteries. The RA, if used in optimal fashion, is probably the conduit of choice if a third graft is required or if bilateral internal thoracic artery grafting is contraindicated.

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Atrial fibrillation: Isolation or ablation?

To the Editor:

The article "Map-Guided Surgery for Atrial Fibrillation" by Nitta and associates¹ confirms and raises important issues. An adequately performed pulmonary vein isolation (PVI) cures most patients with intermittent atrial fibrillation (AF) but fails as an isolation procedure in patients with non-pulmonary vein (non-PV) foci and in those with continuous AF, in whom the PVs and the circuits they harbor become irrelevant to the maintenance of AF. In these patients the goal shifts from isolating the trigger to ablating the macroreentrant circuits. Although a left atrial (LA) procedure is mandatory, the real question is the following: When do we address the right atrium (RA)?

The identification of the transition from intermittent to continuous AF is crucial in determining the pattern of activation and the procedure needed. What was the relationship between the activation pattern and (1) the underlying structural heart disease and (2) the pattern (continuous or intermittent) and duration of AF?