was concern about the adequacy of the subclavian artery as the inflow segment. Moreover, we would be lacking the safety afforded by cardiopulmonary bypass. Ascending–descending aortic bypass has also been described by using the right thoracotomy approach.³

We believe that cardiopulmonary bypass provides safety in the presence of significant left ventricular hypertrophy. Use of a heart-lifting device makes the operation simpler by freeing the assistant's hand and by enabling the procedure to be performed with a beating heart. Strategically placed pericardial stays can also help in keeping the heart mass out of the way during the procedure.

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Reply to the Editor:

We thank Dr Krishnan and colleagues for their letter, which proves that resourceful surgeons can be found worldwide. They report the use of a heart-lifting device to perform an ascending–descending aortic bypass in a 15-year-old girl with previous aortic arch surgery. Because of previous thoracotomy, as in our reported case,¹ they elected this type of bypass, which has been increasingly used for reoperations in the aortic arch and isthmus in view of its excellent long-term results.² The figure in the letter is almost identical to the one appearing in our article, except for the fact that they routed the graft around the right margin of the heart. Direction of the graft should conform to the individual anatomy encountered in each case. Again, the excel-

lent exposure achieved with the use of a lifting device to retract the heart is shown and demonstrates that there is no need to have an assistant's hand cramming the operative field. This report enhances the feasibility of the procedure and might help to popularize it. We encourage surgeons to try it and foresee that it will be performed without the use of cardiopulmonary bypass in selected cases.

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