operation had failure of the re-repair resulting from recurrent mitral regurgitation in 5 and hemolysis in 1.

We are grateful to the Editor for the opportunity to further clarify these points.

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Limitations with aprotinin in thoracic aortic surgery: Understanding the clinical outcome beyond bleeding To the Editor:

I read with great interest the recent article by Dr Sedrakyan and colleagues¹ detailing their experience with aprotinin in thoracic aortic surgery, using a retrospective case-control matching analysis (n = 168 [1995-2003]: deep hypothermic circulatory arrest (DHCA) 64.3%–67.9%). The authors conclude in their article that there is American Heart Association level II evidence for aprotinin in thoracic aortic surgery.

I have the following questions for the authors of this excellent study:

1. What was the reexploration rate for bleeding in this case-control series? Did antifibrinolytic exposure make any difference? This outcome variable is an important determinant of mortality after thoracic aortic surgery.² It would be useful to know whether aprotinin was associated with a lower take-back rate.
2. Were anesthetic technique and anesthetic drug doses equivalent in both groups? This is an important determinant of postoperative ventilation time. Was this potential confounder considered before concluding that aprotinin is associated with a decrease in total ventilation time?
3. Were the clinical outcomes, including renal failure and dysfunction, equivalent in the subgroup with DHCA? Our group has recently reported that aprotinin may be associated with renal dysfunction after DHCA.³ Does a mixed thoracic aortic cohort explain the differences in these studies?
4. Were there criteria for antifibrinolytic choice in this cohort (eg, previous aprotinin exposure; level of

renal impairment)? When was the aprotinin administered (eg, before skin incision or after dissection and cannulation for cardiopulmonary bypass)? It would be useful to understand the dosing style of aprotinin in this study.

5. Were there any hypersensitivity reactions to aprotinin?⁴ Were there any cases of unexpected vascular thrombosis?⁵

I look forward to input from the authors. Again, I congratulate them for a most valuable article on this challenging topic.

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Reply to the Editor:

We appreciate Dr Augoustides' kind comments regarding our article.¹ We are very much aware of the important contributions he and his colleagues have made on the topic at hand.

We provide the following specific responses to the insightful comments and questions raised in Dr. Augoustides' letter.

1. Three patients required reexploration for bleeding—1 in the aprotinin group and 2 in the control group.

2. Anesthesia was by a balanced narcotic/inhalation technique in both groups.
3. Renal failure occurred in 3 patients in the control group and 2 in the aprotinin group.
4. Aprotinin was administered after the skin incision. It is our policy to avoid aprotinin in the rare circumstance of recent prior aprotinin exposure.
5. There were no clinically appreciated hypersensitivity reactions to aprotinin. There were no cases of unexpected vascular thrombosis.

In sum, the points raised by Dr Augoustides are all very cogent. On each point, there was, in our study, no evidence of adverse aprotinin-related outcome.

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Unilateral as well as bilateral infiltrates should remain part of the definition of pulmonary graft dysfunction

To the Editor:

We read with interest the article by Oto and associates¹ in the December 2006 issue of the *Journal*. The authors underestimate the importance of unilateral infiltrates. We disagree with the statement, "only bilateral infiltrates should be used as part of the definition of primary graft dysfunction" despite their convincing statistical methods. We explain why.

The guidelines of pulmonary graft dysfunction (PGD)² and validation³ thereof is for the clinician to make sense of the data and standardize reporting. The emphasis by the consensus committee on PGD was on providing a definition that could also help in management and prognosis.² PGD is a biological process of reperfusion-ischemic injury redefined with respect to alveolar-