ing cannulation, despite the purse string attaching the aortic cannula.

In our opinion, central cannulation is safe in acute aortic dissection repair, regardless of the systematic need for an open distal anastomosis, and the race to find the best arterial perfusion site seems useless since the evidence is right before everybody's eyes.

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doi:10.1016/j.jtcvs.2007.03.039

Reply to the Editor:

We appreciate the comments from Drs Farhat, Sassard, and Jegaden on our article describing our experience with direct cannulation of dissected ascending aorta. They add further evidence speaking to the safety of this technique in specific subpopulations of patients with this disease. Their group uses this technique widely but avoids using it in dissections with suspected rupture or hematoma. Their exclusion criteria were similar to our study. As they describe, we have also placed purse strings in the aorta to secure the cannula without incident. This combined experience speaks to the feasibility of the central cannulation in ascending

aortic dissections, which remains a safe cannulation option in selected situations for surgeons dealing with this disease.

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A meta-analysis of minimally invasive coronary artery bypass versus percutaneous coronary intervention with stenting for isolated left anterior descending artery disease is indispensable To the Editor:

We read with great interest a meta-analysis of randomized trials of off-pump coronary artery bypass versus percutaneous coronary intervention (PCI) by Bainbridge and associates.¹ In response to a meta-analysis by Boodhwani and colleagues² of randomized trials comparing surgical versus percutaneous treatment of isolated left anterior descending (LAD) artery disease, we³ conducted a meta-analysis of then-available 5 trials of minimally invasive direct coronary artery bypass (MIDCAB) versus PCI with stenting in the form of a letter to the editor. In the meta-analysis by Boodhwani and coworkers,² significant heterogeneity existed because of the inclusion of both conventional coronary artery bypass and MIDCAB in the surgical group and both PCI with or without stenting in the percutaneous group. So far as the meta-analysis by Bainbridge and associates¹ is concerned, although 5 of 6 included trials used MIDCAB technique in the majority of patients in the surgical arm, in 1 trial by Eefting and colleagues⁴ (the largest trial in the 6 trials) surgical access to the heart was achieved via median sternotomy in 67%. Although the trial by Eefting and coworkers⁴ included patients with multivessel disease, the other 5 trials were exclusively of LAD stenting versus left internal thoracic artery-to-LAD anastomosis. Furthermore, a flaw of the systematic review by Bainbridge and associates¹ was missing a trial by Kim and colleagues⁵ published in 2005 despite comprehensive searches up until

May 2006. Therefore, we would like to advocate a meta-analysis of currently available 6 homogeneous randomized trials of MIDCAB versus PCI with stenting for isolated LAD disease, including the trial by Kim and coworkers⁵ and 5 trials except for the trial by Eefting and associates⁴ included in the meta-analysis by Bainbridge and colleagues.¹

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doi:10.1016/j.jtcvs.2007.03.047

Reply to the Editor:

Takagi and colleagues are correct in suggesting that the trial by Kim and associates¹ is relevant to our meta-analysis of randomized trials of off-pump coronary artery bypass/minimally invasive direct coronary artery bypass (OPCAB/MIDCAB) versus percutaneous coronary intervention (PCI).² We remain uncertain why this randomized trial was not identified despite multiple independent searches performed by experts. It may be that the trial was not

TABLE 1

Outcome	OPCAB (%)	PCI (%)	OR (95% CI)	I ² (%)	P value for effect
Death, in hospital	1.1	0.4	1.88 (0.56–6.36)	0	.31
AMI, in hospital	2.7	2.8	1.04 (0.48–2.25)	0	.92
Stroke, in hospital	0.5	0.21	1.11 (0.35–2.49)	0	.64
Stroke, 1-5 y	0	1.3	0.34 (0.05–2.38)	0	.4
Angina recurrence, 1-5 y	11.7	22.8	0.44 (0.24–0.83)	38	.01
Reintervention, in hospital	2.3	3.4	0.74 (0.35–1.55)	0	.42
Reintervention, 1-5 y	5.3	19.1	0.23 (0.15–0.38)	0	<.0001

OPCAB, Off-pump coronary artery bypass; PCI, percutaneous coronary intervention; OR, odds ratio; CI, confidence interval; AMI, acute myocardial infarction.

indexed on Medline at the time of our search, or it may have been available on Medline but indexed incorrectly. Either way, it highlights the limitations of electronic searches for the purpose of identifying all relevant trials for meta-analyses. One can never be certain that all trials have been identified, and empiric evidence suggests that up to 50% of relevant articles may be missed despite vigilance in searching.³

As suggested by Takagi and colleagues, we have added this trial to our meta-analysis and would like to share the results to provide readers with the most current estimates of clinical outcomes. Adding this trial of MIDCAB versus PCI (n = 100) resulted in increased power and narrower confidence intervals for the outcomes of reintervention, death, stroke, angina recurrence, and myocardial infarction. The updated results are provided in Table 1. Overall, none of the conclusions changed.

Regarding the suggestion that the trial by Eefting and associates⁴ may introduce heterogeneity, we performed a sensitivity analysis by excluding this trial from the analysis to determine the impact on results. The results were not materially changed by excluding Eefting. This may be because similar results are achievable, whether the procedure is delivered through OPCAB or MIDCAB and whether single or multiple vessels are anastomosed. On the other hand, it may simply be that the analysis is underpowered to detect important differences between subgroups. When the confidence intervals around the nonsignificant outcomes are examined, it is clear that important differences in outcomes have not been ruled out, and further research will be required to enlighten any potential differences among subgroups. As Takagi and colleagues have highlighted, the results of this analysis should not be automatically

assumed to apply to OPCAB performed on multivessel disease, inasmuch as this group was underrepresented.

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doi:10.1016/j.jtcvs.2007.03.046

Leave the left atrial appendage untouched for stroke prevention!

To the Editor:

We read the article by Kamohara and colleagues¹ regarding the short-term and mid-term effects of left atrial appendage (LAA) occlusion on left atrial (LA) function with great interest. An atrial exclusion device

was applied by means of thoracotomy in 19 mongrel dogs in sinus rhythm, and hemodynamic, as well as echocardiographic, data were recorded immediately and after 7 and 90 days. The authors found that LAA exclusion might affect LA reservoir function. We would like to congratulate the authors for their important study. However, there still remain the following questions:

1. When measuring the LA area by means of planimetry before LAA exclusion, was the LAA area included or excluded? If it was included, this might well explain the decrease in LA volume and area after LAA exclusion, as listed in Table 1. If the LAA area was not included, how do the authors then explain the decrease in LA area and volume?
2. There is a great variation in human LAA size.² We do not know whether this is also true for the canine LAA. What was the size of the excluded LAAs, and was there any association between LAA size and the hemodynamic or Doppler measurements?
3. The LAA is known as an important site of natriuretic peptide secretion.³ Were serum levels of natriuretic peptides measured before the procedure and during follow-up? Did the authors observe weight gain caused by fluid retention after LAA occlusion?
4. It is known that in guinea pigs LAA exclusion leads to a decrease in cardiac output.⁴ If the investigated dogs are still alive, it would be very interesting to continue follow-up, measure cardiac output and functional parameters, and compare them with those from control dogs with the LAA left intact.