5. All hemodynamic and Doppler parameters were obtained in healthy dogs in sinus rhythm at rest. Because LAA occlusion is considered in patients with heart disease in atrial fibrillation, an increase in heart rate during exercise might well result in an inappropriate increase of the LA pressure because of impaired LA reservoir function.

In conclusion, there is still no proof that LAA occlusion prevents stroke,⁵ but hemodynamically, this procedure might even do harm and should therefore not be performed in patients with atrial fibrillation.

Claudia Stöllberger, MD^a
 Birke Schneider, MD^b
 Josef Finsterer, MD^c
 Krankenhaus Rudolfstiftung^a
 Wien, Austria
 Klinik für Kardiologie^b
 Lübeck, Germany
 Krankenhaus Rudolfstiftung^c
 Wien, Austria

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Reply to the Editor:

We appreciate the response of Drs Stöllberger, Schneider, and Finsterer to our work¹ and thank them for their comments. Here are our responses to their specific questions:

1. The left atrial appendage (LAA) area was not included when measuring the

left atrial (LA) area. Slight changes in LA area and volume measurements might be expected due to the effect of the LA body shape change caused by occlusion of the LAA orifice. However, we have not detected any statistically significant decreases in the LA area or volume after LAA exclusion.

2. Although we did not measure the size of the LAA in this series, we did measure it in a more recent series of 16 dogs. The width and thickness of the LAA orifice were 27.1 ± 4.8 mm (mean $\pm$ standard deviation) and 12.2 ± 4.3 mm, respectively. As indicated by relatively small standard deviations, there is not a great variation in the LAA size in dogs.
3. Although we did not measure natriuretic peptide levels in this series, we did measure atrial natriuretic peptide and B-type natriuretic peptide levels in a more recent series. There were no significant changes in atrial natriuretic peptide level (32 ± 20 pg/mL at baseline and 41 ± 34 pg/mL after 30 days, $P = .60$) or B-type natriuretic peptide level (always <5 pg/mL). We did not observe any weight gain caused by fluid retention.
4. The investigated dogs were all killed on the day of the terminal study. During our follow-up period, we did not observe any significant decrease in stroke volume.
5. The effects of LAA occlusion on hemodynamics in patients with heart disease and in atrial fibrillation have to be carefully investigated in the future.

We disagree with their conclusion that hemodynamically LAA occlusion might even do harm and should therefore not be performed in patients with atrial fibrillation. There is no solid evidence to suggest that exclusion of the LAA in patients with atrial fibrillation does harm. In fact, there is good evidence suggestive to the contrary^{2,3}; much of this has been gathered from patients undergoing mitral valve surgery or surgical ablation. However, it is also clear that surgical LAA ligation with current techniques and technology is sometimes incomplete. Such incomplete ligation might be responsible for an increased risk of thromboembolic events after attempted ligation.⁴ Our focus is on the development of a method for reliable, complete, and simple occlusion

of the LAA. With such an approach, we will have the ability to study the clinical effects of LAA exclusion. At this time, we believe that such effects have not been fully elucidated.

Keiji Kamohara, MD^a
 Zoran B. Popović, MD, PhD^b
 A. Marc Gillinov, MD^c
 Kiyotaka Fukamachi, MD, PhD^a
 Department of Biomedical Engineering^a
 Department of Cardiovascular Medicine^b
 Department of Thoracic and Cardiovascular
 Surgery^c
 Cleveland Clinic
 Cleveland, Ohio

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Selection of dialysis patients for bilateral thoracic artery grafts

To the Editor:

I enjoyed the recent brief communication "Gastric conduit staple line after esophagectomy: To oversew or not?"¹ This work detailed two patients who had a minimally invasive esophagectomy. During the procedure, the gastric conduit staple line was not oversewn or inverted. The first patient's staple line leak occurred on postoperative day 1 and may have been related to a stapler malfunction. The second staple line leak occurred during the second postoperative week and was probably due to multiple factors.

I routinely oversew gastric staple lines because of an experience with a young patient with renal failure, insulin-dependent diabetes, intravenous drug use, and supra-