identified. Compression of the left coronary system by this expanding cavity was also demonstrated with 3-dimensional magnetic resonance imaging. An open cardiac operation with a Dacron patch was performed without any complication.

Pseudoaneurysm formation in the MAIVF is a rarely seen pathologic condition. Acquired causes are the most common,¹⁻³ although MAIVF aneurysm can be congenital in origin.⁴ Infective endocarditis followed by iatrogenic causes is the most common among acquired etiologies. Cases are generally asymptomatic. The pathologic condition has generally been detected during routine evaluation or at autopsy. The most probable pathophysiologic mechanism is avascular nature of the tissue with insufficient compliance and healing causing balloon-type dilatation and pseudoaneurysm formation. For the diagnosis, noninvasive imaging tools are the first line. Conventional 2-dimensional echocardiograms with Doppler study, either transthoracic or transesophageal, are the initial diagnostic tools. However, limited spatial resolution restricts their usefulness. Real-time multiplane/3-dimensional echocardiography and computed tomographic angiography/contrast-enhanced magnetic resonance imaging are the methods supplying higher spatial/temporal resolution and more detailed anatomic relations.^{2,4} Medical follow-up, percutaneous intervention, and surgery are the treatment modalities.⁵

In conclusion, this rare anomaly should be kept in mind when a dilatation is seen in the para-aortic region, especially after infective endocarditis and valve surgery.

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THE TRAP FOR RESEARCHERS: MISREPRESENTATION OF DATA FROM ARTICLES To the Editor:

We read with great interest the reply by Benedetto and colleagues¹ to our letter,² in which we challenged the inclusion of Gaudino and associates³ data in a meta-analysis (controlled, randomized trials comparing the angiographic patency of radial artery [RA] versus saphenous vein grafts [SVGs]) by Benedetto and coauthors⁴ that was recently published in the *Journal*. In their reply, we were criticized for misrepresentation of the data from Gaudino and colleagues' article³ included in their meta-analysis.⁴ The article by Gaudino and colleagues³ reported 2 controlled, randomized trials including patients with previous percutaneous stent implantation (in any coronary vessel) with preoperative angiographic confirmation of a failed (trial I) or patent (trial II) intracoronary stent. As the authors stated,¹ for the purpose of their meta-analysis they included only Gaudino and colleagues' data³ on conduits randomly assigned to targeted obtuse marginal (OM) branches of the circumflex artery. Therefore, they stated that the Gaudino I study³ included RA versus SVG conduits randomly grafted to previously stented OM branches, and that the Gaudino II study³ included RA ver-

sus SVG conduits grafted to unstented OM branches.

Gaudino and colleagues³ reported that a study inclusion criterion was previous percutaneous coronary angioplasty with successful stent implantation in any coronary vessel at least 1 month before surgery. Although there were no data on stent location, we do not know how Benedetto and colleagues¹ concluded that 60 failed stents were located in targeted OM branches in the Gaudino I study (20 OM branches grafted with RAs, 20 OM branches grafted with SVGs, and 20 OM branches grafted with right internal thoracic artery), as they suggested in their reply.¹ In our opinion, the distribution of compared grafts regarding the stent location in the Gaudino I study definitely was not defined. For Gaudino and colleagues,³ in-stent restenosis and graft failure are markers of aggressive coronary atherosclerosis. For us, they could be a pathophysiologic response to the presence of an intravascular foreign body (stent) that may adversely affect the fate of the conduits used to graft stented coronary arteries. That was the reason we mentioned a subsequent analysis⁵ of Gaudino and colleagues' initial report,³ in which the authors concluded that patients in whom in-stent restenosis developed have a higher risk of early venous graft failure. Even in that article, there were no precise data about the number of failed RAs or SVGs that were distributed to targeted coronary arteries with in-stent restenosis. Although 45 grafts were placed distal to a failed stent, it is possible that the majority of venous grafts were placed on previously stented coronary arteries.

Although we do not know the distribution of occluded conduits regarding the stent locations in the Gaudino I study, we cannot definitively state the reasons that influenced the graft patency. Thus, we do not support the inclusion of the Gaudino I study in the meta-analysis we have discussed. We do agree that we have made a mistake asking for exclusion of the

Gaudino II study from the aforementioned meta-analysis.

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of their article was described in previously published studies.^{2,3}

Figure 1 is a copy of the illustration used in my article.

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TREATMENT OF SUBGLOTTIC STRICTURE

To the Editor:

It was a pleasure reading the article by Mercy George and colleagues in the *Journal*.¹ I would like to note that the technique for treating benign subglottic stricture on pages 414 and 415

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Reply to the Editor:

We thank Dr Demos for his comment on our article on the management of pediatric subglottic stenosis with glottis involvement.

The management of glotto-subglottic stenosis is challenging, and its surgical management, therefore, has evolved over the years with descriptions of the surgical technique and its modifications, along with the use of stents. The technique we have used in this large pediatric series is different from that described earlier by Demos and colleagues in 1969.^{1,2} Notably, this series is the first pediatric series of its kind. The technique combines a subglottic resection and thyro-

tracheal anastomosis with a posterior cricoid split and costal cartilage graft for glotto-subglottic stenoses. This operation was named “extended partial cricotracheal resection.” The LT-Mold prosthesis is also different in that it calibrates the supraglottic and glottic spaces in the abducted position of the vocal cords, while restoring a triangular shape to the glottis with a sharp anterior laryngeal commissure.³ All currently available stents are round or cigar shaped and do not restore a triangular glottis, especially in the case of vocal cord synechia or grade IV transglottic stenosis. The use of the LT-Mold prosthesis has significantly diminished the incidence of postoperative granulations that require repeat endoscopic/open procedures. This study was therefore a synthesis of our experience of complex pediatric glotto-subglottic stenosis that documents the evolution of the technique with an emphasis on the silicone LT-Mold.

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THE FUTURE OF CARDIAC SURGERY

To the Editor:

What is the future of cardiac surgery? This question undoubtedly brings to mind images of fancy new technology, robots, stents, lasers, and other minimally invasive or futuristic techniques.

FIGURE 1. Temporary plastic obturator in upper trachea and glottis fixed with wire. Reprinted with permission.^{2,3}