be a blowout at the previous aortotomy site, because there was no evidence of aortic wall infection intraoperatively, and histologic examination and cultures taken from the pseudoaneurysm remained sterile.

The patient was discharged 4 weeks later. Heart and prosthetic valve function were normal, and computed tomography scan showed no abnormality (Figure 1). We think operation for ascending aortic pseudoaneurysms can be safely performed on femorofemoral bypass without hypothermic cardiac arrest.

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ACUTE KIDNEY INJURY AFTER CORONARY ARTERY BYPASS GRAFTING: DOES RHABDOMYOLYSIS PLAY A ROLE?

To the Editor:

In the August 2010 edition of this *Journal*, Perioperative Management section, the following article was published: "Acute kidney injury after cor-

onary artery bypass grafting: Does rhabdomyolysis play a role?" by Benedetto et al.

The study has hypothesized that rhabdomyolysis may play a role in the development of acute kidney injury after coronary artery bypass grafting. However some important considerations have been ignored in the study. (1) The use of depolarizing muscle relaxant suxamethonium is not mentioned. Suxamethonium has been previously shown in literature as a potential cause of muscle injury and rhabdomyolysis. This is even more important when given to obese patients. (2) The use of antifibrinolytic medications aminocaproic acid (Aminocap) and tranexamic acid (Cyclokapron) is also not mentioned. Several case reports have associated rhabdomyolysis with their concurrent use in cardiac surgery. (3) The use of the antiarrhythmic drug amiodarone has not been addressed. Amiodarone has also been associated with acute renal injury, especially when used along with statins. (4) All statins carry a risk of rhabdomyolysis. However, the Food and Drug Administration authority has said that the risk of rhabdomyolysis developing is more pronounced when simvastatin is combined with amiodarone than it is with other statin medications. The study has not provided the different statin medications the patients were receiving. (5) The study failed to mention whether the statin therapy was optimized before the operation. (6) The anesthetic technique used is totally ignored. Use of several inhalational agents could potentially increase the likelihood of renal injury developing, especially in combination with aforementioned drugs. Was total intravenous anesthesia technique used in any of the patients in the study? (7) No information was given about concurrent use of mannitol (especially during cardiopulmonary bypass).

It is very important to consider all possible causes of rhabdomyolysis that can occur during coronary artery

bypass grafting. I wish to know from Benedetto and associates the information regarding these questions.

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Reply to the Editor:

We appreciate the interest in our work¹ and are pleased to address the aroused considerations.

First, we use cisatracurium, and not suxamethonium, as a muscle relaxant. We do not use aminocaproic acid or tranexamic acid, which is why these drugs are not mentioned in our article.¹ Amiodarone, which is known to play a role in rhabdomyolysis development,² was entered in the multivariable correction, but no statistically significant correlation was found ($P = .75$). Unfortunately, we could not retrieve information on the different types of statins that patients were taking because there were several and it was a retrospective study; however, we do know that atorvastatin, simvastatin, rosuvastatin, fluvastatin, and pravastatin were used. Nevertheless, consistent with the latest guidelines,³ statin therapy was optimized before surgery to achieve a low-density lipoprotein cholesterol level less than 100 mg/dL, and this was achieved in 85% of patients. Anesthetic induction was obtained by means of sevoflurane, and propofol was used as maintenance. We believe these agents do not increase the hazard of renal impairment. Finally, mannitol is routinely administered during cardiopulmonary bypass at a small dose of 200 to 250 mg.

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