2-dimensional speckle tracking and
3-dimensional echocardiography.

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STAGED PERCUTANEOUS CORONARY INTERVENTION AND MINIMALLY INVASIVE VALVE SURGERY: RESULTS OF A HYBRID APPROACH TO CONCOMITANT CORONARY AND VALVULAR DISEASE

To the Editor:

We read with great interest the recent publication by Santana and colleagues,¹ entitled "Staged Percutaneous Coronary Intervention and Minimally Invasive Valve Surgery: Results of a Hybrid Approach to Concomitant Coronary and Valvular Disease." A total of 65 patients who underwent staged percutaneous coronary intervention and minimally invasive cardiac surgery (MICS) valve surgery were compared with 51 patients who underwent combined valve/coronary artery bypass grafting. The authors are to be congratulated for their excellent short-term

results in the MICS group, particularly the lack of mortality. However, drawing conclusions between the 2 groups is problematic in that there were 6 different surgeons in the control group versus 1 surgeon in the MICS group. It is well known that mortality and morbidity rates in valve surgery are highly correlated to the caseload of the individual surgeon.² We would question if the 28% versus 1.5% cumulative incidence of adverse short-term outcomes, including death, stroke, and renal failure, in the control versus the experimental group is merely a reflection of this fact.

Another concern is 61 of 65 patients in the hybrid group had percutaneous coronary intervention of the left anterior descending artery before MICS, and only 55.5% of the stents were drug eluting. In view of the the well-documented durability of the left internal thoracic artery to the left anterior descending artery, with both its salutary impact on longevity and major adverse cardiac outcomes, are these patients possibly being shortchanged in the zeal to perform MICS?

We also noted that in the MICS mitral cohort, there was only a 58% repair rate (14/24) despite no mention of rheumatic causes. Other than 6 calcific mitral valves, it seems plausible that the repair rate should have been higher in the hands of such a high-volume surgeon. Again, perhaps the lack of adequate exposure inherent to a "4- to 5-cm" MICS incision compromised the ability to attain a satisfactory repair.

Finally, nowhere in the article was there any mention of atrial fibrillation (AF). It is unlikely that none of these patients would have any preoperative history of such. Ad and colleagues³ recently reported that only 40.6% of patients with a history of AF have it addressed at the time of concomitant heart surgery. Knowing the favorable effects of a concomitant Cox-maze on ejection fraction, stroke, and life span, as well as the fact that this procedure can be applied via a MICS

approach, the authors should reconsider their strategy in those patients with a significant history of AF.

We applaud this and other efforts to make cardiac surgery less invasive. However, suboptimal mitral repair rates and infrequent use of the left internal thoracic artery, as well as overlooking preoperative AF, may significantly compromise long-term patient outcomes.

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ADENOSINE-PROCAINE CARDIOPLEGIA AND ADENOSINE-LIDOCAINE CARDIOPLEGIA: TWO SIDES OF THE SAME COIN?

To the Editor:

Jakobsen and colleagues¹ are to be congratulated for pursuing alternatives to supranormal potassium cardioplegia in cardiac surgery. Since a 15-year moratorium was placed on Melrose's hyperkalemic solution in the late 1950s, investigators in cardioprotection have attempted to find a method