infection, stroke, respiratory failure, renal failure, reoperation for bleeding, and myocardial infarction in the matched patients? What were the rates of recatheterization, and what was the graft patency? Readers need to have a better sense of exactly what events contributed to the difference in individual and combined reintervention and readmission rates. Readers also need to decide whether a better combined reintervention and readmission rate defines “superiority” of the RITA when there are no differences in perioperative adverse events or survival between the matched patients?

Finally, a very important issue is that the authors seem to have abandoned RA grafting and thus had very few patients in the RA group (only 8 of 149, or 5% of the matched group) in the last half of their 8½ year study. Why the change? What were the RA antispasm protocols? Was the RA used to bypass target vessels only with greater than 70% stenosis? What was the mode of RA graft failure? Were there graft failures at the end-to-side anastomosis of the RA to left internal thoracic artery? Was there consistency in the RA harvest technique and the harvesting personnel? The answers to these questions might help to clarify whether the harvesting technique, the deployment, or the surgical technique of RA grafting contributed to the differing reintervention and readmission rates.

Navia and colleagues¹ are to be commended for their efforts attempting to define the second best arterial graft during CABG. Their study does not, however, support their conclusion that the RITA is superior to the RA. Most other studies comparing RITA and RA, in fact, have shown better or equivalent event-free survival with the RA.²⁻⁴ In addition, we⁵ recently showed that RA grafts have similar patency to RITA grafts and that RA grafting resulted in fewer perioperative adverse events, with similar early and late survivals to RITA grafting. The debate thus continues; however,

most of the literature supports RA grafting as an excellent alternative to RITA grafting. This appears to be especially true for patients who are older or have chronic obstructive pulmonary disease or diabetes.

Robert F. Tranbaugh, MD
Kamellia R. Dimitrova, MD
Darryl M. Hoffman, MD
Beth Israel Medical Center
New York, NY

References

1. Navia D, Vrancic M, Piccinini F, Camporotondo M, Thierer J, Gil C, et al. Is the second internal thoracic artery better than the radial artery in total arterial off-pump coronary artery bypass grafting? A propensity score-matched follow-up study. *J Thorac Cardiovasc Surg.* 2014; 147:632-8.
2. Caputo M, Reeves B, Marchetto G, Mahesh B, Kim K, Angelini G. Radial versus right internal thoracic artery as a second arterial conduit for coronary surgery: early and midterm outcomes. *J Thorac Cardiovasc Surg.* 2003;126:39-47.
3. Hayward PA, Hare DL, Gordon I, Matalanis G, Buxton BF. Which arterial conduit? Radial artery versus free right internal thoracic artery: six-year clinical results of a randomized controlled trial. *Ann Thorac Surg.* 2007;84:493-7; discussion 497.
4. Nasso G, Coppola R, Bonifazi R, Piancone F, Bossetti G, Speziale G. Arterial revascularization in primary coronary artery bypass grafting: direct comparison of 4 strategies—results of the stand-in-Y Mammary Study. *J Thorac Cardiovasc Surg.* 2009;137:1093-100.
5. Tranbaugh RF, Dimitrova KD, Lucido DJ, Hoffman DM, Dincheva GR, Geller CM, et al. The second best arterial graft: a propensity analysis of the radial artery versus the free right internal thoracic artery to bypass the circumflex coronary artery. *J Thorac Cardiovasc Surg.* 2014;147:133-42.

<http://dx.doi.org/10.1016/j.jtcvs.2013.09.078>

SYSTOLIC ANTERIOR MOTION AFTER MITRAL VALVE REPAIR To the Editor:

We read with interest the article “Influence of left ventricular function on development of systolic anterior motion after mitral valve repair” by Manabe and colleagues.¹ They aimed to investigate the effect of preoperative left ventricular function on the development of systolic anterior motion (SAM) after mitral valve repair. They concluded that high preoperative

ejection fraction and small preoperative systolic left ventricular end-systolic dimension were significant risk factors for the development of SAM after mitral valve repair.

The first point that drew our attention was the article’s Table 1. As seen in that table, there were statistically significant size differences among semirigid ring, tailored ring, and Duran rings. This may disallow the standardization of these groups. In addition, the forms, elastic quality, and effects of these rings on the left ventricle are completely different. The other point that drew our attention was in the article’s Table 3. Despite the fact that the relation between SAM and ejection fraction can be explained by physics, as stated in that table, the relations between SAM and thickness of interventricular septum may not necessarily be considered as a causal correlation. Two findings in reported in that table are very worthwhile. SAM was seen in cases with end-diastolic diameter smaller than 25 mm and with ejection fraction higher than 75% (small, hyperkinetic hearts).

We believe that it is possible to avoid SAM in small, hyperkinetic hearts by suturing the free edges of the anterior and posterior leaflets together. One or two simple sutures that do not narrow the area can prevent the anterior movement of the anterior leaflet during systole and thus prevent the development of SAM.

Burcin Abud, MD
Aykut Sahin, MD
Süreyya Talay, MD
Izmir Tepecik Research and
Education Hospital
Izmir, Turkey

Reference

1. Manabe S, Kasegawa H, Fukui T, Tabata M, Shinozaki T, Shimokawa T, et al. Influence of left ventricular function on development of systolic anterior motion after mitral valve repair. *J Thorac Cardiovasc Surg.* 2013;146:291-5.

<http://dx.doi.org/10.1016/j.jtcvs.2013.10.079>