We used resection and end-to-end anastomosis techniques for a huge left anterior descending coronary artery (LAD) aneurysm. We preferred end-to-end anastomoses for the LAD rather than the use of the left internal thoracic artery because the diameter of the LAD was 4 cm, so the use of the left internal thoracic artery could have led to a size mismatch and early graft failure. In this technique, to avoid of bleeding from the suture line or occlusion caused by traction on the LAD, we mobilized the LAD sufficiently and checked for any resulting tension after the anastomoses.⁴

The resection and end-to-end anastomosis technique can be applied with confidence and is a feasible choice among all the available techniques. Furthermore, this technique is advantageous because of native-to-native coronary anastomosis. A variety of surgical techniques should be considered for treatment of huge coronary artery aneurysms.

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THE IMPORTANCE OF PULMONARY ARTERIAL PRESSURE FOR THE TREATMENT OF TRICUSPID REGURGITATION

To the Editor:

We read with great interest the report by Kim and colleagues,¹ in which they evaluated the outcomes of 51 patients who underwent tricuspid valve surgery for severe isolated tricuspid regurgitation (TR). They concluded that preoperative anemia, renal or hepatic dysfunction, right ventricular dilatation, and severe TR after tricuspid valve surgery were significant factors for determination of poor outcome.

TR is more often a secondary rather than a primary valve lesion and usually develops in association with pulmonary hypertension in patients with left-sided cardiac disease (functional TR). Pulmonary arterial pressure (PAP) increases during left-sided cardiac disease and causes elevation of right ventricular pressure. Secondary TR is a consequence of tricuspid annular dilatation and increased tricuspid leaflet tethering in relation to this right ventricular pressure overload. It is also possible to see functional TR in cases of increased PAP without left-sided cardiac disease (eg, asthma, chronic infection, smoking). In the evaluation of the study from Kim and colleagues,¹ we noted that the etiology of TR was unclear. Only 15.7% of patients reported a blunt chest trauma as the etiology. In addition, Kim and colleagues¹ also reported that none of the patients had significant left-sided cardiac disease. They did not report the value of PAP. The frequency of primary TR is thus uncertain. As we mentioned previously, PAP may be elevated for various reasons, and functional TR may occur through a mechanism other than primary valve lesion. Surgical approach to tricuspid valve repair and survival may be changed by the etiology of TR. Functional TR in response to

increasing PAP must be removed to reach a successful evaluation of valve surgery for primary TR. Kim and colleagues¹ reported preoperative right ventricular dilatation to be a criterion for poor outcome. Perhaps patients with right ventricular dilatation also had increased PAP. In addition, they reported moderate-to-severe TR in 41% of cases in a few years. This may have been occurred through the mechanism that we have discussed here.

We believe that PAP is a very valuable datum in the diagnosis and treatment of TR. Determination of the etiology of TR is essential for correct and complete treatment with good long-term results.

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IMPAIRMENT OF TRICUSPID ANNULAR PLANE SYSTOLIC EXCURSION AND TRICUSPID ANNULAR PEAK SYSTOLIC VELOCITY AFTER ARTERIAL SWITCH OPERATION

To the Editor:

We read with interest the article "Left and right ventricular performance after arterial switch operation" by Klitsie and colleagues.¹ In our opinion, this is an interesting study describing the long-term effects of heart surgery on remodeling of the right ventricle (RV) and the left ventricle in children after the arterial switch operation for