surgery in children.⁵ In our study,¹ we could not elucidate the exact mechanism of the deterioration of RV performance. As suggested by Koestenberger and colleagues, however, we hope that our findings encourage future research and routine follow-up of RV performance after correction of congenital heart defects.⁵

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DISTAL IN SITU PEDICLED (NONSKELETONIZED) INTERNAL THORACIC ARTERY GRAFT

To the Editor:

I have read with interest the report by Toeg and Rubens¹ that has recently been published, discussing the

semantics of the adjectives “pedicled,” “skeletonized,” and the Latin term “in situ,” regarding their use in the description of internal thoracic artery (ITA) harvesting and coronary grafting techniques.

It is easy to accept that the terms “skeletonized” and “nonskeletonized” appropriately reflect the degree of isolation of the ITA from the surrounding tissue of the conduit.¹ However, I can hardly agree with the statement that the pedicled graft represents an ITA conduit in which the proximal connection of the conduit to the subclavian artery is preserved, but that when it is divided, it is a free graft.¹

Actually, Kolesov and Petukhov² were the first who used a reversed left ITA (LITA) conduit (LITA transected near its origin and thus supplied by retrograde flow from the superior epigastric and musculophrenic arteries), and Kolesov even protected his author’s right (patent no. 388738–13.04.1973.) for the reversed LITA–left anterior descending (LAD) coronary artery anastomosis. We have recently reported excellent early results using the inverted LITA conduit to revascularize the LAD in carefully selected patients.³⁻⁵

In 1 patient, we used a simple and practical technique of splitting the LITA graft and using its proximal and distal parts to revascularize the LAD coronary artery bed.³ The proximal, in situ (with the origin of the ITA still “in its original place”), nonskeletonized LITA was used to revascularize the large diagonal branch in a classic fashion, and the distal, in situ (with the branching of the ITA and the superior epigastric and musculophrenic arteries still “in their original places”), nonskeletonized LITA revascularized the LAD in a retrograde fashion.³ Furthermore, we have reported a case of accidental damage of the proximal LITA during harvesting⁴ and intentionally division of the LITA near its origin to avoid all complications to which the

classically routed nonskeletonized LITA conduit would be exposed in a patient with a grossly emphysematous lung.⁵ Although in both cases,^{4,5} the proximal LITA connections were divided from the subclavian artery, according to Toeg and Rubens,¹ we should have termed them free grafts, but, obviously, they are not. Therefore, I would suggest, if anyone at all would like to change the present nomenclature, to use the term “distal in situ nonskeletonized ITA” for reversed ITA conduits, instead of “free ITA graft,” as called by Toeg and Rubens.¹

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Reply to the Editor:

We read with interest the letter of Dr Nezic, in which he disagreed with the concepts presented in our recent editorial. In fact, Dr Nezic’s arguments conclusively support the need for a determined effort to police the use of English, and in this case Latin.

We reviewed the articles that Dr Nezic’s team has published. In the