of choice for reconstruction of the coronary artery bed after resection of a CAA.

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Reply to the Editor:

We thank Drs Nezić and Cirković for their comments and contributions to our article about surgical treatment options for coronary artery aneurysm. We think that they are correct in pointing out most of the issues that they stated. As mentioned in our previous article,¹ resection of the aneurysmal segment of the coronary artery and end-to-end anastomosis may cause tension on the anastomosis side. This undesirable tension can lead to fatal complications. As we stated in the previous report,¹ to avoid this situation the coronary artery was mobilized at both ends, and we then approximated the epicardial tissue on both sides of the left anterior descending coronary artery to avoid any unexpected tension on the anastomoses. We believe that it is reliable approach for aneurysm cases because of both the advantage of end-to-end

anastomosis with native tissue and reducing graft mismatch with the dilated coronary artery. On the other hand this method, is not very useful for sequential coronary artery aneurysms cases or if there is not enough intact coronary artery tissue after resection to get closer.

Autografts (left internal thoracic artery, radial artery, saphenous vein) should be carefully chosen to avoid diameter mismatch in coronary artery aneurysm surgery. Vascular structures adjacent to the aneurysmal segment could lack of normal vascular quality and may have become enlarged and tortuous. As in our case, the use of internal thoracic artery or radial artery in interpositional revascularization techniques for dilated coronary artery may lead to diameter mismatch. If the proximal part of the radial artery were to be used as a graft, the diameter mismatch problem would be partially eliminated. Otherwise, patency time would be short because of the graft mismatch. In addition, it should be remembered that radial artery spasm can easily be provoked during manipulation. Finally, use of the radial artery as the interposed graft for aneurysmal coronary artery revascularization has not been sufficiently demonstrated in the literature.

In a case presented by Nezić and colleagues,² a radial artery graft was used as intercoronary end-to-side bypass for stenotic the distal left anterior descending lesions. They used intercoronary anastomosis techniques for occlusion of the left anterior descending coronary artery. Their case is not coronary aneurysm, and their native coronary arteries were more appropriately matched to the radial artery in diameter. We therefore think that a radial artery graft should not be the first choice for interposition in a dilated native coronary segment after resection of coronary artery aneurysm. As a result, in selected cases of short-segment, single coronary artery aneurysm in the setting of a postresectional dilated coronary

artery, we believe that native coronary end-to-end anastomosis technique would be useful.

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Reply to the Editor:

We appreciate the comment from Abud and colleagues¹ regarding our study investigating the influence of left ventricular function on the development of systolic anterior motion (SAM) after mitral valve repair.

Their first comment refers to the effect of annuloplasty on the development of SAM. It is believed that excess annular reduction predisposes the mitral valve to the development of SAM. Although yet to be demonstrated, any reduction in annular circumference may reduce the mitral-aortic angle and consequently reduce the distance between mitral valve coaptation and the left ventricular outflow tract. Dagum and colleagues² demonstrated in their animal study that ring annuloplasty, especially using an artificial ring with some rigidity, displaced the anterior and posterior leaflet toward the left ventricular outflow tract. Kahn and colleagues³ presented a case report suggesting that undersizing of a mitral valve annulus could be the cause of