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CAN WE DISCUSS BILATERAL INTERNAL THORACIC ARTERY GRAFTS WITHOUT EMBRACING SKELETONIZATION?

To the Editor:

We read with interest the editorial from our North American colleagues on the issues hampering widespread implementation of multiple arterial

grafting in our part of the world.¹ Whereas our European contemporaries seem to have heard the message, there are still unexplained roadblocks to fulfilling this strategy for our patients.

The editorial emphasizes the disparity between what we should be doing and what is actually being done. All of us seem to recognize that surgeons' concerns regarding mediastinitis play a key role in the decision not to embrace more aggressive use of bilateral internal thoracic artery (BITA) grafts. We do not believe, however, that this dialog can occur in isolation without also discussing the strategy of using skeletonized internal thoracic arteries.

We believe that successful BITA grafting programs are likely to be programs that embrace the technique of skeletonization. Our own studies have shown definitively that skeletonization results in preservation of blood flow in the healing sternum² and that it is associated with a markedly decreased incidence of sternal wound infection, especially in high-risk patients undergoing BITA.³ Furthermore, there have been no definitive studies that have challenged long-term outcomes with the use of skeletonized BITA grafts.

We agree that our North American colleagues must get with the times and embrace multiple arterial grafting. Now that we know what to do with regard to how many arterial grafts to use, should we not embrace skeletonization as a means to help us to achieve that goal safely?

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FOCUSING ON THE SECOND ARTERIAL CONDUIT

Reply to the Editor:

We appreciate the comments of our Canadian colleagues and support the adoption and use of skeletonized bilateral internal mammary artery (BIMA) harvest for multiarterial grafting. Compared with pedicled harvest, skeletonization of internal mammary artery conduits has been shown to preserve sternal blood supply,^{1,2} reduce postoperative chest wall dysesthesia,^{1,3} and most importantly, may reduce the incidence of postoperative sternal complications,^{4,5} especially in higher risk patient cohorts.

However, we believe that our charge to the cardiac surgical community to use an additional arterial graft has a broader reach and effect if we do not impose strict limits or guidelines on how these conduits are harvested. Instead of introducing 2 novel technical challenges to practicing cardiac surgeons (ie, BIMA use and skeletonization), encouraging either the right internal mammary artery for appropriately selected patients or the radial artery for those with appropriate lesions and unfavorable risk profiles for sternal complications has the potential for more widespread adoption among practicing surgeons. Mandating that all patients undergo skeletonization of both internal mammary arteries may discourage surgeons from adopting this approach.

Therefore, we agree that skeletonization may ultimately be the most