Author has nothing to disclose with regard to commercial support.

have been captured in our primary outcome. Of course, many patients with the primary outcome experienced recurrence before the 12-week point, but only the initial recurrence was necessary to meet the definition for the primary outcome. In fact, almost all patients in whom the primary outcome occurred initially experienced recurrence within the first 45 days after surgery (Figure 2).

Treatment with amiodarone for a short period, such as during the first 3 months after surgery, has been shown to be safe and effective when patients are closely monitored. The results of our study indicate that prophylactic use of amiodarone reduced the incidence of atrial arrhythmia recurrence within the first 3 months after surgery. Future studies are warranted to understand whether this reduction in recurrence during the early postoperative period translates into long-term success after surgical ablation.

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OFF-PUMP CORONARY ARTERY BYPASS GRAFTING VERSUS CONVENTIONAL CORONARY ARTERY BYPASS GRAFTING: WHAT WE DON'T KNOW

To the Editor:

I read with interest the editorial titled “The Emperor’s New Clothes” by Dr Richard Lee,¹ commenting on the article by Dr Fabio Barili and colleagues titled “Impact of Off-Pump Coronary Artery Bypass Grafting on Long-Term Percutaneous Coronary Interventions.”² My purpose is not to agree or disagree with either author, but rather to point out that Barili and colleagues’ conclusions and Lee’s commentary are missing the forest for the trees. To debate the merits of off-pump coronary artery bypass grafting (OPCAB) versus conventional on-pump coronary artery bypass grafting (CCAB) is to have the wrong discussion.

The goal of surgical revascularization should be to relentlessly restore blood supply, by both anatomic and physiologic criteria, to all areas of myocardium possible for the longest interval of time possible. This goal specifies

a new objective framework for all coronary artery bypass grafting procedures that is different from the conventional anatomic framework.

Current techniques for both OPCAB and CCAB do not come close to meeting this goal, but for different reasons. Transposing this conventional framework to OPCAB, both Dr Barili and colleagues and Dr Lee address the important OPCAB liabilities of “incomplete revascularization,” increased late percutaneous coronary intervention, and increased late mortality versus CCAB. By using this newer framework, many recent OPCAB studies document a higher incidence of multiarterial grafting, known to improve late mortality after revascularization by either technique.³ Moreover, Dr Lee’s comment that “he personally continues to use it (OPCAB) in select situations” is precisely a very important component of the Achilles’ heel of a majority of the OPCAB analyses and experience.¹

Likewise, the CCAB surgeons advocate that CCAB outcomes are better than they have ever been, and that CCAB is the “gold standard” for multivessel disease versus medical therapy and percutaneous coronary intervention.⁴ Although this may be true today, it will not be tomorrow. The component Achilles’ heel of this approach continues to include stroke, neurocognitive issues, 15% to 25% graft attrition at 12 to 18 months, the lack of multiarterial grafting in actual practice, and the lack of incorporation of new, important physiologic data into the operative strategy.

Advocating for an “all or none” approach misses the opportunities available and retards progress. The OPCAB setting is an exciting window into the real-time physiology of revascularization blood flow and perfusion, an opportunity not previously available to cardiac surgeons.⁵ This information is critical to all revascularization surgeons committed to making all surgical revascularization better than it is today.

Inherent to this perspective is the ability and responsibility to document at the time of surgery that this goal has or has not been met. More important, whether this goal is met should be a patient-driven outcome, not a surgeon-driven outcome.

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MISSING THE FOREST FOR THE TREES

Reply to the Editor:

I appreciated Dr Ferguson's¹ perspective in "OPCAB versus CCAB—What We Don't Know." However, in it he declares, "Barili's conclusions and Lee's commentary are missing the forest for the trees."

I agree with the suggestion that "advocating for an 'all or none' approach misses the opportunities available and retards progress." In fact, in the related commentary I suggested, "Perhaps, as a field, we should define those indications for off-pump coronary artery bypass (OPCAB) via guidelines that include metrics of competency as well as the surgical volume required to maintain proficiency of the skill. We already do this for other procedures. This type of monitoring may even include long-term follow-up in the Society of Thoracic Surgeons database. As the new reimbursement paradigms evolve, this type of evidence of efficacy will likely be mandatory. It is in our best interest to actively lead the reform."²

This does not advocate an all-or-none approach. Perhaps the trees were in the way. However, ignoring the plethora of data revealing that outcomes are different for OPCAB at least in some hands in some patients is a failure to see the forest.

I again agree with Dr Ferguson¹ that "goal is met should be a patient-driven outcome, not a surgeon-driven outcome." But this should be guided by data. The article by Barili is one of many that suggest OPCAB is not the best option for every patient.³

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OPCAB VERSUS CONVENTIONAL CABG: WHAT WE LEARN TODAY WILL HELP ADDRESSING THE FUTURE

Reply to the Editor:

We read with great interest the comment on our article by Dr Ferguson,¹ and we agree with his general line of thought. It was not the aim of our study to condemn any technique or promote another one. The deep sense of the PRIORITY project from which the study derives is to develop what Dr Ferguson defined a "patient-driven outcome," analyzing the long-term effect of coronary artery bypass grafting (CABG) in terms of mortality and patient quality of life. We did not wish to stigmatize off-pump coronary artery bypass grafting (OPCAB) surgery; we simply added further confirmation to a potential drawback that needs to be taken into account, just as neurologic complications for on-pump CABG are considered.

OPCAB and on-pump CABG represent 2 different tools for surgeons, each with limitations and advantages. The choice of tool should be based on various factors, including the surgeon's learning curve, and should have as a final goal the best treatment for the patient. In this context, we also cannot stigmatize Dr Lee for choosing to use OPCAB in selected situations.² This option represents his personal best choice for the patient, and the extensive literature published in recent years has not contradicted his way of proceed because superiority of OPCAB has not been shown.³

The "Achilles heel" of OPCAB cannot be reduced to the simple matter of a learning curve, however. As we discussed, the incidence of repeat revascularization was close to significance in OPCAB compared with on-pump surgery even in the CORONARY Trial.¹ Moreover, the adjunctive risk of repeat revascularization of the ROOBY Trial compared with CORONARY Trial was similar in OPCAB (odds ratio, 4.5) and on-pump CABG (odds ratio, 4.8), demonstrating that surgical skill and experience have a similar impact independent of the technique used.