Author has nothing to disclose with regard to commercial support.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.10.060>

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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<http://dx.doi.org/10.1016/j.jtcvs.2015.10.105>

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.

A similar evaluation can be conducted for multiarterial revascularization. Arterial revascularization is a well-known predictor of positive outcome independent of surgical technique, and the higher incidence in OP-CAB reported by Dr Ferguson is similar to that in on-pump CABG, simply because they are independent factors.⁴

Again, we agree with Dr Ferguson regarding the dynamic evolution of the gold standard concept for multi-vessel disease treatment. As established in the health technology assessment protocols, technological advances lead to continuous amelioration that needs to be taken into consideration. The incidence of repeat revascularization is expected to be decreased in the future by technological advances, and a fractional flow reserve-guided revascularization strategy could provide a means of addressing effective revascularization beyond anatomic targets on short- and long-term outcomes.⁴ Nonetheless, we should keep in mind that similar advances are occurring in extracorporeal circulation (ECC) technology, and that ECC's Achilles heels will be ameliorated in the future.

The results of our study provide merely a snapshot of a dynamic process that is continuously changing; however, these changes will not be addressed properly without analysis of such snapshots.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.11.019>

Notice of Correction

Re: Almassi GH, Carr BM, Bishawi M, Shroyer L, Quin JA, Hattler B, et al, for the Veterans Affairs #517 Randomized On/Off Bypass (ROOBY) Study Group. Resident versus attending surgeon graft patency and clinical outcomes in on- versus off-pump coronary artery bypass surgery. *J Thorac Cardiovasc Surg*. 2015;150:1428-37.

In the above-noted article, in the Results section of the abstract, the third sentence "Between these 2 techniques, no were found differences ..." should be corrected to "Between these 2 techniques, no differences were found"

In addition, the first column headings of Tables 4 and 5 were incorrect. The heading for Table 4 should be "Short-term and 1-year outcomes." The heading for Table 5 should be "Graft patency and FitzGibbon classification." The corrected tables are reprinted on the following page.