J.S.R. is a consultant for AtriCure. All other authors have nothing to disclose with regard to commercial support.

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corroborate our most recent analysis from the Society of Thoracic Surgeons database.⁶

Finally, we have been very satisfied with our guideline-adherent policy of selective anticoagulation after successful Cox-Maze IV. It streamlines care, and within the limits of our current large institutional experience, it has virtually eliminated hemorrhagic strokes and delayed tamponade. We once again would call on a randomized controlled trial to further evaluate our hypothesis for this mode of postoperative management.

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CAN THE MAZE BE ALL THE RAGE?

Reply to the Editor:

Murashita and colleagues¹ recently published a provocative notion in their article “Oral Anticoagulation May Not Be Necessary for Patients Discharged in Sinus Rhythm After the Cox Maze IV Procedure.” The idea of withholding oral anticoagulation after

surgical ablation for atrial fibrillation and concomitant valve surgery is intriguing, yet conflicting. In response to the study of Murashita and colleagues,¹ McClure and colleagues² adamantly refuted the concept of withholding oral anticoagulation. They postulated that limitations in study size and design vitiated any meaningful conclusion. Furthermore, McClure and colleagues² substantiated their position by citing 2 recent meta-analyses: one regarding surgical ablation and the other regarding left atrial appendage closure.^{3,4} Both meta-analyses support ongoing anticoagulation, because the risks of stroke were not reduced by either therapy. These results are likewise intriguing but must be viewed within the limitations of meta-analyses. Although these studies have reached significant conclusions, the deductive reasoning deserves additional scrutiny as it translates to the work of Murashita and colleagues.¹

First, Murashita and colleagues¹ emphatically stated their results to be “hypothesis generating only.” They were circumspect regarding their limitations and reiterated the need for subsequent studies. Second, they uncovered a potential handicap of the CHADS₂ (congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, stroke [double weight]) scoring system as a therapeutic guide for oral anticoagulation after surgical ablation. Third, they shed light on the bleeding risks in patients 75 years of age and older. Finally, and perhaps most impressively, they established a fairly homogeneous model—a Cox maze IV series with 99% normal sinus rhythm at discharge, an incredible platform for building subsequent prospective studies. We acknowledge that the work of Murashita¹ and colleagues does not meet landmark criteria; nonetheless, it is engaging and insightful. We thank McClure and colleagues² for their critique, which permits a finer dissection of this study. We look forward to the future work in this space.

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LEFT ATRIAL APPENDECTOMY COMBINED WITH THORACOSCOPIC LEFT UPPER LOBECTOMY

Video clip is available online.

To the Editor:

Although thoracoscopic left atrial appendectomy has been recently developed as an effective method for preventing cardiogenic thromboembolism,¹ the application of this

VIDEO 1. The left atrial appendage was exposed through pericardiotomy. After resection, thoracoscopic ligation was added to make the stump smooth. Video available at: [http://www.jtcvsonline.org/article/S0022-5223\(18\)30711-6/fulltext](http://www.jtcvsonline.org/article/S0022-5223(18)30711-6/fulltext).

operation is still limited. In thoracoscopic left upper lobectomy, the surgical site is quite similar to that of thoracoscopic left atrial appendectomy, so combined surgery is feasible. When patients with indications for left upper lobectomy (eg, for lung cancer) have had the preoperative complication of atrial fibrillation, we have assumed that additional left atrial appendectomy is acceptable. This

FIGURE 1. Additional ligation made the resection line smooth.