technical adequacy, the results of the venous grafts could be considerably better.

José Glauco Lobo Filho, MD, PhD^a
 Heraldo Guedis Lobo Filho, MD, PhD^a
 Matheus Duarte Pimentel, MD^b
^aDepartment of Surgery
^bFederal University of Ceará
 Fortaleza, Brazil

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THE SEARCH FOR THE SECOND BEST CONDUIT: A 40-YEAR-OLD DEBATE

Reply to the Editor:

The points in the letter by Lobo Filho and colleagues regarding the 5-year results of the Saphenous Vein Versus Right Internal Thoracic Artery as a Y-Composite Graft (SAVE RITA) trial are very well taken.

The debate on the second best conduit for coronary bypass surgery is at least 4 decades old. As Lobo Filho and associates point out, the use of bilateral internal thoracic artery (BITA) (suggested among others by Barner in 1972¹) remains an exception for most cardiac surgeons. The concern for sternal wound complications (associated with substantial economic penalties in the United States) is definitely a limiting factor in the routine use of the BITA. It is important to note that a clear experience to outcome relationship exists in BITA grafting for both sternal wound complications and long-term outcomes,² so that less-experienced surgeons are likely to have a higher incidence of sternal complications (and thus be even less willing to use BITA). Of note, the radial artery (now a class I indication in the European Society of Cardiology/European Association for Cardio-Thoracic Surgery Guidelines³) is an excellent alternative arterial graft that does not increase the risk of sternal wound complications.

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The use of the no-touch saphenous vein is an interesting alternative to arterial grafts. The lower degree of endothelial damage due to the less traumatic harvesting and dilatation of the vein may have the potential to significantly increase the patency rate compared with the traditionally harvested saphenous vein grafts. This benefit potentially can be further increased by proximally anastomosing the no-touch saphenous vein to an internal thoracic artery graft (as in the SAVE RITA trial⁴). An additional advantage of this strategy is the allowance of a no-touch anaortic bypass procedure and the potential for a significantly reduced neurologic risk.

However, despite the commendable work of Kim and colleagues⁴ and a few other groups around the world, at the moment, evidence supporting the use of the no-touch saphenous vein is very limited. The potential benefits of this approach should be tested in appropriately sized randomized trials.⁵

Mario Gaudino, MD
 Department of Cardiothoracic Surgery
 Weill Cornell Medicine
 New York, NY

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SAPHENOUS VEIN COMPOSITE GRAFTING WILL BE A “Y’S” DECISION

Reply to the Editor:

We thank Lobo Filho and colleagues,¹ who published an important study regarding myocardial revascularization using a saphenous vein (SV) composite graft based on the left internal thoracic artery (ITA), for their interest in our study.