Authors have nothing to disclose with regard to commercial support.

We presented the incidence of postoperative complications in the early results of the trial.² The incidence of postoperative mediastinitis was 0.4% (1 in SV group vs 0 in right ITA group, $P > .999$).

Although composite vein grafting has several theoretic advantages, there are also a couple of caveats.^{3,4} The majority of surgeons are reluctant to perform revascularization using a composite graft because technical failure in the construction of composite graft may cause catastrophic results after revascularization. To avoid any technical failure in the construction of a composite graft, it is mandatory to use a high-power magnification loupe (at least $\times 3.5$ magnification) and intraoperative validation using flow-metry and high-resolution ultrasound imaging if possible. Another issue with composite grafting is the possibility of development of competitive flow. If the last section of the composite graft was anastomosed using a sequential anastomotic technique to the coronary artery that had less than significant stenosis and if there is a valve in the proximal area of the SV conduit where competitive flow develops, the distal SV conduit segment may be occluded later by blood stagnation distal to the valve. We destroy the valve of the SV conduit to avoid graft failure, which may occur in the event of flow competition. After the composite graft is constructed, the left anterior descending coronary artery territory is revascularized first by using the left ITA while the SV conduit is left to be dilated spontaneously by the native flow and pressure of the left ITA. The valve of the spontaneously dilated SV conduit is then destroyed by inserting a 2-mm vessel dilator into the reversed dilated vein lumen, thus preventing blood stagnation in the event of flow competition.⁵ Destruction of the valve may cause intimal damage in the SV conduit; however, we believe a gain with valve destruction is greater than losses without valve destruction.

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A GLOBAL QUESTION Reply to the Editor:

We read with interest Filho and colleagues' perspective¹ in the ongoing conversation on bilateral internal thoracic arteries (BITA) versus saphenous vein grafts (SVG). As we opined in our editorial,² the SAVE-RITA (Saphenous Vein Versus Right Internal Thoracic Artery as a Y-Composite Graft) study³ is valuable in demonstrating potential improvement in SVG patency far above historical rates. The natural question is which way we should proceed, greater adoption of BITA or technical improvement in SVG. Filho and colleagues¹ lean toward SVG, noting that observational BITA studies may not be applicable to patient populations in less-developed countries and that this limited experience leads to a protracted BITA learning curve.

We have no personal experience with patients in less-developed countries, and we appreciate that the patient population may differ. We challenge Filho and colleagues, however, to support their statements with more granular data regarding the risk of the patients they treat. Other cardiovascular surgeons in less-developed countries have championed BITA use; Navia and associates reported on nearly 1500 BITA operations during an 8-year period in Buenos Aires.⁴ A survey in India showed BITA rates to be 10%, double the rate in the US.⁵ In fact, Filho and colleagues do not have to look far from home to find data. A multicenter prospective study in São Paulo has a reported 10% BITA use,^{6,7} and a group from Recife has developed and validated a deep sternal wound infection risk tool, finding that BITA was not significantly associated with deep sternal wound infection (area under receiver operating characteristic curve of 0.729).⁸ With regard to the learning curve, one must consider that there is also a learning curve to mastering atraumatic manipulation and Y-composite grafting.

Saran and colleagues,⁹ commenting on their own recent study on BITA, argue that current low use of BITA is due not to lack of surgical skill but rather to either a knowledge gap or equipoise regarding long-term survival benefits. They suggest that low BITA use is due to “the lure of short-term outcomes” and that the BITA learning curve could be surmounted with adequate training. What surgeon,

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if faced with a personal need for coronary artery bypass grafting, would choose SVG rather than BITA? The option that we would choose for ourselves should be the option that we choose for our patients.

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