Authors have nothing to disclose with regard to commercial support.

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REPLY: ATTENTION TO DETAIL...AND COLLATERAL FLOW Reply to the Editor:

In a previous report, Bosse and colleagues¹ described the use of bypass grafting from the ascending aorta to the femoral arteries concomitant with coronary artery bypass grafting to treat patients with combined coronary artery disease and severe aortoiliac occlusive disease. In the Letter to the Editor in this issue of the *Journal*, Meric and colleagues pose a highly relevant concern relating to the use of such an approach in treating these patients; that is, one must consider the collateral flow to the lower extremities, specifically its reliance on the internal thoracic arteries. Pursuant to recommendations in treating coronary artery disease, using an internal thoracic artery as a bypass conduit in this patient cohort may lead to disruption of critical collateral perfusion. With this in mind, what can one expect in the setting of a concomitant ascending aorto-femoral bypass procedure as described by Bosse and colleagues? Would the impact of

disrupting antegrade collateral flow (by using an internal thoracic graft to treat the coronary artery disease) be mitigated if an aorto-femoral bypass is also performed leading to predominantly retrograde flow to lower abdominal and pelvic vessels? On first pass, one would expect that there would not be significant ischemia or compromised perfusion to these vessels with this combined approach. On the other hand, disruption of antegrade collateral flow does not always have predictable consequences. Perhaps, one can propose that saphenous vein bypass grafting of coronary arteries may be a better compromise, accepting its diminished durability and acknowledging the potential need for lower-extremity revascularization. Or one can consider the use of the radial artery as a conduit, recognizing that any existing renal dysfunction may require later use of this artery for hemodialysis access. Clearly, further discussion in the treatment of these patients will require detailed follow-up. Bosse and colleagues¹ thus are positioned to provide much needed counsel based on their current experience and are encouraged to provide additional guidance in the upcoming years.

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REPLY FROM THE AUTHORS: LIMB ISCHEMIA AFTER INTERNAL THORACIC ARTERY HARVESTING FOR CORONARY ARTERY BYPASS

**GRAFTING IS PREVENTED BY BYPASS
FROM THE ASCENDING AORTA TO
BILATERAL FEMORAL ARTERIES IN
PATIENTS WITH LERICHE SYNDROME**

Reply to the Editor:

Dr Meric and colleagues emphasize the need for concomitant lower-limb revascularization in patients with Leriche syndrome associated with severe coronary artery