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REPLY: CARDIAC SURGERY—ASSOCIATED ACUTE KIDNEY INJURY—A PROTECTIVE ARMOR RATHER THAN A LETHAL AMMUNITION

Reply to the Editor:

We are genuinely pleased to read the reply by Montisci and Miceli,¹ “Reply: Cardiac Surgery-Associated Acute Kidney Injury—Finding the Gunpowder,” regarding our recently published article.² Certainly, to comment about cardiac surgery-associated acute kidney injury (CSA-AKI) is nothing if not a complex chore. In this regard, we would like to discuss only 3 specific aspects.

1. Arguably, brain oxygen saturation monitoring has some drawbacks, which does not necessarily translate into a safer environment to other vulnerable organs, such as the kidneys. In fact, this was demonstrated in our study,² in which the kidney oxygen saturation but not the brain oxygen saturation was closely related to the development of CSA-AKI during the postoperative stage.
2. Undeniably, CSA-AKI is a complex entity.³ Numerous factors intervene altogether in its pathogenesis, taking into account not only preoperative factors and intraoperative factors related to the surgery but also several elements that adversely influence the patient's condition during the postoperative period. This is why it is so difficult to exert absolute control over CSA-AKI, which still today remains a notable complication after cardiac surgery, with increased postoperative morbidity and mortality regardless of our tremendous efforts.⁴
3. Finally, with respect to modifiable factors, as Montisci and Miceli¹ mentioned, some risk factors frequently cannot be modified, such as age, long cardiopulmonary bypass time, or preexisting chronic kidney disease. In addition to these, and taking into account that the mechanisms modulating the pathogenesis of CSA-AKI still remain largely undetermined and that there are no specific treatments for CSA-AKI other than routine

supportive therapy and renal replacement therapy,⁵ we should divert all our efforts toward its prevention, which has to remain as our principal aim in the treatment of this disease, rather than eagerly looking for unsatisfactory interventions for this complication.⁶

All in all, carrying on the original analogy of Montisci and colleagues,⁷ we are yet faced with a shortage of munitions against CSA-AKI. Providing an effective preventive measure could be a much more worthwhile initiative to tackle this problem successfully.

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"I'VE MISSED MORE THAN 8000 SHOTS IN MY CAREER. I'VE LOST ALMOST 300 GAMES. 26 TIMES, I'VE BEEN TRUSTED TO TAKE THE GAME-WINNING SHOT AND MISSED. I'VE FAILED OVER AND OVER AND OVER AGAIN IN MY LIFE. AND THAT IS WHY I SUCCEED."

REPLY: IS PREVENTION OF ACUTE KIDNEY INJURY AFTER CARDIAC OPERATIONS HOPELESS? MICHAEL JORDAN WOULD SAY NO!

Reply to the Editor:

"I can accept failure. Everyone fails at something, but I can't accept not trying again."

—Michael Jordan

We are continually looking for additional factors that can favorably modify perioperative concerns in patients

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should: • Include no more than 500 words of text, three authors, and five references. • Type with double-spacing. • See <http://jtcvs.ctsnetjournals.org/misc/fora.shtml> for detailed submission instructions. • Submit the letter electronically via jtcvs.editorialmanager.com. Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity to offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.