5. Heilman SJ, Carroll SM, Stremel RW, Tobin GR, Barker JH. Vascular delay improves muscle function for use in cardiomyoplasty. Abstracts of the Fortieth Annual Meeting of the Plastic Surgery Research Council, New York: Institute of Reconstructive Plastic Surgery, 1995:149-51.

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Reply to the Editor:

Living in the Detroit area, I am naturally attracted to the concept of "supercharging." Dr. Üstüner's theoretical technical modification to improve distal muscle perfusion in dynamic cardiomyoplasty is predicated on the theory that a clinical failure of the procedure is solely explained by muscle perfusion. If that is true, then microsurgical wizardry is the panacea. Is that the only reason why systolic performance is not enhanced? If efficacy is predicated on prevention of further ventricular dilatation, then the distal perfusion is an irrelevant issue. Furthermore, this technique does not address other major limitations of the procedure, such as the time needed for transformation and the fact that the procedure does not deal with lethal ventricular arrhythmias. Unfortunately, technical modifications alone cannot always improve the efficacy of a surgical procedure if that operation is incompatible with clinical urgency and pathophysiology.

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Axillary artery for extracorporeal circulation

To the Editor:

I read with great interest the contribution of Sabik and coworkers on the use of the axillary artery as an access for extracorporeal circulation (J THORAC CARDIOVASC SURG 1995;109:885-91). Their report focused primarily on the prevention of stroke and organ injury, for which axillary artery perfusion was documented to be superior to other routes in selected patients. I would like to report another variant of this access. In 1984, a 44-year-old female patient came to the attention of my group because of severe aortic insufficiency and root ectasia with an excessively calcified ascending aorta and arch. In addition, she had occlusion of the infrarenal aorta associated with severe leg ischemia. As a result, neither the proximal aorta nor the femoral arteries were available for cannulation. I therefore decided to place an extraanatomic bypass from the left axillary artery to the left common femoral artery to which a side arm was connected, with the sidearm serving for arterial cannulation. A valved composite graft was then inserted, with the distal anastomosis sutured with heavily pledget-supported, interrupted mattress sutures placed with sharp needles. The patient had an uneventful postoperative course, and an infrarenal Y-graft was subsequently inserted. At that time, the extraanatomic bypass was removed. This patient recently required replacement of the originally inserted aortic xenograft but otherwise is doing well.

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