stomach where the right and left GEAs usually connect in a network. If a large arteriovenous fistula had been present, we would have recognized it during GEA take-down. Second, an arteriovenous fistula may have been created in the course of the surgical procedure. Although we skeltonized the GEA at the anastomotic site, the angiographic evidence that the gastroepiploic vein was densely filled to the end of the pedicle strongly suggests a surgically created arteriovenous fistula.

In our case, postoperative graft arteriography showed GEA-dependent flow as described by Nakao and Kawaue⁴—poor native coronary flow, a widely perfused area, and good runoff. Fortunately, because blood flow to the native right coronary artery was much more predominant than that into the gastroepiploic vein, no clinical problem resulted. We will observe the patient carefully to see whether a possible venous steal may cause future myocardial ischemia in the area of GEA grafting.

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Cryopreserved aortic homograft for mycotic aneurysm

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Mycotic aneurysm is a life-threatening pathologic entity with high morbidity and mortality. The optimal surgical management is a subject of controversy.¹ We report in situ

Fig. 1. Computed tomographic scan showing a typical infrarenal mycotic aneurysm. Note moderate aortic dilation with partial disruption of the aortic intimal calcification (arrow).

Fig. 2. A cryopreserved homograft has been implanted in the infrarenal position after excision of the entire infrarenal part of the abdominal aorta. Note that the intercostal arteries arising from the grafts had been ligated by clips (arrows).

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Fig. 3. Computed tomographic scan demonstrating the descending thoracic aorta with calcifications in the aortic wall (arrowhead) and an adjacent eccentric mass, which was confirmed intraoperatively to be a false aneurysm consisting of hematoma, blood, and local inflammation (arrow).

replacement of mycotic aneurysm of the aorta with cryopreserved aortic homografts.

A 67-year-old man underwent an elective operation for a mycotic aneurysm of the infrarenal abdominal aorta (Fig. 1). The aneurysm was resected and the infrarenal aorta was replaced with a cryopreserved aortic homograft tube (Fig. 2). Preoperative blood cultures and cultures from the aneurysm both grew *Streptococcus pneumoniae*. Penicillin G, given intravenously before the operation, was continued after the operation for 4 weeks, followed by cephalosporin given by mouth for another 2 weeks.

The second patient was a 59-year-old man with a mycotic aneurysm of the descending thoracic aorta caused by *Streptococcus pneumoniae* (Fig. 3). The diseased part of the descending thoracic aorta was replaced with a cryopreserved homograft (Fig. 4). Preoperative intravenous antibiotic therapy with clindamycin was continued after the operation for another 4 weeks.

After resection of the mycotic aneurysm and the adjacent parts of the aorta, both patients received cryopreserved homografts harvested from the descending thoracic aorta of donors during harvesting of the heart for transplantation (Fig. 5). The intercostal arteries arising from the grafts were ligated by clips (see Fig. 2), and then the grafts were implanted with end-to-end anastomoses in the usual manner with continuous polypropylene suture. The postoperative courses of both patients were uneventful. The patients received the appropriate antibiotic therapy for 4 to 6 weeks after the operation. The two patients

Fig. 4. Intraoperative view with the descending thoracic aorta replaced by a cryopreserved homograft. The homograft has been implanted in situ after extensive débridement of the diseased part of the descending thoracic aorta.

have remained free of complications 12 and 6 months, respectively, after the operation.

The standard operation for the treatment of patients with mycotic aneurysm consists of arterial ligation, aneurysm excision, and extraanatomic bypass grafting.² This procedure is associated with late complications and, in certain situations, is difficult or technically impossible to do, necessitating in situ reconstruction.^{3,4} However, in situ prosthetic graft replacement increases the risk of recurrent infection.³ The usefulness of homograft cryopreserved tissue has already been proved in cardiac surgery.⁵ When used for infective processes of the aortic valve, homograft tissue reduces the postoperative infection rate and improves survival.⁶ The use of a cryopreserved aortic homograft conduit for treatment of mycotic aortic aneurysm might reduce the rate of late postoperative infections and improve survival of this high-risk group of patients. Therefore, we strongly suggest harvesting of the entire aorta with its branches for further cryopreser-

Fig. 5. Macroscopic view of a cryopreserved homograft ready for insertion. The homograft was removed from the descending thoracic aorta of a donor during heart harvesting for transplantation. Note the intercostal arteries arising from the grafts, which should be ligated before graft insertion.

vation during the harvesting of other organs from a donor. If stored in a tissue bank, the homograft might be used for emergency operations because mycotic aneurysms are usually ruptured when diagnosed.

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Ophthalmoscopic findings demonstrate reduced cerebral blood flow during retrograde cerebral perfusion

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Retrograde cerebral perfusion (RCP) via the superior vena cava has recently been discussed as an alternative method of cerebral protection during aortic arch operations.^{1,2} This method may be simple and useful because it does not require cannulation and crossclamping of aortic arch vessels, and it may enhance the effect of cerebral protection in circulatory arrest.³ However, it is not clear whether this procedure provides adequate oxygen supply for the brain. To resolve this problem, we have observed the optic fundus of a patient undergoing an aortic arch operation with RCP to evaluate the circulatory state of the brain during RCP.

A 78-year-old woman was admitted to our hospital

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