with resectable bronchial carcinoma in a single lung are denied resection because of the operative risk.

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Ostioplasty for isolated coronary artery ostial stenosis

To the Editor:

We read with interest the recent article¹ and correspondence^{2,3} relating to the surgical treatment of isolated coronary ostial stenosis. We would like to add a word of caution.

In 1992, a 46-year-old man presented with a history of rapidly progressive angina. Cardiac catheterization showed severe isolated left coronary ostial stenosis. With the aid of cardiopulmonary bypass and cardioplegic cardiac arrest, a left coronary ostioplasty was performed by insertion of a gusset of long saphenous vein into the left main coronary artery and adjacent aorta. Cardiopulmonary bypass was discontinued without difficulty. Four hours after the operation, the patient's condition deteriorated suddenly and rapidly, and ventricular fibrillation ensued within a couple of minutes. Urgent re sternotomy was performed, at which time it was noted that the right ventricle was clearly well perfused, with a vigorous ventricular fibrillation. However, the left ventricle showed only very fine ventricular fibrillation and was severely discolored. The distinction between the left and right ventricles was marked. A clinical diagnosis of thrombosis of the left main stem artery was made, but despite full resuscitation the patient died. At postmortem examination the left coronary ostium was widely patent and no thrombus could be identified. We believe that the thrombus must have been dislodged during the resuscitation.

We would therefore add a word of caution regarding this new technique, especially as the option of revascularization with the internal mammary artery is well established and carries a very low risk with good long-term results.⁴

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Reply to the Editor:

We have read the letter by Drs. Dihmis and Hutter with great interest. We find it a presumptive conclusion that an enlarged coronary artery ostium should be prone to thrombosis. A widely patent coronary ostium with good runoff, on the other hand, should protect against blood stasis. This theory is further supported by the fact that no thrombus was found at postmortem examination. Many other factors may affect the outcome after coronary artery surgery. Intraoperative myocardial protection may be difficult in the case of a left main stem stenosis, and factors such as hypoxia, acid-base imbalance, and electrolyte imbalance may also cause postoperative cardiac arrhythmias.

A well-constructed coronary ostial enlargement is unlikely to be at high risk for thrombosis. We do, however, welcome the message of the report that coronary ostial enlargement is not a simple operation. Careful selection of patients, adequate intraoperative myocardial protection, proper enlargement of the ostium without distortion, and efficient postoperative care are vital in achieving good results.

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