ischemia as a result of inadequate collateral flow in patients with this coronary anomaly is unknown. In fact, it is uncertain whether these changes will eventually develop in all patients living beyond childhood. However, in view of reported cases of sudden death,² occasionally not preceded by any ischemic symptoms, corrective surgery is usually recommended at diagnosis, even in symptom-free patients with no objective evidence of ischemia, such as the patient described by Dr. Sivasubramanian and colleagues.

Ligation of the left main coronary artery from its origin at the pulmonary artery without additional revascularization eradicates the coronary artery steal phenomenon³ by ablating the coronary-pulmonary arterial shunt. We are concerned that this technique may not be adequate in improving myocardial blood flow to alleviate ischemia in some patients, especially those with clinical or objective evidence of myocardial ischemia. There have been case reports of late-onset sudden death in adult patients who underwent simple ligation of the left main coronary artery alone.⁴ It will be interesting to follow-up carefully Dr. Sivasubramanian's patient to see whether simple ligation of the left main coronary artery from its anomalous origin will prevent any deterioration in left ventricular performance and arrhythmic events.

The fear of developing "the equivalent of left main trunk disease" later in life when obstructive disease develops in the conduit used to reconstruct a double coronary artery system is based on the theoretical assumption that regressed coronary and noncoronary collaterals will not regenerate. Given the widely published long-term patency of the left internal mammary artery when used as a conduit in patients with atherosclerotic coronary artery disease,^{5,6} its use in patients with this coronary anomaly is also likely to result in lasting benefits.

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Massive bleeding at resternotomy despite a polytetrafluoroethylene surgical membrane

To the Editor:

I have read with interest the short communication: "Massive Bleeding at Resternotomy Despite a Polytetrafluoroethylene Surgical Membrane" in the July 1995 issue of the JOURNAL. It is true that the number of reported membrane implantations far exceeds the experience with reoperations in such cases. In my experience, reoperations, especially those involving extracardiac valved conduits, are greatly facilitated by the use of polytetrafluoroethylene membrane. The sternum can be opened quickly and damage to the underlying structures is avoided.

Although the use of polytetrafluoroethylene* membrane is helpful, it is no substitute for careful surgical technique. We always open the external table of the sternum with an oscillating saw, but opening of the interior lamina is by careful dissection. If the saw is used through the entire sternum, the underlying structures can be damaged, whether the pericardium is intact or whether a pericardial substitute is used. This is particularly true if there is a dilatation of the conduit or aneurysm/pseudoaneurysm of the right ventricle, which may be due to residual ventricular septal defect and conduit obstruction. In summary, I continue using the membrane in patients in whom the risk of reoperation is high and would very much recommend its use to readers of the JOURNAL.

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Reply to the Editor:

I thank Mr. Stark for commenting on my short communication.¹ Mr. Stark is known to be interested in pericardial substitutes in general and the polytetrafluoroethylene* membrane in particular and has reported expertly on resternotomy.²

The method of resternotomy that Mr. Stark describes is one of many methods that can all be regarded as "careful surgical technique." In this regard it is most important

*Gore-Tex surgical membrane, registered trademark of W. L. Gore & Associates, Inc., Newark, Del.