approach merits further consideration and trial. Furthermore, I believe combined carotid endarterectomy and coronary artery bypass grafting should be performed on a wider basis to determine potential risks and benefits in various subsets of patients to facilitate improved patient selection.

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Truncus arteriosus repair: Influence of techniques of right ventricular outflow tract reconstruction

To the Editor:

I was pleased to read the recently published article by Lacour-Gayet and associates¹ regarding truncus arteriosus. The implications of different technical approaches used for right ventricular-pulmonary artery outflow reconstructions on the immediate, midterm, and long-term results are widely known. In this study, the authors used different types of conduits and a direct anastomosis to establish right ventricular-pulmonary artery continuity. In five patients, a fresh autologous pericardial valved conduit was used, manufactured according to the description published by my colleague Schlichter and me.²⁻⁴ It is not surprising to us that 100% of survivors in whom this technique was used did not require conduit replacement in more than 6 years of follow-up. In our experience^{4,5} in more than 50 patients followed up for 1 to 10.4 years (median 5 years), the conduit implant's freedom from reoperation was 90% at 5 years and 100% for those that measured more than 16 mm at the time of implantation. It is hard to believe that the 40% immediate mortality in two of five patients treated by this technique was purely related to the pericardial valved conduit and to severe pulmonary regurgitation. Both patients who died had interrupted aortic arch, one of whom was 2 days of age at the time of repair, and young age under 30 days is recognized by the authors as a risk factor. In addition, the diagnosis of severe pulmonary regurgitation in the reported two patients is surprising, because we have not registered any case of moderate or severe postoperative pulmonary regurgitation during the immediate postoperative period. Furthermore, no considerations are made with respect to possible technical problems during tailoring of the conduit. To achieve success, the constructor must be extremely careful and follow all the steps precisely, as they were described.^{2,3}

We continue to believe that the autologous pericardial valved conduit is an effective, cheap, and highly successful option for the Rastelli repair or even the Ross procedure when no previous pericardial adhesions are present. We concur with the authors' observation on the advantageous capability of the autologous pericardial valved conduit to grow with time.

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[Response declined.]

Controlled limb reperfusion in patients with severe limb ischemia

To the Editor:

We read with great interest the recent article by Beyersdorf and associates¹ on limb reperfusion in the April 1996 issue of the Journal. We congratulate them on their excellent results with controlled limb reperfusion in patients having severe limb ischemia.

A factor that weakens this study, however, is the complete lack of perioperative serum myoglobin data. The postoperative effect of residual hypermyoglobinemia after controlled limb reperfusion on renal tubular function is not clarified. In patients treated by uncontrolled normal blood reperfusion we usually see mild increases in serum potassium levels, without rhythm disturbances, but marked increases in serum creatine kinase and myoglobin values associated with postoperative renal failure, which necessitate repeated hemodialysis. Although the authors noted massive washout of creatine kinase ($20,414 \pm 7,710$ U/L), which indicates the presence of rhabdomyolysis, they never saw renal dysfunction requiring hemodialysis in survivors. It was not possible to determine whether their different reperfusion technique might have affected postoperative renal tubular function.

Their technique for controlled limb reperfusion was easily applied. However, this technique has a potential disadvantage in severely ill patients, because all effluent returns to the patient by way of the femoral vein.

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