hemostatic sutures are placed if necessary. Then, both coronary arteries are reconstructed and the distal graft anastomosis is completed.

Although determination of the actual degree of aortic regurgitation might be difficult and the image is only 2-dimensional, the endoscopic method is simple and reproducible. This method allows the opportunity to correct a minor prolapse and leak before aortic declamping.

In conclusion, with the combination of effective height measurement and the aortic root endoscopy, more detailed information on the repaired valve can be obtained. As a consequence, improved results of the aortic valve-sparing operation may be obtained.

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pathology according to the surgical steps. Prolapse postoperatively may result from isolated or combined findings, including commissural stretching, leaflet reduction or elongation by reimplantation, free margin under- or overcorrection, and annulus undersizing. Likewise, in case of a functional accurate but asymmetric valve after repair, no definitive statement to improve the surgeon’s technique is given.

AV endoscopy enables the visualization and differentiation of such important details. The resulting leaflet position and symmetry can be studied and related to the commissural, supra-annular, or free-margin stitches. However, as Sievers mentioned, a pressure level of 60 mm Hg minimum is required to push the leaflets to the end-diastolic position and to evaluate coaptation and symmetry (Video 1). Endoscopy does not reduce the importance of intraoperative tools and techniques that are used for the standardization, safety, and durability of AV repair. Endoscopy enables only the control of the result before clamp release and initiates minor or major corrections, if required. It is the only instrument that can demonstrate directly the result of surgical techniques in cardiac and aortic surgery, giving important information to understand the AV pathology and to improve the surgical technique. In our department, endoscopy enabled a more sophisticated methodology to choose the repair technique.5

We apologize for overlooking and not citing Itoh and colleagues’ important contribution from 1997, which paved the way for us and others, hopefully ameliorating the inevitable learning curve in performing more complex AV reconstructions.

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To the Editor:

We thank Bozinovski and Caton for their valuable article entitled “A Benign PFO in OPCAB Can Suddenly Take a Right Turn, but Maybe It Can’t Tolerate It.” They present a case with desaturation due to right-to-left shunt through a patent foramen ovale (PFO) during off-pump coronary artery bypass (OPCAB). Although rare, this is an extremely important problem in the OPCAB procedure. PFO is a frequent pathology with an estimated prevalence of 25%. However, in cases without a known PFO, intermittent intra-atrial shunting due to an elevated right atrial pressure may be an important problem during OPCAB. Because most patients undergoing off-pump revascularization are high risk in terms of chronic obstructive pulmonary disease and elevated pulmonary artery pressures, opening of a PFO is not infrequent when the right atrial pressure increases. This is particularly evident in cases with left and posterior wall revascularization due to positioning of the heart leading to right atrial compression. These patients are not always capable of tolerating decreases in systemic oxygenation and cyanosis due to right-to-left shunting.

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