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## Reply to the Letter to the Editor

### Reply to Raja SG

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We thank Dr Raja for his interest in our manuscript [1].

The strategy for management of blood glucose in the perioperative period was performed in a standardised fashion, according to our institutional standards, and is in line with the recently published guidelines on the perioperative management of diabetes in cardiac and vascular surgery [2,3]. In general, perioperative normoglycaemia was aimed at, and a minimal disturbance of the patients' habitual blood glucose balance was anticipated. Hypoglycaemia was avoided whenever possible, whereas hyperglycaemia was immediately corrected to a level of 6–10 mmol l<sup>-1</sup>. The evening before the operation, oral antidiabetics were stopped and only the standard dose of long-acting insulin (the patient was used to) was applied subcutaneously. On the day of operation, also any type of oral antidiabetics was avoided and no baseline insulin was applied to the patient. By contrast, the blood glucose level was measured in the early morning and was corrected prior to the operation using actrapid, if necessary. During the operation, the blood glucose level was continuously monitored; if it was too high, it was corrected using an actrapid perfusor (1–6 IE h<sup>-1</sup>) and if too low, glucose 5% was infused (200 ml h<sup>-1</sup>). After the operation, the therapy was changed to the habitual settings as soon as possible.

Bilateral internal mammary artery usage was not associated with increased risk for sternal wound infection in our cohort. In our opinion, this is due to the skeletonised technique [4] of harvest, which is standard at our institution and to the usage of local antibiotic prophylaxis in many patients [5].

As stated in our limitations, the study period was quite long, with most on-pump coronary artery bypass grafting (CABG) patients being from the early part of the study, whereas most of OPCAB patients were from the later part of the study period [6]. Therefore, a certain difference was visible with regard to the choice of grafts, as the usage of arterial grafts or even total arterial grafting constitutes nowadays the standard of care at our institution for patients under the age of 70 years, whereas, in earlier days, the usage of saphenous vein grafts was a common approach to revascularise these patients.

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## Letter to the Editor

### Safety of tranexamic acid in pediatric cardiac surgery: what we do not know

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I have read with interest the article of Martin et al. and I would like to make some comments [1]. The risks, benefits,