

cannulation. The other subject that we wonder about is the cause of mortality in one case. It could be more favorable if the authors pointed out this issue.

Antegrade cerebral perfusion is being performed even when the point of deep or moderate hypothermic perfusion is controversial [4]. We believe that the safety and quality of distal anastomosis is the most important factor for mortality and morbidity, so we think that the quality of distal anastomosis is more considerable than wasting time. We use deep hypothermia, but moderate hypothermia can also be used with more experience.

An additional comment is that in case of dissection that advanced to left main and right coronary arteries with high-grade aortic insufficiency, bicuspid aorta and degenerative aortic valve disease, we prefer inserting composite graft first and then fixating the upper side of left main coronary artery with pledgeted sutures and suturing just lateral and upper side without down side because of intensive fragility during Bentall operation. Punching the composite graft near the valve and in a slightly horizontal position is enough to achieve this procedure.

In our opinion, the surgeon should avoid Bentall procedure as far as possible because resuspension of aortic valve is sufficient in 90% of the cases in acute terms; because of this, tissues become very fragile.

References

- [1] Panos A, Murith N, Bednarkiewicz M, Khatchatourov G. Axillary cerebral perfusion for arch surgery in acute type A dissection under moderate hypothermia. *Eur J Cardiothorac Surg* 2006;29:1036–9.
- [2] Miller JS, Lemaire SA, Coselli JS. Evaluating aortic dissection: when is coronary angiography indicated? *Heart* 2000;83:615–6.
- [3] Ates M. Which suture technique is better in acute type A aortic dissection? *Eur J Cardiothorac Surg* 2006;30:199.
- [4] LeMaire SA, Carter SA, Volguina IV, Laux AT, Milewicz DM, Borsato GW, Cheung CK, Bozinovski J, Markesino JM, Vaughn WK, Coselli JS. Spectrum of aortic operations in 300 patients with confirmed or suspected Marfan syndrome. *Ann Thorac Surg* 2006;81:2063–78 [discussion 2078].

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Reply to the Letter to the Editor

Reply to Ates and Gullu

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We thank Ates [1] for his remarks and interest in our work [2]. Regarding technical aspects, the preferred type of aortic suture can be a matter of debate. We did not experience any particular problem with the continuous suture or even with the application of narrow teflon felt strip. We believe that when the suture bites are equally distributed and adequately spaced, the anastomosis is bloodproof. Concerning the direct or graft-interposed axillary cannulation, we believe that our technique is not traumatic, is less time-consuming, and less hemorrhagic during the operation than the one with the graft interposition. Küçüker et al. [3] performed 181 right brachial artery cannulations for aortic arch operations with only one vascular problem on the brachial artery. The cause of the left arm paralysis in one of our patients was of central origin and not attributed to the cannulation technique. The second patient who was treated with the stent graft suffered from a right arm malperfusion syndrome attributed to the dynamic malperfusion of the right subclavian artery as a result of the recurrence of an intimal flap on the level of the innominate artery. Therefore, we really do not find any ground for Dr Ates's concern about the hypothetical additional risks of the direct axillary cannulation. Indeed, as pointed out in our article, one patient died following an acute respiratory distress syndrome on the 20th postoperative day and this was not related to the aortic operation. To answer Dr Ates's last remark concerning the question of deep or moderate hypothermia, we have to say that, of course, it is still a matter of debate and it would be very interesting if Dr Ates and his group published their results and technique on this topic.

References

- [1] Ates M, Gullu AU. Which is more appropriate for the right axillary artery cannulation in acute type A aortic dissection—directly or with graft? *Eur J Cardiothorac Surg* 2006;30:815–6.
- [2] Panos A, Murith N, Bednarkiewicz M, Khatchatourov G. Axillary cerebral perfusion for arch surgery in acute type A dissection under moderate hypothermia. *Eur J Cardiothorac Surg* 2006;29:1036–9.
- [3] Küçüker S, Ozatik M, Saritas A, Tasdemir O. Arch repair with unilateral antegrade cerebral perfusion. *Eur J Cardiothorac Surg* 2005;27:638–43.

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Letter to the Editor

Ventricular myocardial band concept and ventricular resynchronization device therapy: crossing the roads?

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