Retrograde crystalloid or blood cardioplegia?

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Received 1 December 2011; accepted 30 December 2011

Keywords: Cardioplegic solutions/administration and dosage • Cardiopulmonary bypass/methods • Heart arrest • Induced/methods

We congratulate the authors for their good study [1]. However, the following aspects were noted: the absence of the left ventricle ejection fraction, wall thickness, aortic pressure gradient and evaluation of peroperative MI using CKMB values instead of troponin I; underestimating TNF-α values, blood cardioplegia groups were higher in coronary bypass patients, in crystalloid cardioplegia group the number of patients who were distally anastomosed were statistically higher; and the absence of the size of aortic valves in AVR patients. All of these situations made us believe that this study is incapable of explaining this result.

REFERENCE


LETTER TO THE EDITOR RESPONSE

Reply to Bozok et al.

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Received 24 December 2011; accepted 4 January 2012

Keywords: Cardioplegia • Aortic valve • Cardiopulmonary bypass

We thank Bozok and colleagues for their interest in our article [1, 2]. We would like to remind the readership that our report was a prospective randomized study of 345 consecutive AVR operations, comparing cold crystalloid cardioplegia with cold blood cardioplegia. The demographic data were similar in both groups, including the distribution of valve sizes. The main endpoint was hospital death and the secondary endpoints were low-output syndrome, myocardial infarction, arrhythmias, duration of ventilatory support, stroke or minor neurological dysfunction, renal function, infections, blood transfusions and physical rehabilitation. No statistically significant differences were seen between the groups, also when comparing the patients with the longest ischaemic times. We do not think that more sophisticated tests of preoperative or postoperative myocardial dysfunction would have changed our conclusions. The absence of any differences in clinical variables or complications clearly indicated that none of the two cardioplegia techniques could be regarded as superior.

In our material, there was a slight difference in the frequency of CABG as for the number of distal anastomoses (3.0