Bilateral internal mammary arteries: a new trick for coronary artery bypass grafting

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I read with interest the article in the April 2012 edition by Grau et al. I congratulate Grau et al. [1] for an excellent study. It will be interesting to know how both internal mammary arteries were used—either in situ or as y graft. In spite of the established superiority of left internal mammary artery graft, the use of the bilateral internal mammary artery has not gained popularity.

In recent trials, stroke after coronary artery bypass grafting (CABG) was reported as one of the major complications that reduces the superiority of CABG over percutaneous coronary intervention. It is also evident that avoiding cardiopulmonary bypass is probably not enough to prevent stroke as aortic clamping can lead to stroke after off-pump CABG (OPCAB). OPCAB with aortic-no-touch can reduce the incidence of stroke to the lowest [2].

CABG with aortic-no-touch has become synonymous with left internal mammary artery-right internal mammary artery or left internal mammary artery—radial artery y graft with single inflow. The use of both internal mammary arteries has become synonymous with y graft which has only single left internal mammary artery inflow.

We presented an alternative technique of using both internal mammary arteries during OPCAB [3], in which one internal mammary artery is used to graft the left anterior descending artery and the other internal mammary artery is used for composite graft. We suggest that this technique of using both internal mammary artery in situ can be easily adopted by younger surgeons in newer centres. There is no fear of damaging one in situ internal mammary artery while creating a composite graft.

I congratulate Dr Taggart for a timely editorial comment highlighting the importance of using both internal mammary arteries in the era of percutaneous coronary intervention.

REFERENCES

Reply to Saha

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