The author reported no conflicts of interest.

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benefit provided by bilateral internal mammary artery (BIMA) use. Whatever the reason, we know that BIMA use is not widespread, and in 2014 was estimated to be 4.3% in North America.[1]

Marzouk and colleagues[2] compared BIMA coronary artery surgery outcomes when the RIMA was used as a free graft rather than as an in situ graft. In their commentary, Schwann and Gaudino[3] implied that a more relevant question than *how* to use BIMA (ie, configuration) is *whether* to use BIMA. It is true that most cardiac surgeons are unwilling to use all-arterial or maximal-arterial grafting strategies in their coronary practices,[1] and whether to use BIMA will remain a contentious issue. Who knows what's going on in that "right bar factory"! But how we use BIMA is indeed the question, as Kalavrouziotis and Mohammadi[4] replied in their letter to the editor. With some criticism that we do not know the reason why free RIMA recipients fared worse than in situ RIMA recipients, Marzouk and colleagues[2] showed that, whatever the reason, they fared differently. Thus, "how to BIMA" can be said to matter.

Coronary artery surgery is a subspecialty in itself, and it is doubtful that any subspecialty coronary surgeon would consider not performing a second arterial graft to the lateral wall as the starting point for their revascularization strategy. In combination with the radial artery, BIMA is an integral part of this strategy. When only 2 arteries are used for the revascularization, a radial artery strategy may be associated with fewer complications[5] and greater ease of access. Deference to a radial artery over a RIMA may partly account for the lower use of BIMA strategies. Arterial graft configuration (eg, in situ composite arterial grafts, T grafts, aortoarterial grafts, sequential grafts) may also impact outcome. Becoming facile with extending in situ BIMA-based conduits to reach coronary targets opens the possibilities for maximal arterial grafting. It will be these outcomes, stratified by how arterial grafting is done, that will determine whether it should be done.

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REPLY FROM AUTHORS: A QUESTION VERSUS THE QUESTION

Reply to the Editor:

We read with interest the Letter to the Editor by Kalavrouziotis and Mahommadi[1] regarding our recent invited commentary[2] on their study comparing distinct bilateral internal mammary artery (BIMA) grafting strategies.[3] One goal of an invited commentary is to contextualize a manuscript within the overall fund of knowledge available at a given time. Another goal of an invited commentary is to objectively point out the possible impact of a given manuscript on future surgical innovation and consequent improvement of patient-centric outcomes. This was the exclusive aim of our thoughts expressed in the invited commentary on the excellent study of Marzouk and colleagues. We commend the authors' contribution to the field of multi-arterial grafting, share their belief in the value of multi-arterial grafting, and continue articulating its benefits for our patients. Indeed, we never state anything to the contrary.

Our comments are intended to crystallize to the journal readership the possible formidable obstacles to a broader adaptation BIMA grafting into the clinical practice, which we believe we presented objectively. The "inconvenient truth" is that despite multiple observational studies uniformly documenting the benefits of BIMA grafting, the technique continues to be used rarely, particularly in the United States, except at selected centers with expertise in and dedication to this technique. In those institutions, the reported results are enviable. We certainly agree with the authors that the specific deployment of a BIMA grafting strategy warrants further careful analysis. That certainly is "*a* question" worth asking, and we congratulate the authors for presenting their perspective and excellent results. But

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before we can tackle issue of "how to BIMA," there must be a wider acceptance of BIMA use among the contemporary cardiothoracic surgeons to be able to clearly define the value of BIMA grafting for our patients, regardless of the specific surgical technique. Thus, the decision of whether or not use the BIMA strategy based on the voluminous supportive observational data in the absence of randomized data and recognizing the possible increased risk of deep sternal wound complications will, for the foreseeable future, remain as "*the* question" for the cardiothoracic surgeon of today.

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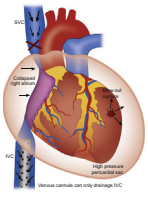

IS PREOPERATIVE

EXTRACORPOREAL MEMBRANE OXYGENATION EFFECTIVE FOR COLLAPSED PATIENTS WITH LEFT

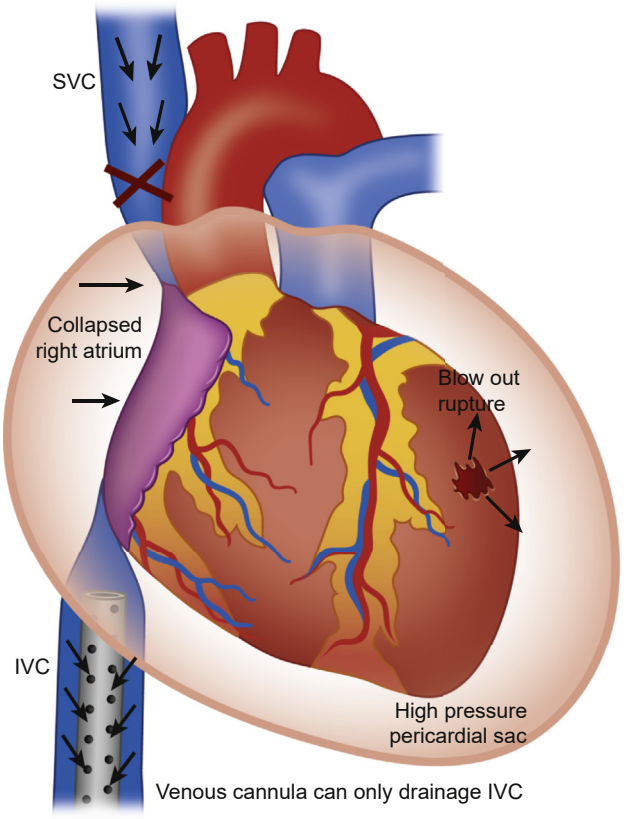

FIGURE 1. Extracorporeal membrane oxygenation might be invalid for brain resuscitation in collapsed patients with blow-out ruptures. *SVC*, Superior vena cava; *IVC*, inferior vena cava.

VENTRICULAR FREE WALL RUPTURE AFTER MYOCARDIAL INFARCTION?

To the Editor:

Left ventricular free wall rupture (LVFWR) is a rare but serious complication of acute myocardial infarction. Okamura and colleagues[1] reported good results using a suture-less repair technique and later discussed some points with Formica and colleagues.[2] These discussions were constructive and interesting, but 2 doubts arose in my mind.

The first point is about preoperative extracorporeal membrane oxygenation (ECMO) support. In the letters to the editor, Formica and colleagues[2] advocated greater use of ECMO (34.3%) than Okamura and colleagues[1] (11.4%) and emphasized the importance of preoperative ECMO for patients with cardiac tamponade or cardiac arrest. Okamura and colleagues[3] agreed and explained the reason for their lower ECMO usage rate as a lower incidence of blow-out ruptures in their cohort. Many textbooks recommend that ECMO should be established as soon as possible in patients with blow-out rupture.[4] However, Formica and colleagues[5] said in their original paper in 2017, "Six of the 8 non-survivors