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“HOW TO BIMA?” IS IN FACT THE QUESTION

To the Editor:

We read with interest the Commentary by Schwann and colleagues¹ written in response to our original manuscript.² We do not agree with the authors, who place the emphasis entirely on bilateral internal mammary

artery (BIMA) use, and state that the configuration of BIMA grafts has no relevance. Although we are firm believers in the benefits of BIMA grafting, the optimal configuration of BIMA grafts still remains a matter of controversy. It was not our goal to compare BIMA versus single internal mammary artery grafting (SIMA), and 100% of patients in both comparator groups were BIMA recipients. Therefore, it is perfectly normal that our study will not “move the BIMA utilization needle” and “offers no compelling reasons to consider the BIMA strategy preferentially over the current left internal mammary artery/saphenous vein graft approach.” In our opinion, the optimal BIMA configuration is a key unknown that may explain why no group has been able to prospectively show the superiority of BIMA versus SIMA, with some authors showing a greater adjusted mortality with BIMA compared with SIMA.³

Our mediastinitis rate of 2.4% was incriminated by the authors as unusually high, but this is very similar to recent trial data⁴ and many previous retrospective studies. The risk of sternal complications post-BIMA depends on the patient’s risk profile, patient selection, and how far the surgeon wants to go to perform BIMA grafting. Mediastinitis was as high as 5.5% in the CATHolic University EXtensive BIMA Grafting Study registry,⁵ or 3.5% in the Arterial Revascularization Trial (ART),⁴ and is not simply a result of



“surgeon experience and skeletonization” as Schwann and colleagues proclaim.

In summary, “How to BIMA?” is in fact the question, and a key question at that, to optimize outcomes post-coronary artery bypass grafting. To claim that conduit configuration is of no prognostic importance is to deny the incredibly nuanced complexity of contemporary coronary surgery, which depends on many different factors, including degree of coronary stenosis, the size and quality of target vessels, and distal run-off, and not only on the type of conduits used.

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REPLY: BILATERAL



INTERNAL MAMMARY ARTERY GRAFTING: SO MANY QUESTIONS. SO FEW ANSWERS

Reply to the Editor:

Marzouk and colleagues¹ recently reported that patients who underwent bilateral internal mammary artery (BIMA) grafting with both utilized as in situ grafts had better long-term survival than those in whom the second IMA was used as a free graft. In a related commentary, Schwann

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