We read with interest the paper entitled “Respiratory dysfunction after coronary artery bypass grafting employing bilateral internal mammary arteries: the influence of intact pleura” by Bonacchi and colleagues, published in Ref. [1]. We would like to thank the authors for addressing, as in previously published papers [2,3], such interesting issues related to internal thoracic artery (ITA) harvesting and utilization. We also congratulate them for the clear exposure of the data recorded but, nevertheless, we would like to add some short comments. (1) As the authors clearly stated, they could not show any statistically significant advantage of the skeletonized technique itself except the favourable utilization for composite graft [2]. Extra-pleural harvesting of ITA, which seems to make the real difference, can be performed, nevertheless, either using the skeletonized technique or using a pedicled technique [4,5]. Unfortunately, as the authors themselves stated, the group of patients in which a skeletonized-open pleura technique was used was not large enough to achieve a statistical analysis, and a pedicled-closed pleura technique was not used in any patient. A complete analysis should be performed, therefore, using two groups of patients (skeletonized and pedicled technique), each one with two subgroups (open and closed pleura techniques). (2) The statistically significant differences in terms of postoperative pain are not surprising, reflecting the discomfort caused by the pleural drainage, whereas the differences in terms of mechanical ventilation time need further clarification. In our opinion, in fact, the mechanical ventilation time itself has to be utilized with caution, due to the influence of a variety of concomitant factors (i.e. different policies in anaesthesia management, time of arrival in ICU, patients co-operation) which are difficult to standardize within the entire division. The incidence of prolonged ventilation is, therefore, in our opinion, more adequate to compare postoperative respiratory dysfunction. Furthermore, we would like to briefly summarize our experience in this respect: we are collecting data in patients undergoing scheduled coronary artery bypass grafting with three different techniques: pedicled ITA with open pleura (group A), pedicled ITA with closed pleura (group B), pedicled ITA with both pleurae opened (group C). From our preliminary results (30, 14 and 24 patients, respectively), we can confirm the difference previously reported [1,4,5] in terms of postoperative bleeding and postoperative discomfort (both reduced in patients of group B), but we have not found any difference in terms of the incidence of prolonged mechanical ventilation (6.6, 7.1 and 4.1% for groups A, B and C, respectively). Furthermore, we found that the routinely double pleural opening and draining was correlated, even if without statistical significance, with a reduced postoperative incidence of pneumothorax and pleural effusion requiring thoracentesis (10, 14 and 4% for groups A, B and C, respectively). In conclusion, we agree with Bonacchi and colleagues regarding the advantages of the preserved integrity of the pleura, regardless of the harvesting technique, in terms of postoperative bleeding and discomfort, but we think that the advantages in terms of preserved respiratory function have to be confirmed by further randomized studies.

References


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