


The author replies:

To the Editor:

Dr. Dianzumba is quite correct in pointing out that we did not mention that the hypertensive groups were given antihypertensive medication during the prolonged followup stage. Indeed, they were treated vigorously when possible, but compliance and infrequent clinic visits in some instances make this data unsuitable for analysis. In several cases, we felt lucky in being able to see the patients once per year. Digitalis and diuretics were used alone during the hospital phase. We had no intention of following these patients to determine the effects of long-standing hypertension.

The interesting facet is not the evolution of hypertension so skillfully summarized by Dr. Dianzumba, but rather that this self-induced heart failure occurs in normotensives as well as hypertensives.

Again, we apologize for our ambiguity.

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References


The authors reply:

To the Editor:

Dr. Bonchek raises three major issues with regard to our study on myocardial infarction in autopsied patients after coronary artery bypass surgery. 1

1. His concern that the findings make myocardial infarction an obligatory consequence of this procedure in a relatively high percentage of cases represents a misinterpretation of the study. By its very nature an autopsy study does not provide incidence data; unless all patients die and are autopsied, it is inappropriate to extrapolate these “percentages” to the living, surviving, population. As a study of pathophysiology and not epidemiology, its aim was to focus on the nature and possible mechanisms of myocardial injury after coronary surgery. Although we know from animal studies that under certain conditions of transient ischemia myocardial injury may be worsened by reflow, 2 our study suggests that a similar injury, under certain circumstances, may occur in the human as well.

2. With regard to Dr. Bonchek’s second concern about intraoperative methods, I would suggest that he read the article again, noting specifically: table 4; the last paragraph of the results section (p. 910); and the second paragraph of the discussion (p. 911). Techniques of myocardial protection were not significantly different between the autopsied group that developed necrosis and those that did not. In the first four years of bypass surgery at this institution, normothermic anoxic arrest was used; subsequently, hypothermic arrest. In the past year we have used cold potassium cardioplegia, but none of the patients in this study had this kind of arrest. Since the autopsy numbers are small, and the patient population heterogeneous (as we are operating on more and sicker patients today than five or ten years ago), that some infarcts seen at autopsy have developed despite hypothermic protection does not mean that the latter is not superior to normothermic arrest. The entire operative experience is necessary to answer this type of question, and not the handful of patients that come to autopsy for a variety of reasons.

3. Dr. Bonchek is correct that this study included patients that died some time ago and in fact the patients span close to ten years,
MI after CABG.
L I Bonchek

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