The authors reported no conflicts of interest.

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LEFT INTERNAL THORACIC ARTERY AND SAPHENOUS VEIN COMPOSITE GRAFTS: THE VALUE OF VALVELESS VEINS

To the Editor:

We read with great interest the study published by Hwang and colleagues,¹ which demonstrated equivalence between the clinical results obtained in coronary artery bypass graft (CABG) surgery with composite arteriovenous grafts when compared with using exclusively arterial composite grafts. Our team has considerable interest in this topic, as we are part of a pioneering and enthusiastic group that regularly performs CABG without cardiopulmonary bypass and avoiding manipulation of the ascending aorta, with studies since the 1990s indicating good results with this technique. In addition, in 2002, in a publication with patients older than 75 years old, we illustrated the reproducibility of the Y-composite left internal thoracic artery (LITA) and saphenous vein graft technique for revascularization of the left coronary system.²

For more than 30 years, in addition to the benefits of not using cardiopulmonary bypass and of avoiding manipulation of the ascending aorta, we also noted that the development of graft venous disease could be minimized with the anastomosis of the saphenous vein to the LITA. This may be associated with factors such as lower pressure stress to which the venous graft would be submitted, benefits of vasoprotective substances from the LITA, and the possibility of using shorter venous segments without valves, as discussed by the authors.^{1,3} We routinely use

valveless venous segments selected at the time of venous graft preparation, as we also have serious concerns about the proatherogenic role of the valve and the possibility of blood stasis, an expected event in flow-competitive circumstances.²

As illustrated in the limitations of the study by Hwang and colleagues, we consider that the use of a valvulotome is positive from the point of view of avoiding the possible occurrence of stasis; however, it leaves remnant tissue with possible histologic damage, which may come to mean grounds for thrombotic events in the short term or development of atherosclerosis in the medium and long term.^{4,5}

Therefore, it seems to us to be more appropriate to avoid the use of the valvulotome and proceed with the selection of valved great saphenous vein segments to obtain even more relevant clinical results with the use of composite arteriovenous grafts. Finally, we congratulate the group for the dedicated study of this topic that is usually little highlighted in the context of the current CABG, and for the excellent results shown.

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<https://doi.org/10.1016/j.xjon.2021.08.026>

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