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REPLY: IMPLICATIONS OF INNOVATIONS ON CLINICAL OUTCOMES

Reply to the Editor:



This letter's authors,¹ and the original source article's authors, reflect opinions in their practice that emphasize that much of what we do is based on personal opinion. We have taken our best shots at trying to parse out physiology to do what surgeons do best—innovate. This process is a practical implementation of ideas that results in the introduction of new goods or services. When one considers the question presented in this strategy of coronary revascularization, we can demonstrate multiple steps at which our true quality as innovators shines through.

The first is the question of the application of the valvulotome, a tool introduced in another surgical specialty for peripheral vascular intervention.² The benefit of this approach is the ability to use the vein in an orientation that preserves its normal tapering course in terms of diameter of inflow and outflow. In contrast, this may result in trauma that could jeopardize long-term outcomes, and are the acceptable outcomes of in situ bypass in the leg due to preserved adventitial blood supply by not removing the vein?³ Having done a

lot of basic research looking at endothelial injury, would I feel comfortable doing this? Likely not.

The next is the question of anastomosing the vein, prone to atherosclerosis, to the smaller internal thoracic artery. Is this folly? The theoretical benefit of local antiatherogenic materials is appealing, but is there proof? Do we need more information to properly avoid the potential complication of jeopardizing the superb results of an isolated left internal thoracic artery–left anterior descending coronary artery anastomosis?

To this reviewer, these papers have supported that this strategy is feasible and in “a pinch” I feel ever so slightly better to apply them if my standard tried-and-true strategy is not available. But, to move forward, we need to encourage surgeons to break down innovations step by step and test each stride along the innovation pathway before encouraging universal acceptance. These communications are what they are—you can do it. Should you do it routinely? That is for another day.

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