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Impact of Aortic Cross-Clamp in Coronary Bypass Surgery



REPLY TO THE EDITOR: We want to thank Dr Narayan¹ for his insightful comments on our article.² We apologize for not sufficiently enough explaining the design of this specific aspect of our analysis.

In this specific analysis, we focused on the effect of cross-clamping on the occurrence of postoperative neurologic complications in a high-risk cohort. Therefore, we included not only patients without aortic manipulation but also patients undergoing side clamping or on-pump beating heart patients in the no aortic cross-clamp group. To address this heterogeneity of the group, we performed another subanalysis of coronary artery bypass grafting (CABG) without any aortic manipulation (no-touch technique) compared with the other techniques (Table 4).

We agree that patients undergoing CABG using the beating-heart technique are exposed to increased stroke risk.³ Nevertheless, despite including these patients in the no aortic cross-clamp group, cross-clamping was still associated with an increased neurologic event rate in our propensity score-matched analysis. In our view, this even underlines the strong effect cross-clamping exerts on the stroke risk in patients undergoing CABG.

The strength of large multicenter studies like the European Multicenter Study on Coronary Artery Bypass Grafting (E-CABG) registry is the ability to reflect daily practice with all its clinical variety. Therefore, we consciously decided to even include this small subcohort of beating-heart patients into the analysis.

We hope this will clarify the issue and take the opportunity to thank you once again for your particular interest in our work.

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Immunosuppression in HIV-Positive Heart Transplant Recipients During the Post-COVID-19 Era



TO THE EDITOR: With great interest, we read the article published by Doberne and colleagues¹ regarding heart transplantation outcomes in HIV-positive (HIV+) and HIV-negative (HIV-) recipients. We commend the authors for their important work reporting no differences in survival among these 2 patient populations. Propensity score matching and Cox proportional hazards modeling both supported the conclusion that HIV+ recipient status was not an independent predictor of posttransplant mortality. Additionally, HIV+ recipients experienced higher rates of acute rejection and treatment with anti-rejection medications before discharge.

Although 5-year posttransplant outcomes suggest similar rates of survival among HIV+ and HIV- recipients, the elevated risk of acute rejection in the former should be highlighted. Regarding this patient population, treatment with more potent immunosuppressants like high-dose corticosteroids has shown efficacy in treating acute organ rejection.² This raises a critical issue that should be emphasized as an additional contraindication to transplanting HIV+ recipients, especially while there remains a risk for coronavirus disease 2019 (COVID-19). Recent studies have demonstrated diminished levels of spike-specific antibodies in immunosuppressed individuals who received the COVID-19 vaccine.³ This is concerning for 2 reasons: 1) protection from COVID-19 is positively correlated with neutralizing antibody titers⁴ and 2) mass vaccination has prompted full reopening and lifting of mask mandates despite underwhelming vaccination rates in several regions across the United States. Immunosuppressed individuals are subsequently placed at greater risk for morbidity and mortality with exposure to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). It should be noted that a comprehensive pretransplant evaluation ensures up-to-date vaccination status before initiating

immunosuppressive therapy. Nevertheless, given the emergence of several variants of concern capable of escaping polyclonal antibody responses,⁵ enhanced COVID-19 disease continues to be a threat to the immunosuppressed. Whether COVID-19-associated mortality risk influences long-term survival in HIV+ transplant recipients remains to be determined. However, we urge the transplant community to consider these factors when evaluating management strategies for their patients before transplantation.

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Cultural Insensitivity Despite the Best Intentions



TO THE EDITOR: I want to express my gratitude to the Editor, to the Society, and to the authors for acknowledging, post hoc, that the “offensive figure” displayed on the cover of the June 2021 issue highlighting a paper on cardiothoracic surgery trainee burnout¹ was racially charged. Apologizing to the membership and removing the image from the Web site were good first steps. Although unintentional, this incident is emblematic of a cultural insensitivity that is more pervasive than we would like to admit.

As an African American cardiothoracic surgeon who is well beyond residency, I am no stranger to overt, covert, and tacit indignities that are racially insensitive. These so-called microaggressions, which African Americans experience in our society at large and in the academic community, have a toll that cannot be fully measured or minimized.² *The Annals of Thoracic Surgery* June 2021 cover represents an unfortunate example that belies

the advances in diversity and inclusion made by The Society of Thoracic Surgeons and the American Association for Thoracic Surgery.

The Society of Thoracic Surgeons has been led by its first African American president, has formed a Workforce for Diversity and Inclusion, and has honored the contributions of Vivien Thomas with a named lecture. Despite these salutary efforts, this incident demonstrates that one lecture, one presidential term, and a workforce report alone cannot bring forth the cultural sensitivity that the Society asserts to seek. Without a constant and unmistakable embrace of diversity, inclusion, and equity by leaders of the major thoracic surgery societies, journal editors, thoracic residency directors, and ultimately the American Board of Thoracic Surgery, there cannot be substantive change.

I urge these above-mentioned leaders to: (1) continue to educate surgeons about the consequences of implicit bias on colleagues, trainees, and patients and (2) commit to increase their mentorship and sponsorship of minority faculty and cardiothoracic surgery trainees.³ These actions may represent an additional strategy to mitigate trainee and faculty burnout.

The effort I am calling for will require the same attention to detail and constant desire to improve that we seek to instill in our trainees and strive for in our daily practice.

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Regarding an Offensive Figure in the Article Entitled “National Survey of Burnout and Distress Among Cardiothoracic Surgery Trainees”



TO THE EDITOR: We authors of *The Annals of Thoracic Surgery* article entitled “National Survey of Burnout and