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Internal mammary artery as a graft in obese patients

To the Editor,

We greatly appreciate the authors for this really large patient pool study published in The Anatolian Journal of Cardiology (1). Reported results of this study related to obese patients confirm the existing clinical practice in our settings and the literature. Sternal dehiscence and sternal infections are commonly encountered complications in obese patients although underlying factors can differ (2, 3). One of the underlying factors is harvested internal mammary artery (IMA) (unilateral or bilateral) as coronary grafts (2-4). For this very reason, use of IMA in obese patients can be challenging and often conservatively denied. We were wondering if there was any significant difference between obese patient groups with IMA as a graft and without IMA in terms of wound infection or sternal dehiscence. There was also considerable difference in terms of bleeding between two groups as the authors stated. IMA can also be a reason for re-explorations due to bleeding postoperatively though it is undeniable for its excellent long-term patency rates (5). We find it really important to gather more information for further considerations on the issue. We would kindly ask the authors to share their valuable knowledge related the above-mentioned topics.

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Author`s Reply

To the Editor,

We would like to thank the authors for their contribution to our study of published in The Anatolian Journal of Cardiology (1). They have emphasized on occurrence of sternal wound infections and dehiscence, and the use of bilateral internal mammarian artery (IMA) grafts. This debate on whether use of bilateral IMA causes increased risk of sternal wound infections and/or dehiscence is still ongoing, in diabetic patients, in obese and non-obese patients. But briefly, in 2010, Arterial Revascularization Trial by Taggart et al. (2), it has been documented clearly that use of bilateral IMA (n:1548) caused a slight increase in requirement for sternal wound reconstruction compared to use of single IMA (n:1554). In our study, use of single IMA, actually left-sided, was 96.7% (n:530/548) in non-obese group whereas 97.1% (n:235/242) in obese group ($p>0.05$). Despite the low number of patients whom IMA was not used for various reasons (n:25), the disuse did not affect the requirement for revision or occurrence of sternal wound infections or dehiscence ($p>0.05$ for both).

In our study, we have not used any bilateral IMAs, therefore it is not possible to make assumptions on this subject.

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