

management of giant aneurysms in their centre concluding that the surgical operation should be adapted to each patient and to the specific cardiac anomaly [4]. Nomura and Ohno reported on the *in situ* repair of a left circumflex coronary artery utilizing an interposing saphenous vein graft [5]. All reported reconstruction techniques have the major disadvantage of using materials susceptible to subsequent stenosis.

The management and surgical treatment of a rare atherosclerotic left circumflex artery is the theme of our paper. The aneurysmectomy followed by a direct end-to-end anastomosis avoiding foreign materials was the technique used in this report, never described before in the literature. This option is not always available for anatomical reasons; in particular, it can be performed only in small-sized aneurysms.

The CT scan performed 30 days after the surgery and the clinical outcome of the patient at 6 months were satisfactory. The long-term success remains unclear as there might be an accelerated development of arteriosclerosis in the vessel. Nevertheless, longer follow-up is required to confirm the safety of this procedure.

Conflict of interest: none declared.

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eComment. Evidence, experience or novelty for achieving the best outcome in surgery?

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I read with great interest the article by Cuttone and colleagues [1]. They reported a unique surgical treatment strategy for the management of circumflex coronary artery aneurysm (CAA) in an adult presenting with myocardial ischaemia. Coronary artery disease (CAD) is an important etiology for CAA formation in adults; however, connective tissue disorders and Kawasaki disease may lead to multiple giant CAAs in children [2]. Although rarely encountered, the cases with CAA present with technical challenges when interventional or surgical treatment modalities are concerned. Boyer and colleagues reviewed the literature and ACC/AHA acute coronary syndrome guidelines recently and the following indications were stated as the indications for surgical revascularization in CAA: (i) CAA involving the left main coronary artery, (ii) multivessel CAD, (iii) giant CAA (the diameter of CAA exceeding the reference vessel diameter by 4 times), (iv) CAA involving bifurcation of significant side-branch vessel and (v) other separate indications for cardiothoracic surgery unrelated to CAA [3]. The surgical indication for this case is questionable in my opinion, unless the stenotic lesion at the right coronary artery deemed a surgical revascularization necessary. When the diameter and the location of the CAA is considered, this case seems to be manageable by percutaneous intervention with regard to the above-mentioned criteria. Boyer *et al.* also mention that surgical revascularization is considered reasonable in cases where the PTFE-coated, bare metal or drug eluting stents cannot be delivered across the lesion [3]. In this case, the CAA was demonstrated to be thrombus free, which would provide safer circumstances for a covered, bare or drug eluting stent delivery.

The second issue to be discussed in the treatment strategy reported by Cuttone and colleagues is the choice of end-to-end anastomosis of the circumflex coronary artery. Although they decided that the suture lines at the native coronary artery walls were healthy at both ends of the artery, it is a well known fact that the traction forces with an end-to-end anastomosis may lead to restenosis of the artery as well as failure in the blood flow through the lumen in long-term follow-up. In case with such a failure and restenosis, the possible percutaneous intervention would also be dangerous due to the weakened arterial walls. The authors commented on their technique to be free of foreign materials but qualifying the saphenous vein graft as a foreign material in surgical revascularization of the coronary arteries is far from being evidence-based in such a case where a 1- to 2-cm long graft could safely be interposed after the resection of CAA.

Conflict of interest: none declared.

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