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Surgery for Coronary Occlusion

SIR,—It is understandable that those who lived through the initial enthusiasm and subsequent disappointment of coronary surgery (omenteopexy, pericardial pouderage, coronary endarterectomy, mammary artery ligation or implantation, etc.) should retain a detached view about the new technique of coronary bypass surgery. In view of the great number of operations already performed, your leading article on surgery for coronary occlusion (25 August, p. 420), though well balanced, needs further comment.

The mortality figures of 3-6% were the figures of initial enthusiasm without adequate follow-up in the hands of experienced cardiac surgeons who pioneered this operation. Because of this low mortality it has spread to less experienced centres with quite different results. In a community hospital where coronary bypass surgery is being practised by "cardiac surgeons of at least seven years' experience in open heart surgery"¹ the hospital mortality in 55 consecutive cases was 20%. Excluding death, the following life-threatening complications were seen in the 44 survivors: pulmonary emboli (20%), myocardial infarction (18%), brain damage (18%), postoperative haemorrhage (14%), and cardiac arrest (10%). Only 20 out of the 44 survivors had no complications. Early postoperative graft patency was 72%. In this series, therefore, the patient subjected to coronary bypass surgery had a 2-in-3 chance of either dying, having no patent graft, or having life-threatening postoperative complications.

This disappointing report was published at the same time as one from a leading cardiac centre.² Here again the mortality figures were far in excess of the 3-6% mentioned in your leader. Out of 60 consecutive patients who underwent coronary bypass surgery, 10 died during the month following

surgery (17%); of the 46 survivors followed up (four were lost for restudy) in 33% the graft became occluded, which restricted surgical success to about 50%. Admittedly, the survivors with a patent graft showed an improvement 3-22 months after surgery in most haemodynamic parameters, in addition to considerable subjective and objective improvements in angina, confirmed by electrocardiogram and treadmill test.

As outlined in your article the indication for coronary bypass surgery is severe, relentless angina with great restriction of effort tolerance; thus its title should have been "Surgery of Severe Angina" and not "Surgery for Coronary Occlusion." In fact, coronary occlusion with impairment of ventricular function where revascularization would be mostly needed is a contraindication to the operation. The best results of coronary bypass surgery are in those in whom medical management claims a reasonable five-year survival rate. This applies even more to preventive surgery in coronary insufficiency, where particularly the antero-septal electrocardiographic pattern has a good prognosis, so much so that it has been given in the past the epithet of "slight coronary attack."³

Before the new drug is as unreservedly accepted as coronary bypass surgery has been, double-blind trials have to prove its value. This is evidently not feasible for bypass surgery; however, at least retrospective studies should prove the superiority of surgery over medical management. The latest progress study of 590 consecutive non-surgically treated cases of coronary disease followed up 5-9 years after coronary angiography is the most complete one so far.⁴ Here the mortality rate for patients with single coronary artery occlusion was 14.6%, with double occlusion 37.8%, and with triple occlusion 53.8%, with a five-year

mortality in the whole group of 34.4%. Myocardial factors, diabetes, and electrocardiographic conduction disturbances had an adverse influence.

In spite of intensive care units there has not been much progress in the medical treatment of coronary occlusion. Anticoagulants proved disappointing and cardiogenic shock has an 80-90% mortality. It is only to be expected that surgery should try its hand in the treatment of these severe cases, in which a surgical mortality of 10-20% would be acceptable. The remarkable surgical success in selected cases of severe angina deals only with a fraction of the coronary problem. At present medical management, in spite of all its shortcomings, remains the treatment of choice for severe coronary occlusion.—I am, etc.,

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¹ Karnegis, J. N., *American Heart Journal*, 1973, 86, 51.

² Lapin, E. S., Murray, J. H., Bruce, R. A., and Winterscheid, L., *Circulation*, 1973, 47, 1164.

³ Papp, C., and Smith, K. S., *British Heart Journal*, 1951, 13, 17.

⁴ Bruschke, A. V. G., Proudfit, W. L., and Sones, Jr., F. M., *Circulation*, 1973, 47, 1147 and 1154.

Psychiatric Aspects of Female Sterilization

SIR,—Professor J. Walker's comments (1 September, p. 497) are appropriate and should help further to dispel the notion that there is anything like widespread psychiatric disturbance following tubal ligation. Indeed, there is in most instances a good deal of improvement in mental outlook, and any serious attempt to deprecate the application of sterilization in the immediate postpartum or postabortion states should be firmly resisted. There are at least two other aspects warranting firm resistance. There appears to be fairly widespread belief among the laity that tubal ligation, when