

Corrigendum: Multi-arterial Coronary Grafting

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The authors regret that in the article “Multi-arterial Coronary Grafting” by Rami Akhrass and Faisal G. Bakaeen in the Summer 2022 issue (27(2):126-146, 2022; <https://doi.org/10.1053/j.optechstcvs.2021.09.001>), Figures 2 and 10 included an error with the course of the right internal thoracic artery (RITA). The corrected figures are included on the next 2 pages. Figure 2 was used as the cover image for the issue. In both Figures 2 and 10, the RITA should be anterior to the superior vena cava and posterior to the pulmonary artery.

Figure 2 In-situ BITA: 2 arterial inflows/transverse sinus: The mainstay of a typical CABG operation includes a LITA-LAD, which the rest of the conduits are planned and built around. Grafting the LITA-LAD first secures the best conduit to the best target, but this might need to be delayed to prevent undue tension on the anastomosis that may occur while exposing a high OM branch. The in-situ RITA is passed

through the transverse sinus and used for a high OM. Disadvantages include possible twisting and/or bleeding through the transverse sinus that is difficult to visualize, as well as the inability to reach distal circumflex targets. BITA = bilateral internal thoracic artery; CABG = coronary artery bypass grafting; LITA = left internal thoracic artery; LAD = left anterior descending; OM = obtuse marginal; RA = radial artery; RCA = right coronary artery; RITA = right internal thoracic artery.

Figure 10 Composite in-situ RITA/RA: The in-situ LITA-LAD is maintained. The in-situ RITA is extended with RA (end-to-end composite RITA/RA) and used for several targets after passing through the transverse sinus. Two arterial inflows are provided. LITA = left internal thoracic artery; LAD = left anterior descending; OM = obtuse marginal; RA = radial artery; RCA = right coronary artery; RITA = right internal thoracic artery.