ventricular performance, and spinal cord and renal ischemia; and the data of pressure at aortic clamping are compatible with the clinical data of Kouchoukos and coworkers. The apico-aortic shunt, like the aorto-aortic shunt, decompressed proximal aorta and reduced preload pressure of the left ventricle to 122%, afterload pressure to nearly baseline, and elevated distal perfusion pressure to 82 mm Hg (61% of baseline). Flow of the descending thoracic aorta was restored to about 54% of the baseline flow by the apico-aortic shunt. Thirty minutes support of the apico-aortic shunt kept hemodynamics of all experimental animals stable and did not cause any metabolic acidosis.

For safe shunt institution in severely diseased or injured aortic wall, judicious choice for the site of cannulation is important. Perhaps, the apico-aortic shunt can become an alternative support technique for surgery on the descending thoracic aorta when the proximal cannulation in the ascending or proximal descending thoracic aorta is difficult.

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Errata

In the paper entitled, “Donor-Specific Tolerance Induction in Composite Tissue Allografts (Am J Surg. 1998;176:418–421), the surname of the third author was spelled incorrectly. The author’s correct byline should read “M. Neipp.”

In the paper entitled, “Management of Casualties from the Bombing at the Centennial Olympics” (Am J Surg. 1998;176:538–543), a typographical error appeared in the last sentence of the “Results” section (p. 539). It should read: “The remaining patients with minor injuries from shrapnel were evaluated in seven other hospitals in the Atlanta area,” not Atlantic area.