Letters to the Editor

Should we always perform radio-frequency ablation while resecting atrial myxomas?

Mert Kestelli, Ismail Yurekli*, Orhan Gokalp, Ali Gurbuz
Izmir Ataturk Education and Research Hospital, Basin Sitesi, 35360, Izmir, Turkey

Received 14 November 2009; accepted 2 December 2009; Available online 8 January 2010

Keywords: Myxoma; Catheter ablation; Fistula

We thank the authors for this article [1]. We noticed that two of our cases developed arterioatrial fistulae after resection of the myxoma while we were investigating our cases [2,3]. Your excellent image demonstrated that this myxoma tissue possessed three arterial branches. Demonstration of these nutrient arteries suggested that, in any case, even though the nutrient arteries of the myxoma could not be visualised, the remaining tissue of the resected area should be damaged by radio-frequency ablation (or by other methods). This procedure should be performed to avoid atrio-arterial fistulation only if the resected area is suitable (e.g., if it is not within the ventricle, away from conduction pathways and coronary arteries). Was it suitable strategy in this case as well?

References


* Corresponding author. Address: 6436 sok 82/3 Karsiyaka, Izmir, Turkey. Tel.: +90 505 5251202; fax: +90 232 2431530.
E-mail address: ismyurekli@yahoo.com (I. Yurekli).
doi:10.1016/j.ejcts.2009.12.001

Reply to Letter to the Editor

Reply to Kestelli et al.

Tomoyuki Goto a*, Takeshi Enmoto a, Natsuya Keira b, Kazumi Akimoto c
a Department of Cardiovascular Surgery, Nantan General Hospital, Kyoto, Japan
b Department of Cardiology, Nantan General Hospital, Nantan General Hospital, Kyoto, Japan
c Department of Radiology, Nantan General Hospital, Kyoto, Japan

Received 1 December 2009 Revised 14 December 2009; accepted 16 December 2009; Available online 29 January 2010

Keywords: Myxoma; Fistula

We thank Dr Kestelli et al. [1] for their interest and comments regarding our article 'Left atrial myxoma with tumour vascularity: three-dimensional images with multi-slice computed tomography' [2]. Dr Kestelli suggests that radio-frequency ablation should be performed concomitant with resection of atrial myxoma to avoid atrioarterial fistula. We disagree with that statement because atrioarterial fistula after the resection of atrial myxoma rarely causes serious problems.

Dr Kestelli comments that his two cases developed atrioarterial fistula after the resection of atrial myxoma, but we have never experienced it fortunately. We always burn or ligate the feeding artery of the atrial myxoma during the operation, if it can be as large as visualised. If it is not so, the feeding artery may not develop atrioarterial fistula. Although we may not notice it, it is certain that postoperative atrioarterial fistula has never been a complication.

In conclusion, we think that an additional radio-frequency ablation to resection of atrial myxoma is unnecessary and saving cardiopulmonary bypass time is more important.

References