Letter to the Editor

Cardiac anomalies associated with supramitral ring

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Keywords: Congenital heart disease; Pediatric

We read with interest the article in the November 2010 edition by Brown et al., in which the authors have presented their experience in managing 27 patients with supramitral ring (SMR) associated with other cardiac anomalies [1].

Coming from authors with many publications to their credit, we were surprised to read the fourth paragraph of their discussion wherein the authors have sought to be the group to originally propose a framework for the classification of anomalies associated with SMR, stating, ‘From our study, we propose that the associated cardiac anomalies can be grouped broadly into two categories: SMR associated with ventricular septal defect (VSD; including tetralogy of Fallot) and SMR associated with LVOT pathologies, especially sub-aortic membrane, bicuspid aortic valve and coarctation of aorta (Shone’s anomaly). In the first scenario, this is important in the context of patients with VSD and turbulence across the MV in which an SMR needs to be ruled out. In the second scenario, in patients with multi-level left heart obstructions, an SMR should be excluded to prevent residual defects, as has been reported previously.’

This paragraph appears to be have almost verbatim, and without acknowledgment, from our article published in 2006 in the Annals of Thoracic Surgery [2], and has been presented as an original idea in the current article. In our publication, aided with the experience of the patients with SMRs that we had treated, and our study of the literature, we were the first to realize that SMR is associated with either ventricular septal defects or left ventricular outflow obstruction. This was an association that had not been commented upon earlier in literature.

We would like the authors to clarify the reasons why they have used our text in this manner, especially since they have quoted our 2006 publication at least 4 times in their article, suggesting that they were aware of the contents of our article.

References


Letter to the Editor

Management of left main coronary disease

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Keywords: Left main disease; All arterial grafting

The report by Chikwe and associates expresses reluctance to advocate more than one arterial graft (left internal thoracic artery, LITA) for management of left main disease [1]. We have used bilateral ITAs since 1985 for left-sided revascularization of this entity [2]. Subsequently, we routinely used the radial artery as a T-graft for the circumflex system in the presence of left main stenosis [3]. We have not recognized hypoperfusion or graft spasm in these patients.

References


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Reply to the Letter to the Editor

Reply to Dr Barner

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Keywords: Coronary artery disease; Coronary bypass surgery; Left main stem

We thank Dr Barner for his comments [1]. We agree that bilateral internal thoracic artery (BITA) grafting is an appropriate strategy in selected patients with left-main-stem disease, and with this in mind, in our article we cite the excellent outcomes obtained by Tatoulis et al. using BITA in 8420 patients, including 849 patients with left main disease [2], and emphasize the value of adjuncts used to minimize the risk of conduit vasospasm. Vasospasm of the ITA is uncommon, and it is possible that the first study cited by Dr Barner was underpowered to detect this, having only 45 patients in the left-main-stem arm [3]. In the second larger study cited, hypoperfusion of myocardium subtended by the lateral ITA (LITA) was observed in one patient [4]. In the absence of direct coronary angiography, however, diagnosis of conduit spasm relies on surrogate markers: without more information, it is impossible to exclude the possibility of conduit vasospasm contributing to the approximately 3% incidence of postoperative myocardial infarction (MI), low cardiac output state, and ventricular fibrillation in both series. We agree with the conclusions drawn in the author’s own 1000-patient series, and highlighted in the subsequent transcript of the discussion of the same article at the 121st Annual Meeting of the American Surgical Association, that the radial artery has greater vasoreactivity than the LITA (which may account for its comparatively poorer long-term patency), and intra-arterial vasospasm requiring vigorous treatment with intraluminal and topical papaverine is seen in nearly 1% of cases performed by an expert in this technique [5]. In less experienced hands than Dr Barner, the incidence is likely higher, and failure to recognize this in a patient with critical left main stenosis may be catastrophic.

References


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Letter to the Editor

Neuromonitoring using near-infrared spectroscopy: still an interpretation problem

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We read with great interest the article by Harrer and colleagues about their initial experience with near-infrared spectroscopy (NIRS) for neuromonitoring during aortic arch surgery [1]. They used this tool in 13 patients and considered the drop of total oxygen index (TOI) beneath 55% and/or the drop of 15–20% of baseline as an indicator of insufficient perfusion and a reason for completing the bilateral cerebral perfusion in 12 patients.

We have used the NIRS in aortic arch surgery routinely for 4 years and performed it in almost 300 patients up to present. Because our experience with this procedure (no switch from unilateral to bilateral perfusion was necessary in any patient) does not correlate to that of Dr Harrer, we feel compelled to comment.

At the beginning of unilateral cerebral perfusion, we also observed a drop of TOI that increased even slightly after few minutes parallel to the opening of collateral pathways and remained stable during the entire period of cerebral perfusion accounting on average for nearly 92% or 88% of the baseline at the perfused and contralateral side, respectively [2]. At the same time, the pressure values in both radial arteries and the transcranial Doppler assessment alluded to sufficient cerebral cross-perfusion, even in those...