Spontaneous restoration of sinus rhythm after cardiac surgery

Chronic atrial fibrillation is the most frequent arrhythmia in rheumatic valvular heart disease. This arrhythmia increases the risk of thromboembolism and impairs cardiac performance. Unless sophisticated surgical techniques are used to decrease atrial size,1,2, mitral valve substitution rarely eliminates chronic atrial fibrillation in patients with enlarged atria.3 In addition, postoperative treatment with both quinidine4 and direct-current shock5 have limited benefits when patients with mitral valve disease have long-lasting atrial fibrillation and large atrial size.

A 53-year-old woman was admitted to our department with chronic heart failure in NYHA functional class III. Chronic rheumatic heart disease was diagnosed at the age of 35 and treatment with digoxin and diuretics was begun. The patient did fairly well until the age of 51 when atrial fibrillation and large atrial size were confirmed. Echocardiography demonstrated loss of venous return, increased left atrial pressure and size. Circulation 1968, 37-8 (Suppl II): II173-7.

Atrial fibrillation in rheumatic heart disease is probably determined more by the degree of atrial myocardial damage than by the severity of the valve disease. Conversion to sinus rhythm can be achieved shortly after surgical correction with the use of antiarrhythmic drugs or direct-current shock. This report is the first to show spontaneous and stable conversion of atrial fibrillation to sinus rhythm in patients with rheumatic valve disease occurring several months after valve replacement.

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References


Pacemaker twiddler's syndrome: delayed transection of permanent ventricular lead

A 74-year-old woman with a permanent ventricular-inhibited pacemaker implanted 1 year earlier was admitted because of dizziness and local muscle stimulation. A year before, she had undergone successful repair of a dissecting aneurysm of the ascending aorta. Appropriate placement of the lead in the right ventricle was confirmed by a chest radiograph. The implantation site was well healed without fluid accumulation. On admission, the electrocardiogram demonstrated loss of ventricular capture. The chest X-ray revealed twisting and knotting with transection of the lead within the subcutaneous pocket and apical dislodgement. The lead impedance was found to be increased from 509 to 680 ohms.

At reoperation, a tightly fitting fibrous capsule was found without fluid build-up. The terminal pin was retracted and removed from the header. Successful reimplantation of a bipolar silicone lead was performed after puncture of the left subclavian