Letter to the Editor

Cardiac anomalies associated with supramitral ring

Sathiakar P. Collison*, Krishna S. Iyer
Fortis-Escorts Heart Institute,Okhla Road, New Delhi 110025, India

Received 8 November 2010; accepted 14 February 2011; Available online 29 March 2011

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 have been taken 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


* The authors of the original paper [1] were invited to reply to this Letter to the Editor but they did not respond.
* Corresponding author. Tel.: +91 11 26825000; fax: +91 11 26825013.
E-mail address: spcollison@gmail.com (S.P. Collison).


Letter to the Editor

Management of left main coronary disease

Hendrick B. Barner*
St Louis University, 3635 Vista Avenue, St. Louis, MO 63108, USA

Received 13 December 2010; accepted 16 February 2011; Available online 29 March 2011

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


1010-7940/$ — see front matter © 2011 European Association for Cardio-Thoracic Surgery. Published by Elsevier B.V. All rights reserved.