Reply to Sahni and Bhatia
Michael Poullis* and Robert Poole

Department of Surgery, Liverpool Heart and Chest Hospital, Liverpool, UK
Centre for Engineering Dynamics, University of Liverpool, Liverpool, UK

* Corresponding author. Liverpool Heart and Chest Hospital, Thomas Drive, Liverpool, L14 3PE, UK. Tel: +44-151-2281616; fax: +44-151-2932254; e-mail: mike.poullis@lhch.nhs.uk (M. Poullis).

Received 29 February 2012; accepted 22 March 2012

Keywords: Aortic • Curvature • Dissection • Aneurysm

We thank Sahni and Bhatia [1] for their careful analysis of our paper [2]. Due to a typographical error, the open diamond data in Figure 3b is indeed incorrectly labelled as being for 50 mm rather than 40 mm. We can confirm the underlying calculations and equations are correct for the concept and the data presented in the figure.

With regard to Figure 6, and the equation for height of impact (H), H = R \times \sin(90 - \theta). Sahni and Bhatia [1] have misread the methodology text, as R refers to the radius of the aortic curvature of the ascending aorta, not the radius of the aorta. The radius of the aorta does not affect the height of impact of the ejected blood. The demonstration that the site of impact is non-physiological in some instances indicates that the direct jet impact may not always be the initiating pathological event for the aortic dissection. The angle nomenclature is 90 - \theta to fit in with the angle nomenclature of the other figures in the manuscript. The equation and Figure 6 are thus correct.

REFERENCES

Right atrial thrombosis and pulmonary embolism after atrial septal defect repair: could it be hereditary thrombophilia?
Ibrahim Cansaran Tanidir*, Alper Guzeltas and Ender Odemis

Department of Paediatric Cardiology and Paediatric Cardiac Intensive Care, Mehmet Akif Ersoy Cardiovascular Research and Training Hospital, Istanbul, Turkey

* Corresponding author. Department of Paediatric Cardiology, Mehmet Akif Ersoy Thoracic and Cardiovascular Surgery Centre, İstasyon Mah, İstanbul Cad, Beşiktaş Mahveki, 34303 Küçükçekmece, İstanbul, Turkey. Tel: +90-212-6922000; fax: +90-212-4719494; e-mail: cansaran@yahoo.com (I.C. Tanidir).

Received 6 March 2012; accepted 22 March 2012

Keywords: Atrial septal defect • Hereditary thrombophilia • Atrial thrombosis • Surgical closure

We read with interest the case report by González-Calle et al. on ‘Right atrial thrombosis and pulmonary embolism after atrial septal defect repair’ [1]. Manlhiot et al. reported several factors that predispose to thrombosis after paediatric cardiac surgery. The factors that the authors suspected—trixamic acid or foreign object—are also listed there [2]. Probably, according to the patient’s clinical course, the most acceptable reason was a foreign object, but we cannot rule out concomitant or primary hereditary thrombophilia. We think that the haematological screening performed for this patient (proteins C and S and genetic [prothrombin gene] tests) were insufficient to diagnose thrombophilia. The haematological assessment should also encompass antiphospholipid antibodies, factor V Leiden, activated protein C resistance, lupus anticoagulant, antithrombin III, fibrinogen, homocystein level and Factors II, VII, VIII and IX [3]. Perhaps the main cause of the right atrial thrombosis was hereditary thrombophilia, which was overlooked.
LETTER TO THE EDITOR

Reply to Tanidir et al.

Antonio González-Calle*, Alejandro Adsuar-Gómez and Amir-Reza Hosseinpour

Department of Paediatric Cardiac Surgery, University Hospitals Virgen del Rocío, Seville, Spain

* Corresponding author. Bendición nº 5, San Juan de Aznalfarache, 41920 Seville, Spain. Tel: +34-653046267; fax: +34-955012359; e-mail: antoniocgc_77@hotmail.com (A. González-Calle).

Received 15 March 2012; accepted 22 March 2012

Keywords: Atrial septal defect • Surgical complications • Atrial thrombosis

We thank Tanidir et al. [1] for their interesting comments about our article [2]. The tests that were carried out on our patient were selected by our haematologists based on the likely causes of the clinical scenario [3]. The haematological evaluation was not comprehensive in view of the acuteness of the postoperative course that rapidly proved to be fatal. Otherwise the matter would have been pursued to establish a precise diagnosis. However, our patient was forming intracardiac thrombi aggressively, despite our use of intravenous anticoagulation and thrombolysis [4]. So, in a practical sense, a coagulation disorder was already diagnosed, even if its precise nature was not established.

REFERENCES


LETTER TO THE EDITOR

Treatment options for the abnormal origin of the right coronary artery

Alfred Kocher and Dominik Wiedemann*

Department of Cardiac Surgery, Medical University of Vienna, Vienna, Austria

* Corresponding author. Department of Cardiac Surgery, Medical University of Vienna, Währinger Gürtel 18-20, 1090 Vienna, Austria. Tel: +43-69911013670; fax: +43-1404005642; e-mail: dominik.wiedemann@meduniwien.ac.at (D. Wiedemann).

Received 26 February 2012; accepted 22 March 2012

Keywords: Repair of anomalous right coronary artery • Coronary artery disease