Correspondence

Diagnosis of right ventricular outflow obstruction in infants by cross sectional echocardiography

Sir,
In a recent issue of the British Heart Journal (1983; 50: 416–20) Silove et al describe their cross sectional echocardiographic findings in the diagnosis of right ventricular outflow obstructions using the right oblique subxiphoid view. The paper does not report on the possibility of detecting a ventricular septal defect with this view.

In our experience, a ventricular septal defect is best assessed either by the subcostal long axis view of the left ventricle or by the right oblique view. With the latter, in cases of tetralogy of Fallot we have detected simultaneously a pulmonary infundibular obstruction and a ventricular septal defect located in the inferior margin of the aorta and separated from the pulmonary valve by the infundibular septum (Fig. 1). Moreover, this projection allows a perimembranous ventricular septal defect close to the tricuspid valve—as in tetralogy of Fallot—to be differentiated from a muscular infundibular ventricular septal defect, in which the defect is in the anterior margin of the aorta and separated from the tricuspid valve by muscular tissue (Fig. 2).

We agree that the right oblique subxiphoid view is the best cross sectional echocardiographic projection for imaging the right ventricular outflow tract, but we believe that the same view can detect, in addition to the obstruction, the presence and the exact location of the ventricular septal defect and its relation to the tricuspid, aortic, and pulmonary valves.

Fig. 1  Cross sectional echocardiogram in right oblique subxiphoid view in an infant with tetralogy of Fallot showing pulmonary obstruction due to the anterior deviation of the infundibular septum and the ventricular septal defect (arrow) located in the inferior margin of the aorta close to the tricuspid valve. RA, right atrium; RV, right ventricle; A, aorta; P, pulmonary artery.

Fig. 2  Cross sectional echocardiogram in right oblique subxiphoid view in an infant with infundibular muscular ventricular septal defect showing the defect located in the anterior margin of the aorta (arrow) close to the pulmonary valve and separated from the tricuspid valve by the ventriculo infundibular fold. LA, left atrium; RA, right atrium; A, aorta; RV, right ventricle; P, pulmonary artery.
Persistent left ventricular disease in clinically “cured” primary endocardial fibroelastosis

Sir,
Schneeweiss et al (1983; 50: 252–6) state that “there is some disagreement concerning the possibility of the clinical diagnosis of primary endocardial fibroelastosis” and base their diagnosis only on indirect and unspecific findings. Such follow up observations seem to me of little evidence, because the direct histological proof is missing. It could, however, be obtained by the simple and safe technique of endomyocardial biopsy, as demonstrated by Neustein et al and our group. During the past two years we could, by this technique, differentiate six patients with endocardial fibroelastosis from six patients with primary dilated cardiomyopathy in a group of 12 children, fulfilling all the criteria of primary dilated endocardial fibroelastosis mentioned by Schneeweiss et al.

Thus, without histological proof, paediatric cardiologists too should follow the recommendations of the WHO/ISFC task force and call a dilated left ventricle with bad function—having excluded various known causes—a primary dilated cardiomyopathy.

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