Correspondence

B Marino,
C Marceletti,
L Ballerini,
Department of Paediatric Cardiology and Cardiac Surgery,
Bambino Gesù Hospital,
Piazza S Onofrio 4,
00165 Rome, Italy.

References


This letter was shown to Dr Silove and colleagues, who reply as follows:

Sir,

We are pleased that Marino et al have confirmed that the echocardiographic plane we described is the method of choice for evaluating right ventricular outflow obstruction. Their use of the term “right oblique” is not quite appropriate in echocardiography; in our spoken presentation at the Meeting of the Association of European Pediatric Cardiologists 19811 we indicated that the plane was roughly equivalent to the angiographic right oblique projection, and presumably this is what they mean. Silverman et al use the term “parasagittal short axis” to describe a similar echocardiographic plane.2 The plane we described is neither parasagittal nor paracoronal, since it lies approximately midway between the two.

Our study was not designed to evaluate various planes for differentiating the sites of ventricular septal defects, and we made the point that “the ventricular septal defect was assessed by several routine views.” The paper by Sutherland et al deals comprehensively with the detection of ventricular septal defects3 and would support the suggestion that a subcostal parasagittal short axis plane may be helpful in determining the site of the defect.

Eric D Silove,
J V De Giovanni,
M F Shiu,
Myint Myint Yi,
Children’s Hospital,
Birmingham B16 8ET.

References


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 unspecified 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 al1 and our group.2 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 force3 and call a dilated left ventricle with bad function—having excluded various known causes—a primary dilated cardiomyopathy.4

Achim A Schmaltz,
Department of Paediatric Cardiology,
University Children’s Hospital,
Ruemelinstrasse,
D-7400 Tuebingen,
West Germany.
References

This letter was shown to the authors, Dr Schneeweiss and colleagues, who reply as follows:

Sir,
We completely agree with Dr Schmaltz’s remark that histological studies of biopsy specimens would improve the accuracy of giving names to conditions of dilated, poorly contracting left ventricle.

We are confident that Dr Schmaltz would agree with us that the role of endomyocardial biopsy in children, particularly its practical value in paediatric cardiology, is very controversial. Serious complications such as cardiac perforation, tamponade, pneumothorax, arrhythmias, heart block, air embolism, right recurrent laryngeal nerve paresis, and right phrenic nerve paresis, although rare, were reported to result from endomyocardial biopsy.

In Dr Schmaltz’s paper, only two of 14 biopsy studies were considered by the authors to be diagnostic. Some of the remainder were helpful but were not considered by Dr Schmaltz as diagnostic. These cannot be considered to be direct or specific findings. Furthermore, 10 of the 14 patients studied by Dr Schmaltz were over the age of 1 year, which is very frequently beyond the age at which fibroelastosis presents. The only patient in whom Dr Schmaltz found the myocardial biopsy to be diagnostic for endocardial fibroelastosis was a 3 year old child.

Based on our experience, we feel that under the age of 6 months children present a distinct clinical picture, and we therefore feel that biopsy should be limited only to babies in whom the biopsy results may affect treatment.

We certainly support Dr Schmaltz’s point that without histological proof cardiologists should follow the WHO/ISFC task force recommendations and, having excluded various known causes, diagnose dilated cardiomyopathy when we see a dilated, poorly contracting left ventricle.

A Schneeweiss,
A A Shem-Tov,
Henry N Neufeld,
Chaim Sheba Medical Centre,
Sackler School of Medicine,
Tel-Aviv University, Israel.

Correction
We regret the error in the letter to the Editor by Kay et al (1984; 51: 237–8). The last sentence in the left hand column of p 238 should have read: “The position of the graft on the subclavian artery may be important since a 5 mm subclavian near to the aorta will carry 25 ml/s but further away at 3 mm diameter will only carry 3–25 ml/s.”

Notices
Postgraduate course on cardiology
A course on the clinical application of new procedures in cardiology is to be held at the Postgraduate Medical School, Budapest, Hungary, from 23 to 29 September 1984. For further information, please contact: Professor Zoltán Antalóczy, 2nd Medical Clinic, Postgraduate Medical School, PO Box 112, H-1389 Budapest, Hungary.

British Cardiac Society
The Autumn Meeting in 1984 will be held on 3 and 4 December 1984, and the closing date for receipt of abstracts will be 15 August 1984.