Imaging the dissected aorta

SIR,—I read with interest and sympathy Mr Treasure’s editorial on imaging the dissected aorta.1 I agree that it is a difficult to achieve a standard approach. I have found the following guidelines for acute dissection clinically helpful.

(a) Type B dissection is defined as dissection confined to the descending aorta—that is, any part of the aorta beyond the origin of the left subclavian artery.

(b) Type A dissection is any dissection that involves the ascending aorta, whether or not it also affects the descending aorta, and irrespective of the site of entry.

(c) Computed tomography (CT) is a reliable method of detecting and assigning type of dissection. It is certainly more reliable than angiography. This is because the flap in type B dissections is usually static and can be reliably imaged by CT, despite the fact that the true lumen may have regained a smooth, circular cross section.

(d) In type A dissection the flap in the ascending aorta is often mobile, giving a significant incidence of false negative CT examinations, but nevertheless . . .

(e) The ascending aorta is always dilated in type A dissection. If a dissection in the descending aorta is accompanied by an ascending aorta of normal size it is reasonable to exclude type A origin or extension of the false lumen.

In passing, I would like to endorse the efficacy of transoesophageal sonography in the diagnosis of traumatic aortic tear, as described by de Belder et al.2 Indeed, I have yet to hear of a falsely negative study.

JB PARTRIDGE
Heartfield Hospital,
Handford,
Middlesex UB9 6JH

This letter was sent to the author, who replies as follows:

Tomography


Anthracyclines and the heart

SIR,—I thank Dr Rohden, Dr Hasleton, and Dr Brooks for an excellent review of anthracyclines and the heart.1 I would like to point out an error. The evidence for doxorubicin-related cardiotoxicity involving myocardial adrenergic derangement as documented by 123I-meta-iodo-benzyl-guainidine (MIBG) rather than from 123I-methoxy-isobutyl isonitrile (MIBI). These radiopharmaceuticals are quite dissimilar. MIBG is derived from the uptake mechanisms into sympathetic nerve endings as noradrenaline. It is therefore ideally suited to imaging both the distribution of sympathetic nerve endings in the heart as well as neuroendocrine derangements such as pheochromocytomas.1,2 MIBI is a myocardial perfusion agent available in cold kit form that is labelled with technetium-99m rather than with iodine-123. MIBI is a lipophilic agent taken up into myocytes independently of the sympathetic nerve endings but roughly proportionally to myocardial blood flow. MIBI is therefore used to assess the patency of coronary arteries rather than the status of the sympathetic nervous system.3

PAUL THOMAS
Department of Medicine,
John Hunter Hospital,
Locked Bag 1,
Newcastle Mail Centre,
NSW 2310, Australia

We thank Dr Thomas for drawing attention to this error in our paper. We apologize for the confusion and introducing this mistake when the technical editor misspelled the abbreviation MIBG for MIBI. Authors can help to avoid such mistakes by spelling out all abbreviations and acronyms at the first mention—EDITOR


Ballooning dilatation (valvoplasty) as first line treatment for severe stenosis of the aortic valve in early infancy: median term results and determinants of survival

SIR,—In their otherwise excellent article Bu’Lock and Hasleton1 make no mention of any details of the morphology of the aortic valve itself, specifically the number of leaflets. This is of importance because in the so-called unicommissural and unicusp variant of aortic valve stenosis recent studies have shown that the leaflet tissue is attached within the aortic root in a circular rather than a semilunar fashion.2 This arrangement would seem, on morphological grounds, to militate against successful balloon dilatation: but morphologists are constantly wary of predicting outcomes in life from their observations on cadaveric hearts. For this reason it would be invaluable to know whether Bu’Lock and her colleagues had information on the number of leaflets present in the valves diluted in their patients?

ROBERT H ANDERSON
Department of Paediatrics,
Royal Brompton Hospital,
London SW3 6LY