Patients with aortic root abscess usually show extension to adjacent structures and dehiscence of the prosthetic valve.[1] Early surgical intervention with scrupulous debridement of all infected material and reconstruction of the aortic root with a homograft or autologous or heterologous patch is the recommended treatment. The use of an aortic homograft has been reported to be particularly promising; Glazier *et al* reported that only two of their 21 hospital survivors had recurrence of endocarditis after homograft aortic root replacement.[5]

Our patient was unusual because transoesophageal echocardiography showed that the abscess persisted for two days after operation. The abscess may have extended too far into the adjacent structures to permit thorough debridement.

We thank Dr Jakob Schneider, Institute of Pathology, University Hospital, Zurich for providing the prepared specimens shown in figures 3 and 4.

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3 Mulcahy D, Shapiro LM, Westgate C, Ross DN, Donaldson RM. The diagnosis of aortic root abscess by cross-sectional echocardiography. *Clin Radiol* 1986;37: 235–8.
4 Cowan JC, Patrick D, Reid DS. Aortic root abscess complicating bacterial endocarditis. Demonstration by computed tomography. *Br Heart J* 1984;52:591–3.
5 Glazier JJ, Verwilghen J, Donaldson RM, Ross DN. Treatment of complicated prosthetic aortic valve endocarditis with annular abscess formation by homograft aortic root replacement. *J Am Coll Cardiol* 1991;17: 1177–82.

CORRECTION

The electrocardiogram is a more sensitive indicator than echocardiography of hypertrophic cardiomyopathy in families with a mutation in the MYH7 gene *S Al-Mahdawi, S Chamberlain, L Chojnowska, E Michalak, P Nihoyannopoulos, M Ryan, B Kusnierczyk, J A French, D M Gilligan, J Cleland, R Williamson, W Ruzyllo, C Oakley.*

We regret that the traces for leads V1 to V6 in an electrocardiogram in fig 2 of this article (*Br Heart J* 1994;72:105–11) were incorrectly mounted during relabelling. The correct version of this trace is reproduced below.