outward displacement of the anulus into the right ventricle. Direct closure of the defect combined with plication of the sinus, as described in our article (J Thorac Cardiovasc Surg 1997;113:253-61), corrects these abnormalities. In contrast, insertion of patches will add to the redundant tissue and does not restore the position of the aortic anulus and cusp to treat or prevent subsequent aortic regurgitation. With regard to the choice of a transaortic or transpulmonary approach, we believe that the transaortic approach offers many advantages, which include the capacity to plicate the thin part of the dilated sinus and accurately attach the crest of the ventricular septum and anulus to the edge of the normal aortic media, below the coronary orifice. In addition, the aortic valve can be assessed and any additional procedures to restore competence can be considered. In this regard, we agree fully with Hisatomi and colleagues that earlier operation obviates the need for aortic valvuloplasty and that maneuvers designed to avoid direct operations on the cusp are preferable. With the widespread use of echocardiography and the distinct and easily detectable echocardiographic features of the syndrome, it should be possible to diagnose and correct the defect before the development of secondary changes in the cusps.

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Thoracic duct ligation for chylopericardium

To the Editor:

In the August 1997 issue of the Journal (1997;114:299), Yüksel and associates stated “no such approach [thoracotomy for ligation of the thoracic duct] to isolated primary chylopericardium has been described in the literature.” My colleagues and I1 described such an approach in 1990 in a case report published in the Journal of Pediatric Surgery. A child with primary chylopericardium had initial left thoracotomy and pericardial window, followed by a no-fat diet. Two weeks later, because of recurrence of the chylopericardium, they performed a right thoracotomy with ligation of the thoracic duct.

Our patient has been seen annually in our center and has had no symptoms indicative of any complications. In June 21, 1991. In this report we specifically emphasized the importance of conventional angiography over aortography by digital substraction for making an early diagnosis of possible new locations of paraganglioma or Carney’s triad.3

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Aortopulmonary paraganglioma: An overview after five years

To the Editor:

In December 1993, we published a case report in this Journal1 concerning a paraganglioma in the aortic arch of a 64-year-old woman. The operation was performed on June 21, 1991. In this report we specifically emphasized the importance of conventional angiography over aortography by digital substraction for making an early diagnosis.

Later, in a letter to the Editor, Lacquet2 suggested a list of recommendations and comments we should follow in diagnosis of possible new locations of paraganglioma or Carney’s triad.3

Our patient has been seen annually in our center and has had no symptoms indicative of any complications. In
October 1996, more than 5 years after the operation, routine radiographs confirmed her satisfactory condition, and the most recent computed tomographic scan ruled out any complications. The appearance of the aortic arch on the computed tomographic scans before and after resection (Figs. 1 and 2) revealed a conservative aortic anatomy with no local complications.

In the absence of local relapse and without any data indicative of other tumors, we recommended less frequent check-ups and arranged an appointment for 2 years after the last examination. We consider that the follow-up period (of more than 5 years) is sufficient to consider that the risk of new tumors associated with the paraganglioma has now been considerably reduced.

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Fig 1. Chest scan before the operation.

Fig 2. Chest scan 5 years after the operation.
I, too, can top this

To the Editor:

I enjoyed Dr. Oury's “Can You Top This?” letter to the Editor (J Thorac Cardiovasc Surg 1997;114:147), and I rise to the challenge. Currently I am aware of two of our patients who underwent mitral valve replacement on May 11, 1976, and April 8, 1977, respectively.

The transthoracic echocardiogram on the first patient revealed a mean transvalvular gradient of 6 mm Hg with a calculated mitral valve area of 1.5 to 1.6 cm². The latter patient has only Doppler evidence of mild mitral regurgitation; however, no murmur is audible. Both echocardiograms were performed in 1995.

The first patient died of chronic obstructive pulmonary disease and liver failure on March 29, 1997 (20 years and 348 days after mitral valve replacement), and the second patient remains alive and well 20 years and 203 days after mitral valve replacement.

I do believe it is even more impressive that a porcine mitral valve lasted this long, particularly in view of continued systolic trauma with cardiac contraction.

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We did top this!

To the Editor:

In response to the letter from Dr. James H. Oury, “Can You Top This?” we wish to submit the following as the longest recorded functioning bioprosthesis.

On November 4, 1997, I (G.P.) explanted a 27 mm Hancock standard aortic bioprosthesis, model 242 (Medtronic, Inc., Minneapolis, Minn.), from a 76-year-old man who had congestive heart failure resulting from structural deterioration and severe aortic insufficiency. The valve had been implanted on December 9, 1976, by Dr. J. C. Davila at Henry Ford Hospital. The duration of implantation for this valve, therefore, was 20 years and 321 days, thus exceeding that of Dr. Oury's patient by 1 year, 63 days. Because of the patient's present age, it was replaced with another bioprosthesis.

Grossly, two of the three leaflets had minor calcifications but seemed quite intact, not unlike the valve described by Dr. Oury. The right coronary cusp was torn along both commissural attachments. The valve was sent to Medtronic for further analysis. Along with the right cusp tear, they found that the right and noncoronary cusps were stiff because of visible mineralization. Radiographs showed moderate mineralization of all the commissures that extended onto the belly of the right cusp and noncoronary cusp near the point of coaptation. The left cusp was flexible and the noncoronary left commissure was intact.

We thereby repeat the previous challenge: Can you top this?

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