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Reply to the Editor:

This letter is to acknowledge the rheumatologic comments and queries by Juna regarding our recently published case reports[1,2] of aortic dissection without Marfan syndrome in ankylosing spondylitis. In regard to the second case,[2] Juna asked us whether other complementary explorations, such as computed tomography scanning, magnetic resonance imaging, or radionuclide imaging, were practiced to obtain the diagnosis of sacroiliitis. We practiced computed tomography scanning (Figure 1), not magnetic resonance imaging and radionuclide imaging, which demonstrated relatively apparent sacroiliitis, not typical ankylosis in the sacroiliac joints, despite no evident sacroiliitis on the abdominal radiography in the figure of the second case report. To be accurate, however, the diagnosis of the 2 cases might not be ankylosing spondylitis itself but spondyloarthropathies, which consist of ankylosing spondylitis, psoriatic arthritis, reactive arthritis, inflammatory bowel disease-related arthritis, and undifferentiated spondyloarthropathy, because the patients met only the European Spondyloarthropathy Study Group criteria[3] for the classification of spondyloarthropathy. In both cases, the diagnosis of psoriatic arthritis, reactive arthritis, or inflammatory bowel disease-related arthritis may be denied because of the absence of psoriasis, genitourinary or gastrointestinal infection, or inflammatory bowel disease. Undifferentiated spondyloarthropathy is one of the probable diagnoses as mentioned by Juna, because criteria might not be fulfilled for any specific spondyloarthropathy in the second patient. Even though the second case is not ankylosing spondylitis but undifferentiated spondyloarthropathy, there have been no cases of aortic dissection in undifferentiated spondyloarthropathy in the literature except for our case.

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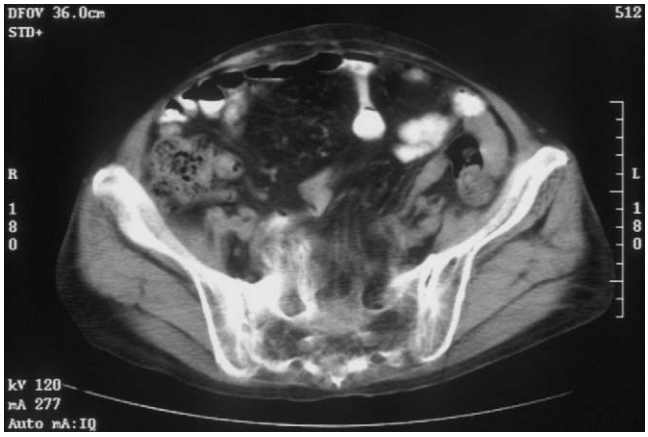

Figure 1. Computed tomography of the second case.

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Implantable cardioverter-defibrillator after left ventricular reconstruction?

To the Editor:

We read with great interest the article by O'Neill and coworkers,[1] which addresses an important question: Is implantable cardioverter-defibrillator (ICD) implantation indicated after left ventricular reconstruction (LVR)?

The authors present their large experience of LVR as a nontransplant surgical strategy for patients with heart failure, with a focus on postoperative malignant arrhythmias. Primary end points were all-cause mortality and appropriate ICD therapies, and median follow-up was 381 days. In addition to the LVR, a small proportion of patients (13%) received a specific antiarrhythmic surgical procedure consisting of cryoablation, about half (46%) underwent a mitral valve procedure, and most patients (88%) were revascularized. The main findings were that patients remain at high risk of ventricular arrhythmias after LVR and that the arrhythmias occur early postoperatively, in two thirds of the cases within 90 days. The authors recommend early ICD implantation or electrophysiology (EP)–guided ICD therapy before hospital discharge after LVR.

We have 2 questions regarding the study by O'Neill and coworkers[1]: (1) How many patients had clinical arrhythmias before surgical intervention? (2) Were EP studies conducted before surgical intervention in any of the patients?

The answers to these questions are important to assess the effect of the procedure per se on the incidence of postoperative arrhythmias. There is some theoretic or indirect evidence that LVR promotes electrical stability in the heart by different mechanisms.[2]