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Letters to the Editor

Early repolarisation and J wave syndrome



We read with interest the review article by Sethi et al in the recent issue of Indian Heart Journal which was timely, provocative and provided a thorough overview of this complex electrophysiologic anomaly (Indian Heart Journal 66: 2014 443–452). The authors must be congratulated for this brilliant overview.

However, there are several errors, which have surreptitiously emerged in the article. For example the lower panel in Figure 3 is labeled as Type 1, 2 and 3 of ER syndrome rather than Brugada syndrome.

While describing the characteristics of ER, the authors correlated it to “pseudo delta wave”. ER is a phenomenon as a result of abnormalities of I_{to} current – an abnormality of repolarization at Phase 1 of monophasic action potential, which appears at the end of depolarization. However, delta wave appears at the beginning of the QRS duration due to preferential conduction over the accessory pathway leading to an abnormality of depolarization—a characteristic that is

completely distinct from ER as it affects Phase 0 of monophasic action potential.

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PCI in a single coronary artery from right aortic sinus: A rare case



A single coronary artery is a very rare anatomic anomaly, present in 0.06% of coronary arteriograms.¹ Although these anomalies and stenosis of anomalous vessels have been described previously, treatment of atherosclerotic lesions by PCI (Percutaneous coronary intervention) has rarely been reported. There is a definite procedural risk during PCI in patients with a single ostium because dissection with the guiding catheter would result in a catastrophic event. Additionally, technical difficulties may occur due to the course of the branch to be stented. We report a very rare case of a single

coronary artery from right aortic sinus in which successful PCI was performed on both LCA (left coronary artery) and RCA (right coronary artery) arising separately from a single right coronary artery (see Figs. 1–4).

A 56 year old male, without any conventional risk factors, had presented with anterior wall myocardial infarction. He was taken up for primary PCI but his LCA was not visualized and the coronary anatomy was not clear. So he was thrombolysed with tenecteplase and a CTA (CT angiography) of coronaries was planned to look into the coronary anatomy later.

His CTA revealed a single right coronary artery with a pre-pulmonic course having lesions in both LCA and RCA. Subsequent Coronary angiography showed lesions in proximal

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