the first rib. Whereas the majority of authors consider the uppermost observable rib to be the first one, others claim that the first rib is not visible during thoracoscopy [5]. Failures following sympathetic ablation have often been attributed to anatomical variability. The technique described in the preliminary report by Weng and colleagues [1] could become a breaking solution to this dilemma. We compliment the authors and urge them to increase their series and publish their results with a detailed description of their technique.

Peter B. Licht, MD
Department of Cardiovascular Surgery
Odense University Hospital
Odense, Denmark

Alan E. P. Cameron, MD
Nuffield Hospital
Ipswich, United Kingdom

Moshe Hashmonai, MD
Faculty of Medicine
Technion–Israel Institute of Technology, Haifa
and
PO Box 359, Zikhron Ya’akov
Israel 3095202
email: hasmonai@inter.net.il

References

Reply
To the Editor:

We thank Dr Licht and colleagues for their comments [1], and we are glad that our report [2] had drawn attention of experts on hyperhidrosis and sympathetic surgery. After decades of research, R3 and R4 sympathectomy had already been proved to be the standard procedures for palmar hyperhidrosis with relative perfect results [3]. However, failures and recurrence still existed without a reasonable explanation. From our experience, anatomic variation may be one of the most significant factors leading to the unsuccessful cases. Until recently, more than 30 consecutive successful cases had been already collected using this fluorescent method to precisely locate the sympathetic ganglions. We are reorganizing all the data and preparing for publication soon. Actually, we have confidence that this novel technique could improve the results of sympathetic surgery for palmar hyperhidrosis. Undoubtedly, randomized controlled trials are still required to validate this conclusion. Moreover, it is noteworthy that the exact physiologic process of this phenomenon still needs to be explored deeply.

Wenhan Weng, MD
Jian Zhou, MD
Yanguo Liu, MD
Fan Yang, MD
Jun Wang, MD

Department of Thoracic Surgery
Peking University People’s Hospital
No. 11 Xizhimen S St, Xicheng District
Beijing, China
email: wengwwl9126.com

References

Regarding Surgical Anatomy of the Aortic Annulus

To the Editor:

Congratulations to the authors for their valuable study [1]. In this context, we reviewed our knowledge of functional anatomy of the aortic annulus. Nevertheless, we want to put some emphasis on several issues. As shown in Fig 1C, a nonflexible external annuloplasty ring would prevent relative dynamic dilation of the ascending aorta during systole. This situation may cause turbulent blood flow within ascending aorta as in aortic stenosis, thus leading to an aneurysm formation. In addition, this turbulent flow may lead to leaflet degeneration. As shown in Fig 1D, a nonexpanding vascular graft interposed into ascending aorta would cause more friction, shear stress, and fluctuation compared with the native ascending aortic tissue, which expands 10% during systole. This hemodynamic deterioration, again, may lead to accelerated leaflet degeneration. Fig 2A states that the “green line indicates the aortic annulus (AA).” This description should be reviewed, because as we all know that there is no “anatomic” aortic annulus. There is an “adhesion site” of the aortic leaflets. Last but not least, the three-dimensional configurations in Fig 2B–D may alter with serum albumin and hematocrit levels, with body surface area and arterial blood pressure levels; thus, these configurations cannot be standardized.

Ismail Yurekli, MD
Mert Kestelli, MD
Habib Cakir, MD
İltcan Peker, MD

Izmir Katip Celebi University Atatürk Education and Research Hospital
Department of Cardiovascular Surgery
6436 sok 82/3 35540 Karsiyaka-Izmir
Turkey
email: ismyurekli@yahoo.com

© 2017 by The Society of Thoracic Surgeons
Published by Elsevier Inc.
Reply
To the Editor:

We thank Yurekli and colleagues for their letter [1] on our article [2]. However, assumptions on dynamic anatomy, aneurysm formation, and leaflet deterioration are not supported by any references from the literature and do not correspond to our experience with long-term results of external aortic ring annuloplasty for aortic valve repair [3]. Furthermore, Yurekli and colleagues refer to a nonflexible external aortic annuloplasty, which is not the aortic ring we illustrate in our work. Indeed, we use an expandable (so flexible) aortic ring annuloplasty (Fig 1 of Khelil and colleagues) [2]. The purpose of Khelil and colleagues’ [2] article is to describe anatomical landmarks of the subvalvular plane for an external aortic annuloplasty; dynamic anatomy is not discussed and is beyond the scope of this anatomical work [2].

We do not agree with consideration on anatomic annulus, which is the term widely accepted in literature, particularly by Anderson [4] and Sievers and colleagues [5], who suggest use of the term aortic “annulus” to describe the ring (or plane) joining the three narhus of the semilunar leaflet attachments.

Three-dimensional figures are scale drawings showing the subvalvular dissection plane line and the schematic 3-dimensional aortic annular view from the each cusps as could be seen in a flaccid heart, which was also the finding of de Kerchove and colleagues [6].

Emmanuel Lansac, MD, PhD
Department of Cardiac Surgery
Institut Mutualiste Montsouris
42 Bld Jourdan
Paris 75014, France
email: emmanuel.lansac@imm.fr

Isabelle Di Centa, MD
Vascular Surgery Unit, Hôpital Foch
Suresnes, France

References

Can Takotsubo Syndrome in the Setting of Pericardiocentesis Be Prevented?
To the Editor:

I enjoyed reading the report by Belluschi and colleagues [1] about the 69-year old man who experienced Takotsubo syndrome (TTS) after pericardiocentesis for a pericardial effusion with tamponade, 6 months after aortic valve repair and ascending aorta replacement. There are no details about periprocedural blood pressure (BP) or heart rate (HR) rise, or symptoms of anxiety experienced by the patient, suggestive of a heightened sympathetic autonomic function, which could have ushered in the TTS. One wonders whether β-blockade, sedation, or both (eg, with benzodiazepines or propofol) could prevent the occasional emergence of TTS in patients undergoing pericardiocentesis. Other authors have emphasized “the importance of careful clinical evaluation (altered HR and dyspnea) in suspecting acute left ventricular dysfunction” instead of an “onset of biventricular impairment immediately post procedure” as in PDS [2] bespeaks TTS. The authors state that their patient had experienced pericardiocentesis-triggered TTS, rather than pericardial decompression syndrome (PDS), which they excluded in their patient “because pulmonary edema and cardiogenic shock were absent” [1]. PDS is thought to be “a well-defined but rather underreported complication of pericardial drainage [3, 4]. In addition, in the present case [1], “the clinical pattern of initial improvement followed by deterioration” instead of an “onset of biventricular impairment immediately post procedure” as in PDS [2] bespeaks TTS. However, the comprehensive review carried out by Ayoub and