Giant pulmonary artery aneurysm due to undiagnosed atrial septal defect associated with pulmonary hypertension

Atrial septal defektin sebep olduğu pulmoner hipertansiyon sonucu gelişen dev pulmoner arter anevrizması

Dear Editor,

We read with great interest a recent article by Tartan et al. (1) ``Giant pulmonary artery aneurysm due to undiagnosed atrial septal defect associated with pulmonary hypertension``.

In this article the authors report on a rare clinical entity: a giant pulmonary artery aneurysm (PAA) due to an even more rare condition - a late diagnosed atrial septal defect (ASD) resulted in Eisenmenger's syndrome. Although read very carefully, we could not come across to an explanation about the rupture risk for aneurysm and follow-up frequency in the article.

When Eisenmenger's syndrome is present, we understand that the ASD should not be corrected; however, we believe that the rupture risk of aneurysm shall not be ignored.

The optimal treatment strategies are not clear when a pulmonary artery aneurysm is diagnosed. Some authors prefer conservative management, while others advocate surgery. The localization and size of the aneurysm predisposing cardiac pathologies and risk of rupture are important for the choice of treatment (2, 3). Symptomatic cases with significant pulmonary regurgitation or stenosis (which is enough to cause right ventricular dysfunction), pulmonary hypertension, or associated with other cardiac lesions, are candidates for surgery. Possible complications such as dissection, embolism, rupture, compression of the surrounding tissues may occur as the most life-threatening complications. The risk of dissection is associated with pulmonary hypertension and/or connective tissue diseases while the risk of rupture increases with advanced age (4).

When a giant PAA is present, we believe that the treatment should include surgical correction. Our experience showed that elective surgical repair is required if signs of compression to adjacent vital structures, thrombus formation in the aneurismal sack, or ≥0.5 cm increase in the diameter of the aneurysm in 6 months are observed during the follow-up period. Sometimes only aneurismal surgery may be applicable; e.g. aneurysmoraphy, reconstruction with pericardial patch, arterioplasty, homograft or synthetic graft interposition (5).

The case presented in the article is a 55-year-old male, who is exposed to possible dissection and/or rupture, and even sudden death. The ASD is inoperable due to Eisenmenger's syndrome, but due to giant PAA surgical management should be recommended. We would like to address the authors these two questions:

1) What is the follow-up frequency?

2) Are you planning to recommend surgical treatment for PAA, and if yes, when?

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Author's reply

Dear Editor,

We would like to thank the authors of the letter for their interest in our article.

1- The patient is not regularly followed -up in our clinic. He is being taken care by another cardiology clinic according to his preference.

2- Surgical treatment was not offered due to increased perioperative mortality and morbidity. The surgery was also not offered by the clinic where he is being followed-up currently.

He is still alive but is having serious dyspnea that requires frequent hospitalizations.

Yours Sincerely

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Ross operation for teenagers: correct indication determines the long-term outcome/ Early double valve re-replacement after Ross operation

Gençlerde Ross ameliyatı: Doğru endikasyon uzun dönem sonuçları belirler/ Ross ameliyatı sonrası erken dönemde çift kapak re-replasmanı

I read with great interest the case report by Özkara et al. (1) in the June issue of the journal and must commend the authors for highlighting the important issue of appropriate case selection for Ross operation and its impact on long-term outcome.

The surgical management of aortic valve disease in children and young adults continues to be a challenging problem. Choice of valve remains a controversial area with both mechanical as well as bioprosthetic valves having their pros and cons in this subgroup of patients. The Ross operation, involving replacement of native aortic valve with a pulmonary autograft, with its advantages of growth potential, optimal hemodynamic performance, and freedom from anticoagulation and hemolysis has become an attractive option for pediatric and adolescent patients requiring aortic valve replacement (2). However, it is extremely important that this technically demanding