1965 Report of Idiopathic Hypertrophic Subaortic Stenosis with Ostium Secundum Atrial Septal Defect

To the Editor:

In an article entitled “Idiopathic Hypertrophic Subaortic Stenosis with Ostium Secundum Atrial Septal Defect: Successful Surgical Correction” (Chest 68:246-248, 1975), Smith and associates reported the surgical correction of coincident idiopathic hypertrophic subaortic stenosis with ostium secundum atrial septal defect. These investigators stated that in 1971 their patient was reported by Forker and Morgan1 as the “first” patient with coincident idiopathic hypertrophic subaortic stenosis and ostium secundum atrial septal defect; however, it would appear that the first case may have been reported prior to that in the American Journal of Cardiology in 1965. Although we are fully aware that, in fact, our case might not have been the first, a thorough review of the literature at that time suggested that it was. Surgical repair was attempted in that four-year-old patient, with initial correction being directed towards relief of the outflow obstruction; however, the patient died in surgery. That surgical correction of both lesions is possible is clearly shown by the report of Smith and associates.

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REFERENCES

Ventricular Unloading Agents

To the Editor:

The editorial by Kattus entitled “Antiangina or Antimyocardial Ischemia Drugs” (Chest 67:632-633, 1975) correctly emphasizes the need to expand the concept of antianginal drugs to the broader designation of “antimyocardial ischemic drugs.” But why stop here? For example, the organic nitrates have been shown to be useful in the management of congestive heart failure.1-3 Their beneficial effects appear to be mediated by systemic (i.e., ventricular unloading) action rather than through their classic “coronary-vasodilator” action. How should we best classify these nitrates (and other vasodilators)? Certainly, the term, “antianginal” nitrates, is too narrow. How about “ventricular unloading agents”? New applications of old drugs always pose these questions. (Should dipyridamole, aspirin, and papaverine, which inhibit platelet aggregation, be reclassified? Probably not. Their main pharmacologic actions require myocardial, analgesic, and peripheral vasodilator classification. Yet many physicians and investigators use them solely as antplatelet aggregation agents to modify thrombus formation.)

I agree that new designations, such as “antimyocardial ischemia drugs,” are probably more precise, at least as they apply therapeutically. Hopefully, such phrases as “ventricular unloading agents” may also be more widely employed.

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Intermittent Mandatory Ventilation

To the Editor:

The editorial of Dr. Petty entitled “IMV vs IMC” (Chest 67:630-631, 1975), while full of witticisms, is not an accurate reflection of the real uses of intermittent mandatory ventilation (IMV), and I submit that intermittent mandatory cerebration (IMC) as advocated by Dr. Petty would allow one to reach a more favorable decision about the utility of IMV.

The advantages of IMV, which has been developed at Gainesville, Fla, and modified at other centers, are the following: (1) In selected patients,