

Letters to the Editor

Letter to the Editor

Are the aortic anatomical normal leaflets, normal leaflets?[☆]

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I read with interest a recent article by Thubrikar et al. [1] where they suggest that in dilated aortic roots the anatomically normal leaflets, however, were not geometrically normal. Thus they conclude that during valve-sparing surgery, it may be necessary in some cases to correct not only the dilatation of the aortic root but also the leaflet free-edge length in order to achieve a competent valve.

We studied the nervous fibers distributions with glycosaminoglycans' (GAG's) leaflet distribution in 15 aortic valve leaflets in aortic root dilated and judged anatomically normal and 15 leaflets in normal aortic valve (homograft). We found a significant decrease in the fibers innervation – acetylcholinesterase positive fibers – and also in GAG's total quantity and distribution [2,3].

The simple, anatomical, analysis of aortic leaflet before the surgery cannot be sufficient. As a matter of fact, this question is particularly relevant in case of plastic of aortic valve leaflets or valve-sparing procedures.

References

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[☆]The authors of the original paper [1] were invited to comment on this Letter to the Editor but declined the offer.

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Letter to the Editor

Can we consider thymectomy before pregnancy in female patients with myasthenia gravis?

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I have read with interest the article by Roth et al. [1] reporting the course of a group of patients with myasthenia gravis (MG) during pregnancy. Roth et al. [1] analyzed retrospectively the outcome in eight patients with MG with a previous thymectomy and seven patients without thymectomy, reporting a better outcome during the pregnancy in thymectomized mothers and also in the babies. Recently our group reported the prognosis of 18 pregnant women with MG during the pregnancy [2]. The majority of the patients in our study had a thymectomy before the pregnancy (17 of 18 patients) and the prognosis was similar to the classical series of myasthenia gravis [3,4], 11% improved, 39% had worsening and 50% remained clinically unchanged. Our study contains patients with a previous thymectomy [2], and the trend demonstrated in the study by Roth et al. [1] at least in this group was not observed. This study was not considered in the analysis of this article [1].

Djelmis et al. [4] reviewed 69 pregnancies among 65 women. Twenty-five percent showed improvement, 45% did not change and 30% suffered exacerbations. Twenty-five patients (38.5%) had a previous thymectomy before the pregnancy. This study suggested that thymectomy before the pregnancy can minimize the likelihood of neonatal myasthenia. Batocchi et al. [3] evaluated the course of 47 females with MG who became pregnant. During pregnancy 41% had no change, 39% improved and 19% got worse. They concluded that the course during pregnancy is highly variable and unpredictable. Forty-two patients had thymectomy before the pregnancy. Both studies did not analyze the prognosis according to the thymectomy status.

The suggestion of Roth et al. [1] that thymectomy can improve the prognosis during the pregnancy is good but the evidence to support this idea is not solid. In our institution, we empirically recommend the thymectomy in the majority of the patients before the pregnancy. We do not have strong basis to support this recommendation but we have the same