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# CORRESPONDENCE

## Helen Taussig

*To the Editor:*

The timely review of the Taussig-Bing anomaly by Konstantinov<sup>1</sup> is a wonderful piece of medical history, spiced with the personal recollections of two towering giants of cardiovascular medicine and surgery, Dr. Bing and Dr. Cooley.

As time goes on, there will be fewer of us who actually met and remember Dr. Taussig. In 1972, when I was a resident in Boston, I attended to Dr. Taussig's sister in a medical emergency, and we as house officers got to know Dr. Taussig quite well. We could even persuade her to conduct an impromptu teaching session, and she later also gave a Grand Rounds presentation on the long-term outcome of Dr. Blalock's "blue baby" surgery. To this day, I remember her sharp intellect, discipline, and great kindness.

In 1921, Helen Taussig was denied admission to Harvard Medical School because she was a woman,<sup>2</sup> yet she wrote the first textbook on pediatric cardiology that incorporated hemodynamic principles.<sup>3</sup> We must also remember that Helen Taussig almost singlehandedly averted the thalidomide disaster in the United States.<sup>4</sup>

To her colleague, Richard Bing (himself a pioneer of cardiac catheterization and also a composer, often described as a Renaissance man), she supposedly once remarked: "I wish you had spent more time with your music."\* Certainly no love was lost between her and Dr. Bing. Although she had no formal training in physiology, Helen Taussig, like Richard Bing, has been one of the great American physicians whose life and work continue to inspire us, especially pediatric cardiologists.

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\*Personal communication: Richard J. Bing; 28 January 2010

## Inadvertent Anastomosis of Internal Mammary Artery to Great Cardiac Vein

*To the Editor:*

The recently published article by Puri and associates<sup>1</sup> is of great interest. Inadvertent anastomosis of the left internal mammary artery (LIMA) to the great cardiac vein is a rare but important sequela of coronary bypass grafting, previously reported by Starling in 1981.<sup>2</sup> In the current case, the patient was treated by placement of a drug-eluting stent to the left anterior descending coronary artery. The stent caused occlusion of the first diagonal coronary artery, but the patient remained asymptomatic.

In some very complex situations, such as when the native artery is severely atherosclerotic or intramyocardial or when the intervention is a redo, placing a coronary artery bypass graft to the target vessel can be impossible. Because the coronary venous circulation is valveless, one can anastomose the LIMA or a reversed saphenous vein graft to the adjacent vein of the target coronary artery.<sup>3</sup> After anastomosis, the vein is ligated toward the base of the heart, reversing flow in the vein to achieve myocardial perfusion.<sup>3</sup>

We have applied this principle on 3 separate occasions when bypass to a target artery was essential but technically impossible. All patients recovered uneventfully without signs of ischemia.

Historically, in cases of inadvertent anastomosis of a conduit to a cardiac vein, treatment has consisted of closure of the fistula and repeat bypass grafting to the target vessel.<sup>1</sup> A simpler solution to this problem could be either the open ligation of the draining vein or the percutaneous closure of the fistula via the coronary sinus.<sup>4</sup>

This timely article by Puri and colleagues reminds us that it is possible to confuse a coronary vein with the corresponding artery, particularly when crystalloid cardioplegic solution is used. If the diagnosis is made on the operating table and the target artery is not found, proximal ligation of the vein is an effective alternative.

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### **Right Superior Caval Vein Draining into the Left Atrium**

#### *To the Editor:*

I read with great interest the recent case report by Baggett and colleagues.<sup>1</sup> In their report, the authors state that theirs is the first patient in whom the diagnosis of isolated right superior vena cava drainage into the left atrium was made exclusively by noninvasive imaging using cardiac magnetic resonance. I just want to call the attention of the authors to an earlier paper that reported the cases of 2 children with the same condition in whom the diagnosis was also made noninvasively, by color Doppler echocardiography.<sup>2</sup> The older child's condition was suspected clinically because of cyanosis and normal cardiac findings; since magnetic resonance was not then available, cardiac angiography was performed

to confirm the diagnosis before surgical correction. In the other patient, a newborn with cyanosis, the diagnosis was made serendipitously: the color Doppler study was performed while an already-flowing upper-limb intravenous line showed contrast material filling the left atrium from the right superior vena cava.

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