CORRESPONDENCE

History of Cardiac Surgery

To the Editor:

I would like to applaud your journal's innovative articles on the history of cardiac surgery. I did part of my residency training with Dr. Albert Starr here in Portland and was fortunate enough to spend some time at the Brompton Hospital under Mr. Tubbs, one of Dr. Cooley's mentors when he was at the Brompton.

Although I ultimately chose not to go into cardiac surgery, I have been fascinated by the history of cardiac surgery in general and open-heart surgery in particular.

I am astounded at the depth and maturity of these articles produced by medical students. I would like to applaud their efforts and to let them know that their work is appreciated.

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To the Editor:

The article by Adora Ann Fou (Tex Heart Inst J 1997; 24:1-8) regarding the development of the pump oxygenator was interesting and instructive. The dedication and perseverance of the Gibbons in this endeavor is exemplary and worthy of review for contemporary medical students and surgeons.

In the interest of historical accuracy, it is also worthwhile recording the fact that the evolution of cardiopulmonary bypass into a relatively safe clinical procedure was not universally accomplished in such a meticulous and painstaking manner. The hurried attempts in some places to get into the heart surgery business were not the finest days of medical history.

An important exception was the modification of the Gibbon apparatus for extracorporeal circulation and the development of intracardiac surgical procedures at the Mayo Clinic in the early 1950s and subsequent years. Now a 1st-year medical student might be excused for attributing this fine work to a nonhuman entity (the Mayo Clinic). On the other hand, at least some members of the editorial board of the *Texas Heart Institute Journal* are aware that John Kirklin deserves a good deal of the credit for the careful and responsible manner in which intracardiac surgery was developed in Rochester, Minnesota. It is my recollection, also, that Dr. Kirklin frequently acknowledged his debt to his colleagues in the engineering department and in the experimental surgery and physiology laboratories.

In these days of a surfeit of medical ethics problems and apparently changing social mores, it is appropriate to recall *all* the times and places where important medical and surgical techniques and procedures were developed meticulously and humanely and with primary concern for the patients' welfare.

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Congenital Isolation of the Subclavian Artery in Adults

To the Editor:

The article "Congenital Isolation of the Subclavian Artery in Adults" by Guinn and Weathers (Tex Heart Inst J 1997;24:58-63) nicely describes the condition and graphically illustrates embryologic changes in brachial artery development that might explain its pathogenesis. A deletion from the long arm of chromosome 22 may be the *primum mobile* for congenital isolation of the subclavian artery. Patients with this anomaly well could have the CATCH-22 syndrome.

In a report by Momma and colleagues[1] of 22 patients with 22q11 deletion and tetralogy of Fallot, 3 had isolation of a subclavian artery—a rare anomaly—and 3 had aberrant origin of this vessel, while none of 22 tetralogy patients without 22q11 deletion had subclavian isolation or aberrancy. Eleven of the patients with 22q11 deletion had a high (cervical) aortic arch and 9 had right arch. Recently Kumar and associates[2] published the 1st report of cervical aortic arch in association with CATCH-22 syndrome, which was found in 2 patients who had no other conotruncal anomalies. Figures 1-3 of Guinn and Weathers suggest that their patient 1 might have a high arch (defined as reaching the 3rd rib posteriorly).

Guinn and Weathers did not mention whether their patients had facial dysmorphia or other features that suggest CATCH 22, or whether fluorescence in