Matters arising

Postmortem radiology in children with congenital heart disease

We noted with interest the paper by Russell and Berry describing postmortem radiology in children with congenital heart disease. We would like to add a further case in which radiology proved essential in determining the patency of coronary arteries after anatomical correction for transposition of the great arteries.

Clinical history

The patient was seen at Birmingham Children's Hospital on the day of delivery because of cyanosis. An echocardiogram showed transposition of the great vessels and a patent ductus arteriosus. A balloon septostomy was performed, followed 10 days later by an arterial switch operation. The anatomy of the coronary artery was noted to be abnormal at the time of surgery with the right coronary artery giving rise to the circumflex branch which passed to the left. Coronary artery ostia were mobilised and the aorta switched posteriorly. The left coronary ostium was translocated to the facing sinus of the pulmonary artery. Both ostia seemed to be patent, but there was bleeding from around the left coronary ostium. Although this was controlled, the patient developed an intractable arrhythmia which failed to respond to all measures and subsequently died.

The possibility of a mechanical obstruction of one of the coronary ostia as a cause of death was considered. At necropsy the aorta was opened 1.5 cm above the aortic valve and the distal aorta tied off. Water soluble contrast medium was then injected into the aorta and the specimen examined radiologically.

There was filling of both coronary arteries, by contrast, together with filling of the left ventricle with reflux into the pulmonary veins (figure). The latter may have been due to the injection pressure being insufficient to force valve closure.

We were thus able to state that the coronary artery anastomosis was technically sound and that there was no evidence of kinking of the coronary arteries. Moreover, the lumen was patent excluding obstruction from thrombosis or embolism. We would, therefore, agree with Russell and Berry that postmortem radiology is a simple but invaluable technique for assessing vascular anatomy in congenital heart disease, particularly where surgical repair has been performed.

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References


Condoms and safe sex

The advice that using a condom reduces the risk of transmission of human immuno-deficiency virus (HIV) infection would have to be questioned if latex condoms were found to have the same 5 μm tortuous channels which were recently reported to exist in latex surgical gloves.¹

Freeze fractured sections of Mates, Durex Featherlite, and Durex Elite condoms were studied at magnifications of up to 10,000 times with scanning electron microscopy. Some fracture artefacts were seen, but no other form of channel was detected. Pendle and Cobbold² suggested that the channels described by Arnold et al¹ were artefacts produced by cracking of the electrically conductive coating that was applied during the preparation of the sample for scanning microscopy.

There is no evidence that condoms contain channels of greater than 300 nm in diameter.

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References


Figure Radiograph of infected heart with attached lungs. LAD, left anterior descending coronary artery; CA, circumflex coronary artery; LV, left ventricle.
How specific is the rapid urease test for diagnosing Campylobacter pylori?

We read with interest, the letter to the editor by Vaira et al. We describe our experience with the rapid urease test, which differs from that reported by Vaira et al and from those reported earlier.

Three pieces of antral biopsy specimen were taken from 53 patients with dyspepsia. Two pieces were transported to the microbiology laboratory, one piece for Gram staining and another for culture in the Campylobacter medium; a third piece was immersed in CLO-gel, as described by Marshall et al. Results were read after 20 minutes, three hours, and 24 hours. Twelve (20-69%) cases grew Campylobacter pylori (table).

The sensitivity of the rapid urease test has been shown to vary from 59-97%, but our study shows a sensitivity of 100%. Unlike studies showing 100% specificity, this study showed a specificity of 95-7% at 20 minutes, 93-5% at three hours, and 80-4% at 24 hours. Unlike other studies there were no false negative results with the test, but there was a false positive rate of 4-4% at 20 minutes, 6-5% at three hours, and 19-6% at 24 hours.

Vaira et al concluded that a positive C pylori (CP) test before 20 minutes of incubation is strong evidence of C pylori infection. To substantiate the authors’ observation, it would be important to know the sensitivity, specificity, false positive and false negative rates at 20 minutes, three hours, and 24 hours of the CP test compared with those of the 2% RUT and CLO-tests. Results of the CLO-test were read at 20 minutes, 90 minutes, and 24 hours; results of the 2% RUT were read at three hours, four hours, and six hours; results of the CP test were read at 15 minutes, 20 minutes, and two hours. We feel that it would have been better if the results were read at the same time intervals with these three tests.

Table: Comparative efficacy of various tests for Campylobacter pylori

<table>
<thead>
<tr>
<th>Culture</th>
<th>Gram staining</th>
<th>Rapid urease test at: 20 minutes</th>
<th>3 hours</th>
<th>24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>12</td>
<td>10</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Negative</td>
<td>46</td>
<td>48</td>
<td>44</td>
<td>43</td>
</tr>
<tr>
<td>Sensitivity</td>
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<td>83-33%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Specificity</td>
<td>100%</td>
<td>95-65%</td>
<td>93-48%</td>
<td>80-43%</td>
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<tr>
<td>False positive</td>
<td>0</td>
<td>4-35%</td>
<td>6-52%</td>
<td>19-57%</td>
</tr>
<tr>
<td>False negative</td>
<td>16-67%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Demonstration of aluminium on bone using different staining techniques and spectrophotometry

We were interested to see the paper of Ellis et al. To our knowledge, it is the first time that anyone has attempted to validate the technique we originally described in 1985 for showing the presence of aluminium within bone, and we note with some pleasure that they have been able to confirm our results.

We have now examined more than 1800 biopsy specimens using the solochrome azurine technique and have had an opportunity on many occasions to compare the strain distribution with that perceived by energy and wavelength dispersive electron probe analysis, secondary ion mass spectrometry, and laser microprobe mass analysis, and believe we can resolve two of the anomalies described by Ellis et al.

The "false" positivity that they describe is not false but real. Atomic absorption spectrophotometry (AAS) by its nature gives a measure of aluminium expressed as a proportion of total dried weight of bone. Localised deposits of aluminium, as frequently occur after treatment of aluminium related renal osteodystrophy (AIROD), would be "diluted" out by AAS analysis giving a low mean aluminium concentration, whereas in truth, the local concentration may be relatively high and well within the concentration range detected by solochrome azurine. Thus by comparison with AAS, solochrome azurine may appear to be reacting with bone containing only low aluminium concentrations. The opposite may also apply. Aluminium may be deposited diffusely within bone but with local concentrations too low to be detected by solochrome azurine. We have found this to be particularly true in patients with a moderately decreased glomerular filtration rate in regions like ours where the ionic aluminium content of tap water is relatively high. This group of patients gradually accumulate aluminium in bone but the concentration in the extracellular fluid is...