vascular surgery, which means that hybrid procedures are becoming increasingly important.

Although this technique has been described in some isolated cases,2,3 we present the first report in Spain of a hybrid procedure involving pneumology, thoracic surgery, and interventional cardiology to resolve a postoperative fistula.

In this case, closure using an Amplatzer® was proposed as an alternative after bronchoscopy with a tissue sealant had failed, as published elsewhere.2 Nevertheless, this could become a first-line technique in this condition as experience with the procedure is gained. One case has already been described in which the technique was used as the first-line option;2 in patients like ours who have previously received chemotherapy and radiotherapy, and in whom surgery may be more complex, it is even more justified to consider it as a first-line option.

In short, this technique can provide a solution to complications stemming from other medical and surgical specialities and is an example of the possibilities offered by hybrid procedures between various specialties and different techniques.

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REFERENCES


Heart Transplantation in an HIV-1-Infected Patient With Ischemic Cardiomyopathy and Severe Pulmonary Hypertension

Trasplante cardiaco en un paciente infectado por VIH-1 con miocardiopatía isquémica e hipertensión pulmonar grave

To the Editor,

We report the case of a 39-year-old homosexual male patient diagnosed through routine testing in 1998 as infected with human immunodeficiency virus type 1 (HIV-1). He had not developed any AIDS-defining disease and had no history of intravenous drug abuse, hepatitis C or B viral infection. His CD4+ T-cell count at the time of presentation was 758 cells/μL; the nadir CD4+ T-cell count was 512 cells/μL. Plasma RNA HIV-1 viral load was always undetectable (<50 copies/mL). He was treated with a fixed-dose formulation of 3 nucleoside analog reverse transcriptase inhibitors: zidovudine, lamivudine and abacavir (Trizivir®).

In August 2000 he suffered the first clinical manifestation of coronary artery disease (CAD) when he was admitted for an inferior ST-elevation acute myocardial infarction (STEMI). In August 2004, after a new anterior NSTEMI, his left ventricular ejection fraction was 20%. From this moment on, the patient developed progressive shortness of breath and symptoms of right heart failure. He required several hospitalizations despite optimized therapy, and was referred to our heart failure and heart transplantation (HTX) unit for evaluation. Right heart catheterization showed non-reversible

![Figure 1. CD4+ T-cell count and percentage of lymphocytes, HIV-1 viral load, antiretroviral regimen and immunosuppressant drugs from heart transplantation to 24 months follow-up. cART, combined antiretroviral therapy.](image-url)
Closure of Ventricular Septal Defect After Surgical Septal Myectomy by Hybrid Procedure in an Adult Patient

Cierre de comunicación interventricular tras miectomía septal quirúrgica mediante procedimiento híbrido en un paciente adulto

To the Editor,

Iatrogenic ventricular septal defect (VSD) is a rare complication following septal myectomy that can cause a rapid postoperative hemodynamic deterioration. We report the case of a 76-year-old dyslipidemic, hypertensive woman who presented with a severalmonth history of progressive dyspnea. The diagnosis was severe degenerative aortic stenosis, severe hypertrophy of the basal septum (22 mm) with a subaortic gradient of 30 mmHg, and a mild double mitral valve lesion. On the basis of these findings and a EuroSCORE of 6, the decision was made to perform double valve replacement, mitral and aortic, with bioprostheses, as well as septal myectomy.

The postoperative course was indolent and the patient developed complete atrioventricular block that required implantation of a permanent pacemaker. Transesophageal and transesophageal echocardiography (TEE) led to the diagnosis of a VSD measuring approximately 5 mm following myectomy. This defect produced severe pulmonary hypertension (85 mmHg) with moderate-to-severe tricuspid insufficiency and a situation of low output (Fig. 1). Due to the progressive hemodynamic...