Sir,

The article of Hamamichi and colleagues[1] is very interesting, and important to our clinical practice. Although the reported diagnosis is uncommon, we have learnt that, in all young athletes, it is important to identify at least the normal origin of the left coronary artery. In our opinion, the description of the electrocardiogram can be improved. Thus, we would suggest that it showed normal sinus rhythm, normal PR interval, left anterior hemiblock, hyperacute anterolateral myocardial infarction (note the ST elevation in leads I, aV_L, V5, V6), and reciprocal changes of the ST segments in the inferior leads. The depression of these segments in leads V1, V2 and V3 can represent true posterior myocardial infarction. It seems to us that, in Figure 2, the septum does not seem to be involved. Rather, there is an anterolateral and posterior infarction.

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Reference

1. Hamamichi Y, Okada E, Ichida F. Anomalous origin of the main stem of the left coronary artery from the non-facing sinus of valsalva associated with sudden death in a young athlete. Cardiol Young 2000;10: 147–149.

The letter was shown to the authors, who replied as follows:

Sir,

We thank Doctors Roguin and Wishniak for their interest in our paper, and for their helpful comments concerning the electrocardiogram. It can, indeed, be interpreted as consistent with anterolateral and posterior myocardial infarction as they have suggested. The findings at autopsy, however, clearly showed an acute, and almost circumferential, transmural myocardial infarction extending from the base to the apex. The area of infarction included the anteroseptal region and papillary muscles, sparing only the posteroseptal region of the left ventricle, as shown in Figure 2. Left coronary arterial dominance was present, and this feature explains the almost circumferential myocardial infarction.

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