

LETTERS TO THE EDITOR

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Remote ablation of accessory pathways

We read with interest, pleasure, and satisfaction the recent study by Chun *et al.*¹ which definitively confirms our previous pivotal experience on the efficacy of remote ablation in hundreds of patients with single or multiple accessory pathways.^{2,3} However, in our experience, soft magnetic catheters (1 M, 3 M, or 3 M quadripolar) are all able to easily record the AP potential and once identified such important target, ablation of AP is successful in almost all patients regardless of the type of catheter.^{2–4} Obviously, it is easier to use 3 M quadripolar catheters particularly at the beginning of the learning curve but the success rate is similar as reported later by other authors.⁵ This pilot study by the St George Hospital group on few patients (18, 27, and 14 patients treated with 1 M, 3 M, and 3 M quadripolar catheters, respectively) in our opinion represents just a chronologic learning curve with remote ablation which gives a wrong message to the readers of the Journal, since the authors come to a conclusion that is exactly opposite to what is stated in the limitations. How can a limited non-randomized ‘chronological experience’, such as this, allow the authors to conclude that there is a ‘significantly improved efficacy of the procedure’ with the three-magnet quadripolar ablation catheter? This is not scientifically correct. Similarly, their pilot experience on AVNRT which reported a relatively low success rate with remote ablation again represents in our opinion the beginning of their learning curve with this novel system.⁶ Our previous extensive experience in hundreds of patients with AVNRT⁴ demonstrated that remote ablation is highly successful as in patients with AP suggesting that only when the operator is experienced with

magnetic navigation and ablation, randomized studies are appropriate to demonstrate a potential difference between catheters. We again thank the authors for reproducing our firstly reported results on remote ablation of AP since reproducibility is considered essential for scientific progress.

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Carlo Pappone

Department of Cardiology
Division of Electrophysiology
and Cardiac Pacing Unit
San Raffaele Scientific Institute
Via Olgettina
60 20132 Milan
Italy
Tel: +39 02 26437310
Fax: +39 02 26437326
Email: carlo.pappone@hsr.it

Vincenzo Santinelli

Department of Cardiology
Division of Electrophysiology
and Cardiac Pacing Unit
San Raffaele Scientific Institute
Via Olgettina
60 20132 Milan
Italy
Tel: +39 02 26437347
Fax: +39 02 26437326
Email: vincenzo.santinelli@hsr.it

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Otto Klein—the forgotten founder of diagnostic cardiac catheterization

Otto Klein’s pioneering work. Werner Forsmann introduced a catheter into his own heart in 1928 to show the feasibility of this technique for injection of drugs directly into the heart.

However, Otto Klein has to be credited for the first diagnostic right-heart catheterization. In 1929, he performed, as the first in the world, 11 successful right-heart catheterizations including passage of the catheter into the right atrium and right ventricle and estimated the cardiac output using the Fick principle. Cardiac output in three patients without heart disease was 4.5, 5.6, and 6.67 L/min. Klein presented his data during lectures in Prague (November 1929) and at the Congress of the German Society for Internal Medicine held in Wiesbaden (April 1930) and published his work in *Münchener Medizinische Wochenschrift*, 1930.¹ Unfortunately, he was not allowed to continue his studies by Professor Nonnenbruch, head of the II Medical Department, German Medical Faculty, Charles University, Prague.

When the Nobel Prize for diagnostic catheterization in 1956 was awarded to Forsmann, Courmand, and Richards, the Nobel Prize Committee was not aware of Klein’s pioneering work. It was only later,

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