**Bubbles in the Heart**

To the Editor:

The image by Catapano et al gives misleading information concerning bubbles in the heart in patients with prosthetic valves. They speculated that “bright particles” seen in the left ventricular cavity are consistent with gas bubbles that occur in scuba divers after hypobaric decompression. We disagree with this speculation, because this phenomenon is well documented in patients with prosthetic valves. In their large series, Gencbay et al found a strong correlation between serum lactic dehydrogenase levels and quantity of bubbles. They suggested hemolysis as a cause of bubble formation. Moreover, Kaymaz et al determined the prevalence of bubble formation in 279 patients with valve replacement and found that none of the patients with bioprosthetic valves demonstrated bubble formation. Bubbles were present, however, in 128 of 227 (56.4%) prosthetic mitral valves ($P<0.0001$). Bubbles were documented in 75.4% of the normal bileaflet valves compared with 38.5% of the tilting-disk valves in their cases ($P<0.0001$). Also in their study, the bubble intensity score was also significantly higher in the bileaflet valves. The passage of bubbles in the aortic root was not documented in any cases in their study. They concluded that bubbles are normal echocardiographic findings depending on the type and function of the mechanical prosthetic mitral valve.

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Response

Davutoglu et al argue that in our case bubbles may reflect hemolysis rather than a cavitation process. Indeed, hemolysis has been shown to be an effect rather than the cause of bubble formation. Surprisingly, the idea that cavitation is the mechanism triggering bubble formation is even supported by one of the authors to which Davutoglu et al refer. More specifically, Kaymaz et al state “The microbubbles occur at the inflow zone of the valve when flow velocity and pressure drop suddenly at the time of valve closing. The cavitation potential was correlated...” Furthermore, if hemolysis were an invariable effect of cavitation, the prevalence of hemolytic anemia in patients with prosthetic valves would be expected to be much higher than currently reported. To our knowledge, the highest prevalence documented is 30% in patients with double mechanical prostheses. In the case of our patient, then, hemoglobin was 14.7 g/dL, and LDH and bilirubin serum concentrations were within the normal range.

Second, Davutoglu et al point out that specific types of valve prosthesis vary substantially in their likelihood of being associated with bubbles in ventricular cavities. We were unable to discuss this issue in detail in our article, but our patient had a Carbomedics (No. 26) prosthesis.

Finally, in contrast to the assertion by Davutoglu et al, there have been several reports documenting the concomitant presence of cerebral gaseous emboli and bubbles in the left ventricle of patients with mechanical heart valves. Indeed, the elegant work by Lin et al documents that intracavitary bubbles can be sufficiently stable to reach the aortic root.

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Circulation. 2004;110:e51
doi: 10.1161/01.CIR.0000141258.69121.7E
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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