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was 14%. The cardiac output was normal. Because the cardiac aneurysm contributed very little or nothing at all to the cardiac output, there was no hesitancy in performing aneurysmectomy. After operation the ejection fraction rose to 58%, and there was no change in the basal cardiac output. After convalescence, he returned to work and is still working. He is asymptomatic. His echocardiogram indicates that left ventricular function has deteriorated during the past few months. He was last seen on July 19, 1993.

A 36-year-old man, an amateur tennis champion, suffered a myocardial infarction on August 12, 1969. Except for repeated bouts of Dressler's syndrome over a 14-month period, he remained asymptomatic and continued playing tennis until 1985, when a routine chest film showed a curvilinear calcification on the lateral film. The cardiac silhouette was mildly enlarged. Cardiac catheterization revealed a huge aneurysm occupying the distal half of the left ventricle. The global ejection fraction was 14%. The cardiac output was normal. Because the cardiac aneurysm contributed very little or nothing at all to the cardiac output, there was no hesitancy in performing aneurysmectomy. After operation the ejection fraction rose to 58%, and there was no change in the basal cardiac output. After convalescence, he returned to work and is still working. He is asymptomatic. His echocardiogram indicates that left ventricular function has deteriorated during the past few months. He was last seen on July 19, 1993.

We would like to thank Dr Soloff for his interest in our article.1 Our data support his argument that global ejection fraction is not the best measure of ventricular function in the presence of an aneurysm. Dr Soloff makes the point that calculating the ejection fraction of the aneurysmal portion of the left ventricle is a more physiological measure of ventricular function. In fact, as we mentioned in the “Discussion” section of our article, Garan et al reported that the ejection fraction of the nonaneurysmal segment calculated as an “excess ejection fraction” was a significant predictor of operative survival after subendocardial resection. However, a significant limitation of this technique is that it requires the presence of a visually discrete aneurysmal region to be an accurate measure of regional left ventricular function. A significant number of patients in our series had a dyskinetic anteropapal segment in which the visual boundaries between the dyskinetic and nondonyskinetic segments of the ventricle were difficult to define (as illustrated in Fig 3B of our article). We therefore did not measure the ejection fraction of the contractile portion of the left ventricle in our series but rather used centerline chord motion analysis to calculate regional wall motion. This method is a validated and relatively easy technique to measure regional left ventricular function that can be used in all patients.3
Meaning of ejection fraction after subendocardial resection.
L A Soloff

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