

aortic perfusion to the spinal cord, viscera, and lower extremities may obviate the need for deep hypothermia during aortic arch reconstruction.

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Repair of Anomalous Origin of Right Pulmonary Artery From Ascending Aorta: Double Trap-Door or Double-Flap?

To the Editor:

We appreciate Dr Pritfti and colleagues for their comments on our article [1]. In their opinion, the double trapdoor technique [2] that we employed to repair an anomalous right pulmonary artery from the aorta might enlarge the anastomosis area but would not adequately increase tissue length. He also raised the concern that the reconstituted aorta would have caused late compression of the right pulmonary artery (RPA) if it were placed posteriorly. His technique of using a segment of the aorta and placement of the RPA anterior to the aorta deserves consideration [3]. However, as experience gained from procedures such as the arterial switch operation, a thorough mobilization of both branch pulmonary arteries can provide significantly extra length to the arteries. In this case we did find very adequate length of tissue for the right pulmonary anastomosis. The tissue removed at the aorta in our technique is clearly much less than the one described by Pritfti and colleagues [1], which calls for removal of a ring of the ascending aorta 1.5 times more than the diameter of the RPA. In our case, with extensive mobilization of the brachiocephalic vessels, the aorta was anastomosed with no tension. Therefore, we do not think that placement of the right pulmonary branch anteriorly would be necessary.

Again, we have found the technique described in our article works well for its intended purpose. The patient was seen recently more than 2 years after the repair. The transthoracic echocardiography confirmed normal growth of the right pulmonary artery with no obstruction.

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Compensatory Sweating After Thoracoscopic Sympathectomy Deserves More Attention

To the Editor:

We read with great interest the article by Dumont and associates [1]. Compensatory sweating after thoracoscopic sympathectomy has been widely discussed in Taiwan society in the past few months.

Lots of people in Taiwan suffer from hyperhidrosis palmaris [2]. Thoracoscopic sympathectomy is covered by the National Health Insurance, and patient billing for this operation does not exceed \$60 in United States currency. This is why this operation is so popular here. In 2001, there were 7,504 claims to the Bureau of National Health Insurance for this type of operation. Many people have undergone this type of operation, and there are quite a number of people bothered by postoperative compensatory sweating.

Patients with serious compensatory sweating must change clothes several times a day (eg, some patients complained that they change as often as 10 times per day), resulting in serious impact on work and social interaction. Patients suffering from such serious side effects in Taiwan have formed a support group based on an Internet discussion forum to request the government to take this problem seriously (see: <http://home.pchome.com.tw/family/vivi12175/>). Starting in October 2004, The Department of Health, Executive Yuan, Taiwan prohibited surgeons from performing this operation on patients younger than 20 years of age. At the present time, this support group is striving to promote a total ban on performing this type operation in Taiwan. To our knowledge, this type of support group also exists in England, Sweden, Spain, and Japan.

Our current knowledge on compensatory sweating is very limited. Based on our personal experiences, compensatory sweating does not improve after removal of the clips in patients who underwent the clipping method operation. Informing the patient of the seriousness of the consequences before this operation is absolutely necessary.

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Reply

To the Editor:

We thank Dr Hsu and colleagues for their comments [1]. The two points about the existence of support groups and clip use are very interesting. I think that the same groups exist or will soon exist in Europe. This incites us to extreme caution concerning surgical indications. The best indication is patients with palmar dripping.

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Compensatory Hyperhidrosis after Thoracoscopic Sympathectomy

To the Editor:

Dumont and colleagues [1] raise the issue again of compensatory sweating (CH) after thoracoscopic sympathectomy for hyperhidrosis, but leave unanswered the basic question of whether the specific level of sympathectomy influences the frequency and severity of CH. Are there different rates and severities of CH between sympathectomies at T2 alone, T3 alone, T2-3 combined, T2-4 combined, or T3-4 combined? No study has definitively shown a difference, and it is likely that the incidence of CH at the various levels approximate one another. Perhaps far more important with regard to extent and patient acceptance of CH is appropriate patient selection for the procedure. The patient's preoperative and postoperative perceptions of the sweating disorder are critical in patient satisfaction and postoperative complaints. Someone with massive severe palmar sweating who had surgery that cured his hands but causes severe back wetness will nonetheless be extraordinarily happy with the surgery. Conversely, someone who has less severe palmar sweating who had the same amount of postoperative back wetness develop might be very disappointed. The level and intensity of the preoperative problem will determine what the patient is willing to endure to achieve a cure for the original problem.

In our experience, the ideal patients for thoracoscopic sympathectomy have the following four characteristics: (1) profound level of hand sweating, to the point of dripping or near dripping; (2) near equal level of plantar to palmar hyperhidrosis, with or without severe axillary hyperhidrosis; (3) spectacular exacerbation of palmar hyperhidrosis with application of ordinary hand lotion; and (4) bimodal time of onset of the disorder, either in early infancy or puberty. Although patients without all four of these characteristics have received gratifying surgical success, it can be said with confidence that it is almost unheard of for the patients who do have these four hallmarks and who have

undergone curative thoracoscopic sympathectomy to have regrets after the operation, regardless of the presence or absence of severe CH. It can be further stated with confidence that thoracoscopic sympathectomy is the treatment of choice in these patients, and there is not a nonoperative treatment (including aluminum chloride, iontophoresis, anticholinergics, and botulinum toxin injection) that will have any significant long-term curative benefit whatsoever [2, 3]. A family history of the disorder is a strong corroborator as well, and was found in at least half of the patients in our series [2].

Although surgical sympathectomy at various levels, usually between T2 to T3, is curative for palmar hyperhidrosis, the critical importance of proper patient selection in achieving a true surgical success cannot be overestimated.

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Reply

To the Editor:

We thank Dr Baumgartner [1] for his interest in our study and we greatly appreciate the comments. I agree with his use of the four characteristics mentioned and his consideration of family history. Other criteria I consider are sweat stopping during sleep, and the wearing of blue jeans (cotton is very convenient for wiping hands). At the first contact with the patient, it is easy to establish if it is a typical form or not. For the non-typical forms, we are very prudent and rather dissuasive in regard to surgery.

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