

Tight BP Control Maintains Aortic Repair

BY BRUCE JANCIN

FROM THE ANNUAL MEETING OF
THE AMERICAN SURGICAL ASSOCIATION

BOCA RATON, FLA. – Beta-blocker therapy and strict, lifelong control of hypertension are key to avoiding late reoperation after repair of acute type A aortic dissection, including in patients with Marfan's, according to a large, 25-year, single-center follow-up study.

Operative mortality was 16% among 252 patients who underwent repair of acute type A aortic dissection at the hands of 26 surgeons at Barnes-Jewish Hospital in St. Louis during 1984-2009. Of 28 variables that were scrutinized in a multivariate analysis, only one proved to be an independent risk factor for operative mortality: branch vessel malperfusion at presentation, with an

associated 2.5-fold increased risk, Dr. Spencer J. Melby reported at the meeting.

Some 27 of 211 operative survivors required 30 late reoperations. Four variables were independently predictive of late reoperation: male sex, Marfan syndrome, not being on a beta-blocker at last follow-up, and systolic blood pressure (SBP) greater than 120 mm Hg, according to Dr. Melby of Washington University in St. Louis.

The rates of freedom from reoperation among patients on beta-blocker therapy at 10 and 15 years were 86% and 83%, respectively, compared with 57% and

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Major Finding: The rates of freedom from reoperation after aortic dissection repair among patients on beta-blocker therapy at 10 and 15 years were 86% and 83%, respectively, compared with 57% and 37% in patients not on the medication.

Data Source: A follow-up study of 252 patients who underwent repair of acute type A aortic dissection at a single center during 1984-2009.

Disclosures: Dr. Melby said that he has no relevant financial interests.

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37% in patients who were not on the medication.

Patients who maintained their SBP below 120 mm Hg had 10- and 15-year rates of freedom from reoperation of 92%. Among those whose SBP was 120-140 mm Hg, the rates were 74% and 66%. In patients who maintained SBP in excess of 140 mm Hg, the 10- and 15-year rates of freedom from reoperation were 49%

and 30%.

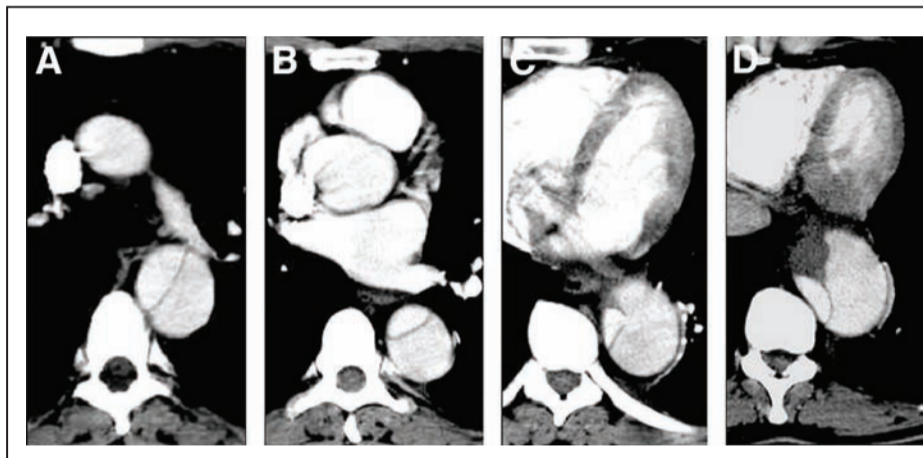
In terms of perfusion techniques that were utilized in the initial repair, 35% of patients were placed on an aortic cross-clamp only, 30% had hypothermic cardiac arrest with retrograde cerebral perfusion, and 35% got hypothermic cardiac arrest without retrograde cerebral perfusion.

Importantly, long-term survival was not related to operative approach. Late survival was decreased, however, in patients with previous stroke or chronic renal insufficiency.

Discussant Dr. Thoralf M. Sundt III noted that although acute aortic dissection is an uncommon condition, it is nonetheless the most common fatal catastrophe of the aorta. Multiple studies over the years indicate that not much progress has been made in improving the high perioperative and long-term morbidity and mortality.

"We don't seem to be learning very much over time. It's not getting better. So a study such as this one that can impact the long-term results in these patients is important," said Dr. Sundt, chief of cardiac surgery at Massachusetts General Hospital, Boston.

He particularly welcomed Dr. Melby's emphasis on lifelong beta-blocker therapy. ■



Spiral computed tomography shows a chronic aortic dissection of the descending thoracic aorta in a patient with Marfan's syndrome (images A to D).

Think Raynaud's When Nursing Moms Say "Ouch!"

BY MICHELE G. SULLIVAN

FROM THE AMERICAN ACADEMY OF
DERMATOLOGY'S SUMMER ACADEMY
MEETING

NEW YORK – Raynaud's phenomenon can cause nipple pain in breastfeeding mothers – but a small case series found that it is almost always misdiagnosed.

Of 86 women in the series – the largest ever accrued – 24 patients had Raynaud's, all of whom were misdiagnosed as having fungal mastitis, Dr. Honor Fullerton Stone and her colleagues reported in a poster presented at the American Academy of Dermatology's Summer Academy Meeting.

Although the physical exam can be complicated by other factors – a flare of atopic dermatitis or a fungal or bacterial superinfection – Raynaud's should always be considered in the differential diagnosis of lactating women with nipple pain, according to Dr. Fullerton Stone of Stanford (Calif.) University.

She presented a chart review of 86 lactating women complaining of nipple pain; the cases were accrued from 2004 to 2010 in a single medical center. Of these, 24 (28%) were diagnosed with Raynaud's, based on the presence of at least two of the following diagnostic characteristics:

► Color changes of the nipple (blue, white, or red), especially with exposure to cold.

► Cold sensitivity or color changes of acral surfaces with cold exposure.

► Chronic deep breast pain for 4 weeks or longer and failed therapy with oral antifungals and/or antibiotics.

All 24 women with Raynaud's presented with enlarged breasts, mild to moderate erythema of the areola, and desquamation of one or both nipples. Two also had plugged milk ducts.

All were initially diagnosed as having a candida breast infection. Ten of them reported that their babies had experienced an episode of oral thrush. And 20 of the 24 (83%) had been unsuccessfully treated with topical or oral antifungals, including at least one course of fluconazole (18; 75%).

Two also had a skin superinfection, growing *Staphylococcus aureus* on a bacterial culture; these women also received a course of oral antibiotics.

After being diagnosed with Raynaud's, about 16 (67%) received a course of nifedipine; 3 discontinued the drug because of headache, dizziness, or nausea. Of the 13 who continued the drug, 10 (77%) reported a decrease or elimination of their nipple pain.

Other Raynaud's-specific treatment included advice to wear warm clothing, to take hot showers before nursing, and to avoid caffeine and other vasoconstrictive drugs that could precipitate symptoms.

In addition to the Raynaud's-specific treatment, all of the women were treated for accompanying issues, including

breast dermatitis and antifungal therapy.

All received a prescription for a low- or moderate-strength hydrocortisone butyrate cream or alclometasone dipropionate to be applied twice a day for 2 weeks. They were also told to apply Aquaphor two or three times daily, over the steroid cream. Most (23) also had an additional standard course of oral fluconazole (400 mg on day 1 followed by 200 mg daily for the next 8-10 days).

Twenty women participated in a follow-up survey. Most (15, 75%) also reported that they had cold sensitivity or color changes in their hands and feet.

Two reported having been diagnosed with an autoimmune disease – either lupus or Sjögren's syndrome, and two reported having had a breast cyst removed.

They also described the pain they experienced during a Raynaud's episode of the nipple.

All said the pain continued throughout breastfeeding; 25% said that the pain increased during the beginning of lactation. Most, however, (75%) said the pain occurred before, during, and after breastfeeding.

Since the physical exam may be inconclusive, the quality of the pain can be a diagnostic clue to Raynaud's in the nursing mother, Dr. Fullerton Stone not-

ed. Letdown pain is more common in the weeks after birth, and usually improves. It is typically experienced as a mild pain during the first minutes of breast feeding, which may continue for 12-15 minutes afterward.

Candida infections are described as causing moderate, burning pain that is worse when the baby latches on for a nursing session. The pain can radiate from the nipple throughout the breast; it

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Major Finding: All (24) lactating women with Raynaud's of the nipple were initially diagnosed as having a fungal breast infection.

Data Source: A retrospective review of 86 lactating women with a complaint of nipple pain; the cases were accrued from 2004 to 2010 in a single medical center.

Disclosures: Dr. Fullerton Stone had no financial disclosures.

typically improves dramatically within the first few days of oral antifungal treatment.

Raynaud's is usually described as moderate sharp, shocking-type, or throbbing pain before, during, and after nursing.

As is typically observed with Raynaud's of the hands and feet, there is a color change that signifies the vasoconstriction characteristic of the disorder.

Dr. Fullerton Stone said she had no financial declarations with regard to her work. ■