Authors have nothing to disclose with regard to commercial support.

PECTUS EXCAVATUM: A RARE CAUSE OF DYSPHAGIA

To the Editor:

I read with great interest the case report by Borrhomé and colleagues,¹ which presented a rare symptom of recurrent syncope caused by right ventricular obstruction by pectus excavatum (PE) with a history of repeated median sternotomy for repair of a ventricular septal defect and infundibular stenosis. After cardiac surgery, adhesions between the sternum and the mediastinum developed and fixed the heart in position, which led to severe cardiac compression and disruption of right ventricular filling by PE.

PE is a congenital chest wall deformity and causes cardiopulmonary symptoms due to compression of the heart and lungs.^{1,2} A rare case of inferior vena cava compression resulting in lower-extremity edema from PE was reported.³ I would like to share our experience of another rare symptom due to PE. A 23-year-old man presented with chest discomfort and a feeling of fullness after

eating. His chest appeared extremely sunken (Figure 1, A). Chest computed tomography scans showed severe depression of the anterior chest wall with indentation on the heart and liver and inadequate space around the esophagus (Figure 1, B). He underwent the modified Nuss procedure under the assistance of a 2-mm needle-scope, and the symptoms were relieved. Pectus bar insertion elevating the anterior chest wall resulted in release of the cardiac compression and enough space for esophageal peristalsis. The Haller index changed from 37.5 to 2.76. Correction of PE alleviated the swallowing symptoms.

There has been no report of swallowing disturbance due to narrowing of the space around the esophagus by PE. In our case, the Nuss procedure provided enough space for esophageal peristalsis and relief of the swallowing symptoms.

Sang Yong Kim, MD, PhD^a

Jin Yong Jeong, MD, PhD^b

^aDepartment of Pediatrics

^bDepartment of Thoracic and Cardiovascular Surgery

Incheon St. Mary's Hospital

College of Medicine

The Catholic University of Korea

Seoul, Republic of Korea

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should: • Include no more than 500 words of text, three authors, and five references. • Type with double-spacing. • See <http://jtcvs.ctsnetjournals.org/misc/fora.shtml> for detailed submission instructions. • Submit the letter electronically via jtcvs.editorialmanager.com. Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity of offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.

References

1. Borrhomé S, Lenoir M, Gouton M, Fadel E. Syncope caused by right ventricular obstruction by pectus excavatum. *J Thorac Cardiovasc Surg.* 2016;151:e67-9.
2. Mansour KA, Thourani VH, Odessey EA, Durham MM, Miller JJ Jr, Miller DL. Thirty-year experience with repair of pectus deformities in adults. *Ann Thorac Surg.* 2003;76:391-5.
3. Iannucci GJ, Slesnick TC, Kogon B, Samai C. Lower extremity edema in a child due to pectus excavatum. *Ann Thorac Surg.* 2015;99:e29-30.

<http://dx.doi.org/10.1016/j.jtcvs.2016.04.012>

FIGURE 1. Pectus excavatum with severe depression of the anterior chest wall (A) leading to inadequate space around the esophagus (red circle), resulting in dysphagia (B).