rhythm occurred after a period without apnoeas.³ On the other hand, atrial fibrillation usually reduces cardiac output and the reduced cardiac output may lead to central apnoea during sleep, mainly owing to the chemoreflex enhancement and prolonged lag to ventilatory response.⁵ We should further clarify whether subjects with atrial fibrillation have a central apnoea pattern by polysomnography.

Atrial fibrillation is a common arrhythmia with associated complications of stroke and other adverse outcomes. Furthermore, atrial fibrillation is an extremely costly public health problem; the direct cost of atrial fibrillation was estimated as 459 million in the year 2000, equivalent to 0.97% of the total National Health Service expenditure.⁶ This study suggests that the detection of SDB and its successful treatment could be one of the public health approaches to reduce the risk and the cost of atrial fibrillation.

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TT, TS and HI designed the study. TT, KY, SS, HN and IM collected and analysed the data. IM and TT carried out statistical analysis of the data. HI, TT and TS coordinated the study. The manuscript was prepared mainly by TT and HI, with contributions from SS, KY and TS.

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IMAGES IN CARDIOLOGY

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Unusual diagnosis of ascending aorta dissection with left ventricular angiogram

Left ventricular angiogram after ejection of the contrast product. Note the intimal flap in the ascending aorta between the true and the false lumen. See video 1 to observe retrograde opacification of the false lumen.

A 49-year-old patient with no medical history was referred to the cardiology department for an acute coronary syndrome. The patient presented with an acute, oppressive chest pain associated with nausea. Physical examination showed symmetric arm blood pressure, all peripheral pulses were present, and there was no evidence of cardiac murmur or abdominal signs. The ECG showed an ST segment elevation on the anterior leads. A coronary angiogram was performed showing normal coronary arteries. The left ventricular angiogram showed an acute dissection of the ascending aorta (see panel and video 1; to view video footage visit the *Heart* website—<http://www.heartjnl.com/supplemental>). The delayed retrograde opacification of the false lumen toward the aortic root suggested a site of origin close to the aortic arch. The patient was prepared for emergency cardiac surgery. In the operating room, the patient's pressure collapsed while transoesophageal echocardiography showed a total obliteration of the ascending aorta by the false lumen (videos 2 and 3) resulting in cardiac arrest. Extracorporeal circulation was quickly instituted between the right femoral artery and the right atrium. Surgical treatment consisted of the resuspension of the native aortic valve and sus coronary replacement of the ascending aorta (26 mm Dacron tubular graft). The intimal tear was localised close to the origin of the innominate artery and removed with the ascending aorta. The patient recovered with an uneventful postoperative course. A wide range of clinical manifestations characterise aortic dissection. The diagnosis of ascending aorta dissection should be evoked even in the case of typical acute coronary syndrome.

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