seems that the common trunk arising from the right coronary sinus divides into the RCA and LAD just after the division. The LMCA then divides into the LCx and LAD. The RCA is dominant and turns at the apex. The authors' Figures 1 and 2 show the courses of both arteries very well.

We recently published a report about a single coronary artery in a patient who presented with inferior myocardial infarction.² The LMCA arose from the same ostium of the RCA. The LMCA then followed an unusual course to the left side and divided into the LAD and LCx. The LCx was occluded just after the division. We performed primary percutaneous coronary intervention with use of a Judkins left 3.5 guiding catheter.

Single coronary artery has been diagnosed in only 0.3% to 1.3% of patients who have undergone coronary angiography.³ When the anomaly presents with acute myocardial infarction, cannulating the ostium and performing percutaneous coronary intervention is difficult. Successful intervention necessitates appropriate catheter selection and skill on the part of the operator.

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Giant Coronary Artery Aneurysms

To the Editor:

I appreciated the case report and literature review on giant coronary aneurysms by Crawley and colleagues.¹ Their report details the various facets of this unusual condition and its management.

In 2009, my colleagues and I reported our experience with a patient who had multiple giant coronary aneurysms.² In Crawley and associates' patient, it is notable that the large aneurysm size was diagnosed on coronary angiography, which indicated a lack of aneurysmal sac "content." In our patient, and similar to aneurysmal disease elsewhere in the body, the aneurysms' sacs contained large amounts of debris, and the true sizes of the aneurysms were found intraoperatively. Our patient underwent mitral valve repair 6 years later for severe mitral regurgitation and continues to do well.

I thought that I would mention our earlier case, to augment Crawley and colleagues' nice review.

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