Reply to the Letter to the Editor

Reply to Tang

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We appreciate Dr Tang’s interest in our study and are grateful for the opportunity to answer her questions. The basis for treatment selection in our study was not elusive, but based on the decision of a surgeon to try a new management strategy. Innovation can only happen if individuals have the courage to commit themselves to a new way. We were intrigued by the assumption that our diagnosis of sternal osteomyelitis rested largely on a clinical impression and not on microbiological criteria. In the methods section we explicitly described the microbiological culture findings for all patients in both groups [1]. As the extent of infection and type of organisms were comparable in both groups, the presented data cannot invalidate the comparison between these modalities. We agree that adequate wound debridement is an important cornerstone for eventual successful outcome, and practice radical wound debridement of all avital and infected tissues. Repetitive wound debridement was not necessary in all but one of our patients (in the conventional group). Also, at 5 weeks follow up, after discharge from rehabilitation, none of the patients had developed late fistulas or sinus formation involving sequestrated pockets of infected or necrotic tissues. Dr Tang points out two ways in which vacuum assisted therapy contributes towards a successful outcome of a sternotomy wound infection. However, she does not mention the foremost advantage over conventional therapy, which is the accelerated formation of granulation tissue. We demonstrated that even large defects can be covered within a short period of time and additional mutilating surgery can be avoided. That is the essence of our single centre experience.

Reference


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Thus we believe, for several reasons, that simple closure of the mouth of the aneurysm is a satisfactory mode of treatment for such entity:

1. The distending high pressure in the aorta is essential for progressive enlargement of the aneurysm, and hence, simple closure of the mouth will halt the process.
2. Gradients across the ventricular outflow tract are due to distended and bulging aneurysm. Once the aneurysm collapses, the obstruction will disappear.
3. Very often, the wall of the aneurysm is calcified and sometimes the aneurysm sac extends up to the apex of the heart. In such conditions, resection may not only be time consuming but hazardous.

Similarly, Bapat and colleagues in their experience [3], and several other investigators have also reported simple closure of the mouth as treatment modality.

Special mention should be made about the aortic valve replacement in presence of a large and/or calcified mouth. In such conditions, if the valve sutures are passed across the mouth of the aneurysm to obliterate its opening, there are high chances that the sutures will be under tension and would give way. This may have happened in cases handled by Wu and colleagues and Bapat and colleagues. In such cases, we always close the aneurysm opening with a prosthetic patch, and if aortic annulus is not spared, the valve sutures are passed through the lower end of the patch.

References


I agree with Dr Shiv Kumar Choudhary that the mouth of the aneurysm can be simply closed if the opening of the aneurysm is from 4 mm to 2 cm and the wall of the aneurysm is calcified or strong enough. Then the aortic valve can be repaired or replaced. Actually, we had one patient like that using the same procedure.

Unfortunately, in some patients, the mouths of the aneurysms were very large and the aneurysms extended to the mitral valve and the right ventricular outflow tract. The walls of the aneurysm were very weak and fragile due to edema. Some aneurysms even had communications with the left ventricle. The wall of the aneurysm would be torn if we just simply close the mouths of the aneurysm. We encountered this kind of situation in our first patient. We first explored the pathology of the aneurysm and considered the cause of the aneurysm before we were able to decide which way was better to solve this problem. We think that the pathology of the aneurysm may be different and still unclear, therefore, different methods should be taken into consideration correspondingly.

Letter to the Editor

Ostial coronary artery stenosis following aortic valve surgery

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The excellent image that was printed in the July 2002 issue of the EJCTS by Zamvar et al. [1] was a graphic illustration of the potentially serious complication of ostial stenosis following coronary cannulation during aortic valve replacement.

Having experienced two similar complications in the last