Reply to the Letter to the Editor

Reply to Raja

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We thank Dr Raja for his comment, and we are very glad that the article by my colleagues and me arouses interest. We fully agree that in case of excessive postoperative chest tube output, aprotinin, desmopressin, and platelet transfusion may reduce or control bleeding. We also agree that the results of our study contradict the expected effect of clopidogrel administration. It is clear that clopidogrel, like aspirin, irreversibly inhibits platelet aggregation for their lifetime. However, the decision to discontinue aspirin preoperatively in patients undergoing coronary artery bypass grafting (CABG) is still controversial. Dacey and colleagues [1], on behalf of the Northern New England Cardiovascular Disease Study Group, have shown that preoperative aspirin use was associated with a decreased risk of mortality in CABG patients without significant increase in hemorrhage, blood product requirements, or related morbidities. It has also been shown that aspirin did not increase bleeding-related complications in either on- [2] or off-pump [3] CABG. Recently, Woo and colleagues [4] reported similar bleeding, transfusion requirements, and reexploration rates in patients exposed to clopidogrel treatment compared to the patients who did not receive clopidogrel before off-pump CABG.

The first few cases in our practice were patients requiring emergent surgery, in whom it was impossible to delay the surgery. The encouraging results of these patients influenced our clinical practice and now, we do not delay surgery in a patient exposed to clopidogrel.

It has been documented that the risk of dying while waiting for CABG is 1.3% per month making a peak in first 2 weeks [5]. It should be always remembered that to minimize the risk of the ‘death on the waiting list’, CABG must be offered within a week after diagnostic coronary angiography, even for ‘elective’ cases.

In an era in which CABG is performed with 1–2% mortality rate, it seems not to be rational to delay the surgery in patients exposed to clopidogrel.

References


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Letter to the Editor

Which is better for treatment of mediastinitis following heart surgery, omental or muscle flap transfer?

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With great interest, I read the paper by Klesius and associates, entitled ‘Successful treatment of deep sternal infections following open heart surgery by bilateral pectoralis major flaps’ [1]. They conclude that bilateral pectoralis major flap repair is a safe technique to cure severe mediastinitis necessitating complete sternal resection, and that cosmetic results as well as stabilization of the chest were good. Post-sternotomy mediastinitis is problematic for cardiac surgeons because of its lethal outcomes. While I congratulate their excellent clinical results, I have some comments about their strategy for infective mediastinitis.

I have also experienced infective mediastinitis after open-heart surgery [2,3]. Our strategy for mediastinitis is complete debridement and omental transfer with or without continuous mediastinal irrigation for a couple of days. Muscle flap transfer is limited to cases whose omentum is not available because of post-omentumectomy or multi-laparotomy. For treatment of infective mediastinitis, occupying the dead space after debridement, antibiotic therapy, and draining exudates are inevitable procedures.