Regarding the valve repair and the modified Alfieri stitch, after initial repair, we obtained a competent valve and also severe outflow obstruction due to systolic anterior motion (SAM) that we unsuccessfully tried to address with a conventional A2–P2 Alfieri repair. SAM persisted; hence, we removed the midline A2–P2 Alfieri stitch and placed a new edge-to-edge stitch now between the A1–P1 segments as shown in the picture. Actually, in the picture, we can see the most anterolateral of the two sets of GoreTex neochordae (in the A2 scallop close to A1) used to correct the prolapse of A2. We can also see the green pledgeted Ti-Cron sutures used for the posterior annulus plication after the quadrangular resection that mark the midline of the mitral valve. With these two references, it is clear that the newly placed Alfieri stitch was moved, as explained in the text, towards the anterolateral commissure and now holds the A1–P1 scallops together. We hope this helps clarify this technique that allowed us to preserve the mitral valve in this case of complex repair for myxomatous bileaflet prolapse.

REFERENCES


Della Pona et al. recently reported a case of ‘absolute’ contraindication to percutaneous tracheostomy due to anomaly of aortic-arch branches’ origin [1]. We are less convinced.

Percutaneous dilatational tracheostomy (PDT) has become the procedure of choice in many intensive care units for patients who need the ventilator support [2] but is still argued for patients with some relative contraindications, such as anatomic difficulty, obesity, and coagulopathy. Here, we present a case of a 76-year-old male patient who underwent total arch repair for aortic-arch aneurysm. Postoperative chest computed tomography revealed a high-riding artificial graft crossover of the cervical trachea. PDT was scheduled due to respiratory failure. After bedside sonography checking, the percutaneous tracheostomy was performed with Blue Rhino Cook (Bloomington, IN, USA). The postoperative course was uneventful, and he was weaned successfully from mechanical ventilation 1 month later.

Although the tracheoinnominate artery fistulae, a rare complication after tracheostomy, have also been reported by Cohen et al. [3], the advantage of PDT, including more tamponading [4] and less wound-infection rate, could avoid repeated disturbing movement around the wound and resulted in erosion of the closed artery. Therefore, PDT might be a better choice in this kind of situation than open tracheostomy.

The only absolute contraindication for tracheostomy is skin infection and prior major neck surgery which complete obscures the anatomy [5]. Those perceived relative contraindications and guidelines potentially exclude a significant number of patients from the benefits of undergoing PDT and subsequently lose the possible chance to wean from mechanical ventilator, such as the patient we reported in this case. In our opinion, PDT should be evaluated individually and could be performed safely and accurately by the thoracic surgeons who are experienced with standard surgical tracheostomy in intensive care units, especially for those patients with the relative contraindications.

REFERENCES