• The line for urine output (at the proximal tip of the Foley catheter) must be occluded to avoid aspiration of air.
• In case of a fall in blood drainage, gentle retraction of the venous cannula may improve the aspiration.

There are several possible pitfalls of our technique:
• The right atrium must be opened to push the Foley catheter toward the caval veins. In cases of isolated mitral surgery, incision of the right atrium for internal snaring is not recommended.
• We had no experience of patients with pacemaker wires.
• The central venous line should be retracted away from the SVC to avoid interference with the occlusion.

4. Conclusions

In conclusion, internal snaring may represent a ‘trick’ in some specific situations in lieu of external dissection. The technique appears to have particular utility in reoperations where it is desirable to avoid extensive external dissection of the atrio caval junctions. However, the number of patients treated in this way has been small, and the risk of pitfalls is certainly an issue for further debates, to be clarified by increased experience with this approach.

References


eComment: Right thoracotomy for mitro-tricuspid valve redo surgery

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I think the concept proposed by Sansone et al. [1] is very interesting. The maneuver with two Foley catheters into the right atrium can adequately control a very delicate situation such as the proper drainage of both venae cavae during a mitral/tricuspid reoperation. As the authors mention [1], this maneuver is only applicable for cases in which a tricuspid surgical procedure is needed. My experience is limited to 13 cases operated on for redo mitral valve surgery through a right thoracotomy with unclamped aorta and ventricular fibrillation [2]. Of these, only 5 cases have required tricuspid surgery. Dissection of both venae cavae has been without problems. However, when there was need for cardiopulmonary bypass quickly, we used special clamps to occlude the vena cava with the venous cannula included. So, minimal or no dissection around the vena cava is employed. But note that the scenario described here by Sansone et al. [1] is slightly different to the traditional approach used by me to cannulate the venae cavae through the same thoracotomy. Over the course of my practice, I have found that the inferior vena cava is sometimes difficult to occlude completely from inside because of its great diameter. However, in this discussion, I take a broader view and assume that the Foley catheter introduced into the inferior vena cava was uneventful. I hesitate to draw profound conclusions, per se, from these data other than to emphasize the diversity of the actual surgical armamentarium in order to address these special situations.

References