isation. Furthermore, it allows the surgeon to operate from the right side of the patient.

Adequate and sustained haemodynamic support was achieved in these high-risk patients without significant complications, thus reducing peri-operative risk.

The femoral artery remains the route of choice. Transbrachial route should be considered as an alternative for patients with coexisting peripheral vascular disease. The main limitation has been due to the small diameter of the brachial artery. Report from the first transbrachial insertion of an 8Fr IABP [6] did result in left-hand hypo-perfusion necessitating early withdrawal of the IABP.

The availability of smaller 7.5Fr IABP catheters facilitates safe transbrachial insertion as described.

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References


eComment: Extended duration of brachially inserted intra-aortic balloon pump for myocardial protection in two patients undergoing urgent coronary artery bypass grafting

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Patients with existing impaired cardiac function are considered to be high-risk candidates for cardiac surgery. Anesthetic agents and the procedure itself can place increased myocardial oxygen demands on the already impaired heart. Use of intra-aortic balloon pump (IABP) provides haemodynamic stability by assisting in balancing myocardial oxygen supply and demand, preoperatively, intraoperatively, and during the critical post operative period when the demands on the heart are particularly high. Traditionally, the femoral artery access is used for IABP insertion. The submitted report [1], which is devoted to the technique for left trans-brachial insertion of an IABP in patients with concomitant occlusive peripheral vascular disease, seems very interesting because in such cases we should keep that method in our mind. But by applying that technique there is a high risk of the development of neurological complications. So that maybe it would be safer to use left trans-subclavian insertion of an IABP.

Reference