LONG-TERM PATENCY VERSUS LEG WOUND HEALING IN CORONARY ARTERY BYPASS SURGERY: SURGICAL ASPECTS OF THE NO-TOUCH HARVESTING TECHNIQUE

Reply to the Editor:

We thank Kopjar and colleagues for the constructive and thoughtful comments in their letter. We undoubtedly agree regarding the reluctance of surgeons to adopt the no-touch (NT) harvesting technique, despite considerable evidence supporting its contribution in improving the results of coronary artery bypass grafting. We believe that the main issue for preventing the NT technique from being internationally embraced is that it is a completely new technique for many and that all new surgical techniques require some considerable time for the surgeons to become familiar with and eventually implement them.

Furthermore, if the NT technique is not used correctly, as previously described,¹ wound complications may occur more often. There are some aspects that are very important to improving wound healing, such as preoperative ultrasonographic mapping of the saphenous vein (SV). This practice has been shown to reduce the size of the scar and the harvest time, in addition to minimizing unnecessary incisions.² Likewise, mapping of the SV allows us to select in advance the segment of the SV most suitable for grafting.

We emphasize that it is crucial to follow every aspect of the technique from harvesting to grafting. To be precise, it is not only essential to harvest the vein with a pedicle but also to avoid directly grasping the vein with surgical instruments. In addition, checking for leakage should be performed with the SV connected to the arterial line of the heart-lung machine, instead of with high-pressure distention by syringe.

To date, we have operated on more than 3000 patients with the NT harvesting technique, and by implementing this technique as described previously we have managed to reduce wound healing complications considerably. This has also been shown in a recently published study, in which functional wound healing was similar between the NT and conventional harvesting techniques 12 months after surgery.³ We are convinced that when cardiac surgeons get accustomed to the NT technique, they will appreciate and never abandon it.

We would certainly prefer a conduit that performs longer, even if there is a higher risk for wound infection. An ideal situation would be to have a superior conduit combined with minimal risk of harvesting complications. Mannion and colleagues⁴ showed in a recent study that NT vein grafts harvested with an open technique had a higher patency rate than did traditionally endoscopically harvested veins, but

the NT group did have significantly higher harvest site complications. Our future aim therefore must be to harvest the SV with an endoscopic NT technique or to develop a minimally invasive NT technique.

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<http://dx.doi.org/10.1016/j.jtcvs.2015.10.025>

COR TRIATRIATUM DEXTER: MORE THAN A SIMPLE MEMBRANE

To the Editor:

We read with interest the article published by Hussain and colleagues¹ entitled, "Cor Triatriatum Dexter: A Rare Cause of Myocardial Infarction and Pulmonary Embolism in a Young Adult." In the wake of that reading, we would like to make a few comments that we believe to be important.

Myocardial infarction described by Hussain and colleagues¹ fits well within the context of a cor triatriatum dexter, an atrial septal defect, and a right-to-left shunt. We should keep in mind, however, that pregnancy itself may be a risk factor for myocardial infarction, increasing its incidence by 4 or 5 times relative to the risk in nonpregnant women of similar age. For this reason, we should rule out other diagnoses, such as atherosclerosis, spontaneous coronary dissection, fibromuscular dysplasia, or coronary thrombosis without evidence of atherosclerotic disease.² Although the age of the patient does not suggest an atherosclerotic etiology, we should rule out cardiovascular risk factor such as smoking, obesity, arterial hypertension, hypercholesterolemia, diabetes mellitus, drug abuse, or family history of acute coronary events.