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REPLY FROM THE AUTHORS: MINIMALLY INVASIVE ALTERNATIVES IN DEVELOPING COUNTRIES: EXCESS OR NEED?

Reply to the Editor:

We sincerely thank Vervoort and colleagues¹ for their valuable contribution to highlight the central message of our case. The surgical scar is definitively the only sign of a cardiac repair or palliation, and surgeons should make every effort to reduce the number and dimension of incisions. On the other hand, increased expertise and available sources have decreased the risk related to re sternotomy.² The question is, how much of this consideration is applicable outside developed countries?

The management of univentricular physiologies must consider the benefit to the patient, which is the first and leading goal of each procedure. A beneficial effect means reducing risks (as those encountered when performing re sternotomy, such as bleeding) when you cannot rely on

plentiful resources (eg, blood products). A subaxillary incision has the advantages of being hidden under the arm and having a lower rate of readmission for healing problems (eg, infections, dehiscence), which are a daily issue in underdeveloped countries. However, beyond the speculation about surgical risks and costs, the real concern is about the number of patients who continue to be followed after a Glenn procedure and reach Fontan completion. Over a 5-year program, our center performed 19 Glenn palliations, but none of these involved a total cavopulmonary connection. These numbers strongly encouraged us to think about a subaxillary off-pump approach, which seems to be costless, but effective.³

In conclusion, despite the growing effort to guarantee reasonable follow-up for pediatric patients undergoing cardiac surgery in developing countries, we still face constant economic, geographic, and cultural limits. At some point, these barriers lead us to shift from a “what we should do for the good of the child” to a “what we can do” approach, where sometimes a small incision becomes a precious need.

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