LETTERS TO THE EDITOR

Subxiphoid drainage for pericardial tamponade

To the Editor:

We fully concur with Dr. Moores and his associates¹ in the policy of subxiphoid drainage for pericardial tamponade as a treatment option because it entails minimal anesthesia in a sick patient and is easily performed. We wish to share our experience.

We performed partial pericardiectomy and drainage of pus through an anterolateral thoracotomy in a young patient. The patient was in good hemodynamic condition with normal hepatic, renal, and pulmonary function. Her only symptoms were high fever and precordial pain. The operation was performed with the use of general anesthesia. A large collection of pus was found, with moderate tamponade, and no intraoperative problems occurred. Postoperatively, however, low cardiac output progressively developed. She died within 6 hours despite inotropic support and resuscitative measures.

Similarly, another young patient with chronic pericardial effusion and tamponade who underwent subxiphoid tube pericardiostomy under local anesthesia had low cardiac output, but it was possible to resuscitate him with inotropic support.

Neither of these patients had any underlying cardiac problem. The question is, why should low output develop after pericardial decompression in young patients with normal hemodynamic status? We presume that sudden pericardial decompression is the cause for this phenomenon. The same may have been the cause for the mortality in the published series by Moores and colleagues.

We fully agree that subxiphoid tube drainage is the best for pericardial tamponade. In chronic effusion we advocate gradual decompression of the effusion by clamping the tube and gradually releasing it.

B. Neelakandan, MD

N. Jayanthi, MD

R. Kanthimathi, MD

Lister Hospital

*94, Kanagasabai nagar
Chidambaram 608 001, India*

REFERENCE

1. Moores DWO, Allen KB, Faber LP, et al. Subxiphoid pericardial drainage for pericardial tamponade. *J THORAC CARDIOVASC SURG* 1995;109:546-52.

12/8/68917

Reply to the Editor:

I suspect that the first patient reported on by Neelakandan and associates died of complications of overwhelming sepsis associated with the pyopericardium. I have no good explanation for the development of low cardiac output in second patient, although it may have been related to his chronic underlying disease and unrelated to the actual

pericardial drainage. One patient in our series died within 48 hours after the operation. This was a patient with pneumonia, sepsis, and multiorgan failure who died of overwhelming sepsis 48 hours after pericardial drainage. We do not think the pericardial drainage contributed to the patient's death. Our experience does not corroborate the presumption of Neelakandan and coworkers that sudden pericardial decompression may cause low cardiac output. Our experience has been that patients with pericardial tamponade have marked, sudden improvement in their hemodynamic status after drainage of the pericardial effusion.

Darroch W. O. Moores, MD^a

Keith B. Allen, MD^b

L. Penfield Faber, MD^b

Stanley W. Dziuban, MD^a

David J. Gillman, RPA/C^a

William H. Warren, MD^b

Riivo Ilves, MD^a

L. Lininger, PhD^c

Department of Surgery

Division of Thoracic Surgery

Albany Medical Center

Albany, N.Y.^a

Department of Cardiovascular-Thoracic Surgery

Section of Thoracic Surgery

Rush-Presbyterian-St. Luke's Medical Center

Chicago, Ill.^b

Department of Biometry and Statistics

School of Public Health

University of Albany

Albany, N.Y.^c

12/8/68916

Skeletonization of internal thoracic artery grafts

To the Editor:

I would like to comment on two articles appearing in the August 1995 issue of the *JOURNAL*. I read with interest the article by Kushwaha and associates¹ regarding the late function of free and pedicled internal thoracic artery (ITA) grafts. In this report, the authors state, "Skeletonization [of the ITA] may provide greater length but still usually does not permit grafting of the left anterior descending coronary artery or its branches." As the primary author of one of their references regarding the technique of skeletonization,² I would like to politely disagree. In fact, one of the advantages of skeletonization is the ability to use the right ITA to bypass the left anterior descending coronary when the left ITA is anastomosed to a circumflex coronary branch. In my experience, inability to reach the left anterior descending coronary artery with a skeletonized right ITA is a rare exception rather than the rule. I do agree with the authors that free ITA grafts