Letter to the Editor

Sersar technique, I was present

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Keyword: Sersar Technique

I read with interest the article entitled as Inhaled Foreign Bodies: Management according to Early or Late Presentation by Sersar et al. [1]. I must congratulate the authors for their novel technique (Sersar Technique) [2]. I was lucky to work with Sersar group for 3 years 4 years ago. I witnessed the delivery of the technique introduced by Dr Sameh Ibrahim Sersar. The chance helped them a lot. Postural drainage associated with chest percussion and gentle manipulation are the basic principles of this technique. I must congratulate them for their extensive experience in this practice, a few of which I have attended. This series includes an apparently large number (2165 of proved inhaled FB) as it was done in Mansoura University Hospitals (1512 beds) and Mansoura Emergency Hospital (184 beds). This Department serves more than 13 million people. Accurate history and a high index of suspicion are needed to prevent delayed diagnosis and the complications. The causes of late diagnosis of foreign body aspiration (group III) in those children were parental negligence, fear to tell the father, misdiagnosis by the fellows professionals and pediatricians, the normal chest roentgenographic findings, lack of typical symptoms and signs, mismanagement and a negative bronchoscopic finding. I have few comments. I noticed that left-sided FB are more common than right-sided FB opposite to the general belief that right-sided FB are more common.

Second, the number of radio-opaque FB is too much, why?

References


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Reply to the Letter to the Editor

Reply to Dr Abdel Hakam

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Keyword: Sersar Technique witnessed

Thanks a lot to our friend Bahaa. He actually witnessed the evolution of our novel Egyptian technique (Sersar Technique) before we published it a few years ago. He encouraged us and started with me in the first few cases. Our series includes an apparently large number (2165 of proved inhaled FB) as it was done in Mansoura University Hospitals (1512 beds) and Mansoura Emergency Hospital (184 beds). Our Department serves more than 13 million people. Accurate history and a high index of suspicion are needed to prevent delayed diagnosis and the complications [1]. The causes of late diagnosis of foreign body aspiration (group III) in our children were parental negligence, fear to tell the father, misdiagnosis by the fellow professionals and pediatricians, the normal chest roentgenographic findings, lack of typical symptoms and signs, mismanagement and a negative bronchoscopic finding. We have a policy of indicating rigid bronchoscopy even with suspicion; thus, early in our practice, rigid bronchoscopy was done for cases of misdiagnosed or refractory pneumonia. A past history of foreign body aspiration is itself an indication for bronchoscopic examination of the airways because some children with aspirated foreign bodies are without symptoms and chest X-ray films may not show abnormalities. Bronchoscopic removal of the foreign bodies requires close communication between the anesthesiologist and the endoscopist [1].

We found the inhaled FB to be more on the left (54.7%). This finding contradicts with most published series and agree with the studies of Cohen et al. [2], Daniilidis et al. [3], and Van Looij et al. [4]. We tried to explain this dilemma observing that the frequency of left-sided FB decreases with increasing age supporting our belief that right tracheobronchial angle increases with age. Van Looij et al. [4] explained this by the finding that FBI occurs mainly when children are lying down, holding the FB in their right hands thereby straightening the angle between the trachea and the left bronchus. The third explanation may be that right-sided inhaled FB are easily coughed, and so they do not go to the hospital. The fourth explanation is that parents tend to pick up their children when they choke and put them on the back, holding them left side down [4]. Left-sided FB are associated
with delayed diagnosis and more complications, especially failure in removing them. They are more common in the younger age groups. Plain chest radiography revealed radioopaque foreign bodies (FBs) in 22.12% of all patients with proved FBI. This is a high incidence due to the habit of muslim girls and women to cover their heads using a veil approximated using pins.

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Letter to the Editor

Immediate ischemic preconditioning for spinal cord protection following descending thoracic aortic cross-clamping

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I read with great interest the article titled ‘Immediate ischemic preconditioning based on somatosensory evoked potentials seems to prevent spinal cord injury following descending thoracic aorta cross-clamping’ [1]. I congratulate Contreras et al. on their study of immediate ischemic preconditioning (IPC) utilization to provide ischemic spinal cord protection. IPC has been found to protect various organs from ischemic injury and there is experimental evidence that IPC protects the spinal cord after aortic cross-clamping. IPC is a biphasic phenomenon, with an early and a late phase of protection and these two phases have been documented in the spinal cord of big mammals as well [2—5]. In this study, Contreras et al. evaluated the effect of immediate IPC in a canine model of 45-min descending thoracic aortic cross-clamping. They used somatosensory evoked potentials to determine the duration of IPC. Controls underwent only 45-min aortic cross-clamping, while animals in group A underwent one cycle of IPC and animals in group B three cycles of IPC prior to 45-min aortic cross-clamping. They found that the three cycles of IPC reduced spinal cord injury when compared with the controls at 72 h (P = 0.03).

In our recent published studies, we have demonstrated that immediate IPC without hypotension prevents spinal cord injury in a porcine model of descending thoracic aortic occlusion [3,5]. We used 20 min of brief ischemia, 80 min of reperfusion and the duration of the occlusion of the descending thoracic aorta was 35 min or 45 min. We assessed the neurologic outcome of our animals at the fifth postoperative day. In our studies, it was very important to maintain the arterial systolic blood pressure higher than 100 mmHg during the 80-min reperfusion interval. Two animals had an arterial systolic blood pressure of 80—90 mmHg during the reperfusion period. Although, they had a Tarlov score of 4 at 24 h postoperatively, these two animals became paraplegic at 48 h, and the histological examination showed loss of neurons and a moderate grade of inflammation [3].

In the study by Contreras et al., it is mentioned that the proximal arterial blood pressure was monitored continuously during the experimental procedure, however, it is not clear whether there was any difference among groups in blood pressure during the reperfusion interval between the brief and prolonged ischemia periods. Was there any difference in mean arterial pressure during the reperfusion in comparison to baseline mean arterial pressure in the three groups? In other words, did the authors observe any hypotension during this reperfusion interval and how did they deal with it? It is also shown in Table 1 of the study that mean arterial pressure was not significantly increased during aortic cross-clamping (control group from 117 to 121 mmHg, group A from 111 to 116 mmHg and group B from 111 to 119 mmHg) in contrast to other studies [2,3,5]. How did the authors explain this phenomenon and what is its effect on neurologic outcome? It may be possible to correlate neurologic or histopathologic outcome with differences in arterial pressure during reperfusion or aortic cross-clamping time intervals.

References


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