surgery is desirable but was outside the scope of our study, and can only be obtained by means of a carefully designed prospective and randomized trial.

In other words, our study does not provide information regarding the incidence of surgical complications of ASD devices, but hopefully increases the reader’s awareness that potentially disastrous complications can occur even years after device closure, and that surgery for these complications is associated with significant mortality.

We also noted with interest Dr Schachner’s experience with 7 dislocated ASD devices which were successfully removed endoscopically, and congratulate him for these results. Most patients in our study were approached via median sternotomy, which was judged safer especially when hemodynamic instability was present, e.g., in patients presenting with cardiovascular collapse or cardiac tamponade. Given Dr Schachner’s significant experience with dislodged ASD devices, it would be of interest to know the number of percutaneous ASD closures in his institution, the incidence of related surgical complications, as well as whether, during the same time period, he encountered other ASD device complications causing hemodynamic instability, which may have necessitated treatment via sternotomy.

References


Reply to Gasparovic

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On behalf of my co-investigators, I would like to thank Dr Gasparovic for his comments [1] on our study [2]. The impact of cardiotomy suction on the inflammatory response to cardiopulmonary bypass has been often described. Westerberg et al. [3] even demonstrated a drop in systemic vascular resistance in response to re-transfusion of pericardiotomy suction blood. Nevertheless, most prospective randomised studies comparing conventional heart lung machines with pericardiotomy suction to minimised perfusion circuits (MPCs) without pericardiotomy suction have failed to demonstrate a difference in clinical outcome, some even failing to show benefits in terms of transfusion...