infections leading to device explants or wound revisions was observed. Nevertheless, meticulous attention has to be paid to make sure that no blood is emerges the wound as it defines insufficient closure.

**Limitations**

This study was conducted as a prospective register with randomization according to the operation date. The mode of assignment to the treatment group may have an influence which might be overcome by a proper randomization. Another major limitation is the relatively short observation period of only 3 months as pocket infections often appear after several months often years post-implantation. A controlled prospective and randomized trial with longer follow-up period would be useful for a final conclusion.

**Conclusion**

This study shows no benefit using skin adhesive in comparison to absorbable intracutaneous suture regarding surgery times for the implantation of cardiac rhythm devices. The rate of early adverse events after wound closure is higher after skin adhesive but no difference in long-term adverse events occurred.

**Conflict of interest:** none declared.

**References**


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**Endocardial pacemaker implantation: what is the lead course?**

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A 57-year-old woman with a previous history of mechanical mitral prosthesis surgery was referred for congestive heart failure complicating permanent atrial fibrillation. As an efficient rate control could not be obtained, a pacemaker implantation with atrioventricular junction ablation was carried out.

During pacemaker implantation, after left subclavian puncture was performed, the guide wire could not be pushed through. Angiography showed a complete thrombosis of the left brachiocephalic vein, but well-developed collateral circulation. With help of a soft guide wire and prudently pushing the sheath forward, the lead could finally be placed through a transversal collateral vein into the right ventricle.

**Conflict of interest:** none declared.