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The eversion technique for reinforcement of the suture line in aortic surgery

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Prosthetic graft replacement has been almost the most standard surgical therapy of the aortic aneurysms and/or the dissections. Bleeding from the suture lines is one of the most serious complications in early postoperative period which may lead to re-establishing the cardiopulmonary bypass. At late postoperative period, the pseudoaneurysm formation may occur due to this operative procedure. Some preventive techniques have been reported to overcome those complications such as using strips, inclusion of the prosthetic graft into the aorta or applying of tissue adhesives, etc. But, almost all of them are not free of adverse effects, such as inflammation, infection and dense adhesions, etc. We have described a new novel technique, named eversion technique to minimizing the complications of aortic graft replacement. The technique is described simply as everything the native aortic tissue during the anastomosis and so reinforcing the suture line by a fresh and living tissue. We have applied this technique on 42 patients who underwent ascending aortic replacement for the ascending aortic aneurysm and dissection in a period of 2 years. Those groups have been analyzed retrospectively, and the derived data reported. We haven't seen any complication due to the operation in-general and due to the described technique itself. In conclusion, the eversion technique in aortic surgery is a simple, reliable, and reproducible technique to reduce the complications of the aortic prosthetic graft replacement.

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Bipolar lead misplacement contriving an electrocardiographic pseudoinfarct

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Introduction: Electrocardiograph machines and clinicians can recognize much common lead misplacement. However, errors in arrangement of bipolar leads potentially create the unique predicament of pseudoinfarct ECG patterns. Discerning a limb lead misplacement from a true myocardial infarction is challenging and, unless there are a high clinical suspicion and an astute reader, is frequently overlooked. Here we illustrate a case of left arm (LA)/left leg (LL) lead reversal, and briefly review the mechanism and clinical importance of this under-recognized entity.

Case Report: A 91 year old hypertensive male, in otherwise excellent physical health, was evaluated for an isolatedsyncopal episode. His vital signs and physical examination were unremarkable. A routineelectrocardiogram (ECG) was initially read as sinus rhythm, LVH with repolarization abnormality andinferior infarct (new as compared to old ECG from 2013). An echocardiogram later revealedresults within normal limits. Further analysis by expert electrocardiogram readers found that the (pseudo) inferior wall infarct pattern was due to a LA/LL lead reversal.

Discussion: Although in our case this error was quickly identified and rectified this type of LA/LL reversalhas the potential to create confusion and in the right clinical setting can lead to expensive, unnecessaryand risky investigations and treatment leading to patient anxiety due to misinterpretation as an infarct. In our patient, due to LA/LL reversal, the lead IIIwas upside down; this lead to a pseudo inferior wall infarct pattern on the surface 12-lead ECG. Frequently, this error will lead to a near isoelectric line lead I, II or III, which might be the only sign ofLA/LL lead reversal in routine clinical practice. Computerized algorithms often lag in the automaticrecognition of this type of lead misplacement underlying the need for recognition of this subtle error.

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