Letter to the Editor — Editre Mektup

Treatment of superficial incisional infection

Dear Editor,

We read the manuscript entitled "Stapling for wound dehiscence after cardiac implantable electronic device implantation" with great interest.[1]

We congratulate the authors, but there are some points that should be clarified.

Surgical site infection (SSI) is defined as an infection that occurs 30 days after surgery with no implant, or within 1 year of an implant and the infection appears to be related to the surgery, even in the absence of a positive culture. A superficial incisional SSI typically presents with erythema, localized swelling, heat, and/or pain. SSI may also present with incisional dehiscence.[2] We think that the authors' cases can be categorized as superficial incisional infection with wound dehiscence, but not as isolated generator pocket infection. Blood, pocket swab, and tissue cultures should be obtained when identifying the causative organism in all these patients. The guidelines recommend pathogen-directed antimicrobial therapy for 2 weeks for these patients. It is not easy to understand why the authors did not obtain cultures from all of the patients and why they used oral antibiotics for as long as 45 days in addition to intravenous antibiotics for some patients, in which the duration was not noted.

In general, the effective therapy for culture negative, incisional SSI consists solely of incision and drainage without the additional use of antibiotics. Antibiotic therapy is reserved for patients with a significant presence of cellulitis, or who concurrently manifest a systemic inflammatory response syndrome. The open wound often is allowed to heal by secondary intention, with dressings changed twice a day and without suturing, and especially without metal stapling, which can create an additional infection nidus.[3] We think that the authors' figures demonstrate secondary healing, not the success of stapling.

We think that these patients must have a consultation with a surgeon and infection specialist before starting therapy.

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Authors reply

Dear Editor,

We thank the author for this letter and the questions that were raised. Our 11 cases of wound dehiscence were categorized as a superficial incisional surgical site infection with wound dehiscence, but without generator pocket infection. None of our cases had any alarming signs of pocket infection or abscess.

In relation to the septic workup, 8 of 11 patients were admitted to the hospital, where labs, blood cultures, and wound cultures were collected. Those patients received intravenous antibiotics for 48 hours and they were discharged home on oral antibiotics when their blood cultures were negative for any growth. The

other 3 patients who were not admitted to the hospital and were managed as outpatients had wound dehiscence of less than 0.5 cm and the risk of a pocket infection was low. Therefore, we decided to treat them empirically with oral antibiotics without the full septic workup. Incision and drainage was not indicated, as none of the patients had any abscess to incise, and patients with abscesses necessitate aggressive treatment, up to device explantation.

Patients in our study received oral antibiotics for a mean of 3 weeks. The termination date was determined by observing complete healing without any residual openings. Only 2 patients required a prolonged antibiotic course due to some residual dehiscence that required more time for skin integrity to be repaired.

We agree that the wounds were healing by secondary intention, but we believe that the staples provided support to the tissue and helped with edge approximation without adding significant tension. This enabled any secretions to leave the site while at the same time prevented further dehiscence in weak tissue. Other factors may also play a role in wound healing, including any excessive arm movement, showering, or inappropriate care and hygiene, which can lead to tissue separation and delay in healing. Such factors are difficult to control, as they are patient-related and frequent wound clinic visits might not be feasible in certain healthcare systems. We recognize the fact that staples can be a nidus for infection and that is why we removed them as soon as the wound was completely healed.

The stapling technique mentioned in our article was used only in patients who had a superficial incisional surgical site infection with wound dehiscence. Stapling helped with tissue approximation and provided support. Patients who have any worrisome features of pocket or device infection should have their device explanted per the guidelines and were not part of our study.

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No-touch method: New devices need new approaches

Dear Editor,

I would like to congratulate Çöteli et al.,[1] who successfully performed the procedure described in the article "Left atrial appendage closure using Amulet device in a patient with prior percutaneous atrial septal defect closure," published in the Archives of the Turkish Society of Cardiology. A 79-year-old woman who was treated with a 18-mm atrial septal defect (ASD) device 2 years earlier was considered to have atrial fibrillation (AF) and a high risk of bleeding and ischemic stroke. Left atrial appendage (LAA) closure was planned due to an oral anticoagulation contraindication. Inferoposterior puncture of the interatrial septum (IAS) was performed without touching the ASD device during LAA occlusion using fluoroscopy and transesophageal echocardiography. An inferoposterior location is the preferred site for puncture and transesophageal echocardiography can provide life-saving guidance. In some case reports, it has been observed that the LAA closure device can be implanted in the same IAS setting and dilated with a balloon.[2,3] However, the sufficiency of the IAS rims can change the strategy of the approach.

The number of cardiac intervention methods is growing. However, there is often not enough information yet about the optimal technique and approaches for the interventions when reintervention is needed (transcatheter aortic valve implantation [TAVI], ASD closure, percutaneous mitral procedures, LAA closure, etc.). It is not known whether the time required for endothelialization of the device should be considered in such cases. Device placement with the "no-touch method" provides an advantage in terms of independent installation and it looks safer. When considering old age, the indication for ASD closure should be clarified clearly due to the risk of AF.

Using new percutaneous devices increases the need for new approaches. For example, there is no accepted optimal strategy for new approaches such as coronary intervention after TAVI, mitral clipping, mitral valvu-