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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loplasty, paravalvular leak closure, or LAA closure after ASD closure. In this context, the increasing use of mechanical devices can frequently solve the initial, primary pathology, but may create a new mechanical problem that must be overcome in the late period. This kind of case presentation is important to show how we can deal with these problems. It makes more sense to me to implant a new device without ever touching a previously placed mechanical device. It will be important to use this “no-touch method” carefully to achieve a successful reintervention procedure.

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