

simultaneous prophylactic antithrombotic therapy could theoretically be considered in order to prevent the development of thrombotic events in high-risk patients.

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Paraplegia Because of Hemostatic Agents in the Costovertebral Space: This Occurs Even in Thoracic Aorta Surgery

To the Editor:

We read with interest the article by John et al¹ reporting a case of delayed paraplegia because of the migration of hemostatic material used to control bleeding at the costovertebral junction that occurred after lung decortication surgery. We fully agree with the authors that, for this potentially reversible complication, a high level of suspicion should be kept in every case of general thoracic surgery complicated by the occurrence of postoperative paraplegia/papaparesis, and this is especially true when hemostasis at the costovertebral angle has been tedious. We would like, however, to stress that as much attention should also be given to this possible cause of paraplegia even when it occurs after thoracic aorta surgery. As we previously described,² bleeding problems in the costovertebral angle can occur anytime when a posterolateral thoracotomy is performed; but when the surgical procedure is a vascular one on the thoracic aorta, in case of papaparesis/paraplegia it is much easier to think about a problem related to the replacement of the aorta (ie, an irreversible problem) instead of considering migration of hemostatic sponges, which, in some cases, is reversible.² Considering this, theoretically, could avoid some cases of postoperative paraplegia occurring after thoracic aorta surgery.

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Central Venous Catheter: A Journey Through the Central Vein—Destination Pulmonary Vein!

To the Editor:

Central venous catheters (CVCs) are routinely used to monitor central venous pressure (CVP) during open-heart and closed-heart surgery. We report an interesting case of a CVC malposition in the left pulmonary vein.

A 9-month-old male baby weighing 6.3 kg was admitted with central cyanosis, difficulty in breathing, and failure to thrive and referred to the cardiology department for further evaluation. A transthoracic echocardiographic examination revealed situs solitus, complete atrioventricular canal defect, aorta arising from the anterior ventricle, pulmonary atresia, and ductus-dependent circulation with right aortic arch. The chest roentgenogram showed pulmonary oligemia. The preoperative hemoglobin was 20.3 g/dL with a hematocrit of 61%.

The child was scheduled for a left modified Blalock-Taussig shunt. Under general anesthesia, the right femoral artery was cannulated for direct arterial pressure monitoring. An 8-cm triple-lumen CVC (Certofix Paed S 508; Braun Melsungen AG, Destrui, Germany) was inserted via the left internal jugular vein (LIJV) without any difficulty. The authors prefer the internal jugular vein on the same side as the thoracotomy for easy access to the CVC as well as to identify and treat complications such as pneumothorax or hemothorax. On the right side, the catheter is usually introduced up to the 6-cm mark; whereas on the left side, the whole length of the catheter is introduced because it has to travel extra distance to reach the right superior vena cava. The CVP was 6 to 7 mmHg with good waveform. The left thoracotomy was performed, and while assessing the anatomy, the surgeon noticed the presence of a vessel that was running vertically downward from the neck and entering into the left upper lobe of the lung. The green tip of the



Fig 1. The chest roentgenogram shows the course of the catheter (open arrows) and the tip of the catheter (closed arrow).