During the catheter placement time hyperosmolar solution was given to the 1st group, isoosmolar solution to the 2nd group. All of the catheters had single lumens. A cutdown technique was used in all catheters and the basilic vein was used in all instances. Totally, 60 catheters were placed on the right side (indication for CVP) and 40 on the left side (indication for TPN). The total number of catheter days was 1412, for an average catheter placement time of 14 days. All catheter sites were cleaned daily with iodine solution and dressed with dry sterile packs and all infusion tubes were changed sceptically every day.

Intraoperative complications were not observed. When removed, catheter tips were placed in a sterile container and taken immediately to the microbiology laboratory for plating. 15 cases of catheter related sepsis were found (13%).

Catheter sepsis was diagnosed when clinical symptoms (38°C fever and signs of sepsis) resolved after removal of the catheter in 15 patients. 7 patients had continuing signs of infection despite removal of the catheter. This group had negative catheter tips cultures. In 60 patients, catheter-related sepsis (placed for CVP measurement) was confirmed in 18% (n = 11) while in the other group (placed for TPN) the sepsis rate was 10% (n = 4 [p < 0.05]). The isolated microorganisms from the catheter tips were as follow: 5x staphylococcus epidermidis, 3x staphylococcus aureus, 3x pseudomonas aeruginosa, 2x E. coli, once enterobacter and once candida albicans.

Discussion

The percutaneous catheter placement (technically easier and faster) has a higher complication rate compared with the cutdown method (2). Due to this reason we performed a cutdown technique in all cases and had no intraoperative complications.

It’s widely believed that the risk of infection is higher for central catheters than peripheral plastic catheters and the risk of infection is smaller in TPN than for CVP measurement, chemotherapy or vascular access (1, 2). In addition, the risk of catheter-sepsis increases when the catheter is used for a longer period (1, 5).

In most studies staphylococcus epidermidis is the most common organism causing catheter sepsis and the catheter-related sepsis occurs in about 5.5 to 33% (1-4). In our study the overall catheter-related-sepsis comprised 15%, and the most common organism causing catheter-related sepsis was staphylococcus epidermidis (5-15).

In 60 patients (catheters placed for CVP measurement) the catheter-sepsis rate was 18%, while in 40 patients (catheters placed for TPN measurement) the catheter related sepsis rate was 10%. The difference was found to be significant (p < 0.05).

As a result of this study it is concluded that catheter related sepsis rate is more frequent using catheter for central venous pressure measurement than placed for total parenteral nutrition.

Literature


Perikardverschluß nach A.-mammaria-interna-Bypass


Key-words: Mammary artery bypass – pericardial closure – infection.


Pericardial Closure After Internal Mammary Artery Coronary Bypass

Summary: Mammary artery coronary graft shortening occurs due to bodysize or inadequate vessel size, lung herniation in pulmonary emphysema and intra- or postoperative sigh breathing. To overcome this problem the free left cut edge of the pericardium is stitched to the retrosternal periost. The use of one stitch only minimalizes lung inflation limitation. Additional pericardial incisions are described, which prevent the graft from angulating around the edge of the pericardium and enables the surgeon to protect the heart and venous bypass grafts from suction tubes and sternal wound infection.

Einleitung

In der neueren Literatur wird dem A.-mammaria-Bypass eine längere Funktionstüchtigkeit als dem Venenbypass zugeschrieben. Die emphysematische Lungenblähung, insbesondere bei tiefen Atmzügen, und ein durch Körpergröße oder Gefäßgröße bedingtes kurzes A.-mammaria-Perpendikel limitieren die chirur-
that catheter related sepsis rate is more (p <0.05).

In 60 patients (catheters placed for TPN measurement) the catheter-related sepsis was staphylococcus epidermidis (5-15). Common organism causing catheter-sing catheter sepsis and the catheter-related-sepsis occurs in about 5.5 to 33% (1- midis is the most common organism causing infection is smaller in TPN than for CVP access (1, 2). In addition, the risk of catheter-sepsis increases when the catheter is used for a longer period (1, 3). Due to this reason we performed a cutdown technique in all cases.

Catheter sepsis was diagnosed when clinical indications for TPN). The total number of catheter placements and had no intraoperative complications. A cutdown technique was used in all catheters and the basilic vein was used in all instances.

The isolated microorganisms from the catheter tips cultures. As a result of this study it is concluded that the cutdown method (technically easier and faster) has a higher complication rate compared with the cutdown method (2).

In 60 patients, catheter-related sepsis (placed for TPN) the sepsis rate was 18%, while in 40 patients (catheters placed for TPN measurement) the catheter-related sepsis was confirmed in 18 % (n = 11). Intraoperative complications were not observed. In 60 patients (catheters placed for TPN), the sepsis rate was 10% (n = 4 [p < 0.05]).

In 3x staphylococcus aureus, 3x pseudomonas aeruginosa, 2x E. coli, once enterobacter and once candida albicans. After removal of the catheter in 15 patients, 7 patients had continuing signs of infection despite symptoms (38 °C fever and signs of sepsis) resolved after removal of the catheter. This group had negative cultures and had no intraoperative complications.

7x staphylococcus aureus, 3x pseudomonas aeruginosa, 2x E. coli, once enterobacter and once candida albicans. The isolated microorganisms from the catheter tips cultures. As a result of this study it is concluded that the cutdown method (technically easier and faster) has a higher complication rate compared with the cutdown method (2). Due to this reason we performed a cutdown technique in all cases.

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