Reply on “What Is the Role of Surgeons When Implanting a Totally Implantable Venous Access Device to Prevent Immediate Complications?”

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To the editor:

We appreciate your great interest in our article [1]. First of all, I agree with the comments concerning the risk of a blind technique and the need to check the catheter's position during the procedure. In terms of safety, a surgical cut-down procedure on the cephalic vein or the external jugular vein is excellent, especially for avoiding fatal complications such as a pneumo- or a hemothorax [2-4]. Also, ultrasonography guidance makes the procedure safer [5, 6]. I think that the main issue is whether or not ultrasonography or fluoroscopy is available in the operation room. In fact, in the past, neither ultrasonography nor fluoroscopy was freely available in the operation rooms at Konkuk University Medical Center. However, recently with the availability of these medical devices, ultrasonography is routinely used to insert the totally implantable central venous access devices (TICVAD) and to check the position of the catheter tip during the procedure, as you recommended. As to the terminology of port migration, your comment is correct, and changing “port migration” to “dislocation/dislodgement of port chamber” would be much clearer, as you mentioned [7].

Additionally, I would like to comment on the classification of complication according to the period. The standard of early and late complications is different in different reports in the literature. Knebel et al. [7] classified complications as perioperative and postoperative. You have classified them as immediate, early and late complications or as early and late complications [2, 4]. As you have indicated in your comments, complications within 24 hours

after the procedure are important because they are related to the surgeon or to technical failures. We were interested in the surgeon's influence on the complications. Therefore, we wanted to focus on complications within 24 hours after the surgery, which we defined as early complications.

As to your comment on heparin usage, we indicated the usage of 10 mL of diluted heparin. This means that a total of 10 mL of diluted heparin solution was used to flush and fill the catheter before and after TICVAD insertion into the central vein. Also, we used a solution of heparin sodium (500 IU of heparin in 10 mL of isotonic saline) for flushing.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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