To the Editor,

First, I join the authors of “Massive Air Embolism in a Fontan Patient” in their appreciation and approbation of the Children’s Hospital Boston Cardiovascular Program. The establishment of a milieu, wherein an error may be made and learned from, with a concomitant improvement in the quality of care delivered, has been frequently and properly hailed as a mature and effective approach to the inevitable, if occasional, error during cardiovascular surgery, as well as medical practice in general. Unfortunately, the self-righteous and the deluded infallible insist on assigning blame and inflicting punishment. The result is the loss of valuable, if unpleasant, experience among staff, and the stifling of publication of errors. Every time a danger is discovered and smothered, the non-reporters become, in part, responsible for the next instance, where ever and whenever it occurs.

Man is a forgetful creature; the literature is vast; the dangers inherent in something as complex as cardiovascular surgery are countless. Sometime in the mid 70s, a colleague of mine, unfortunately no longer among us, conducted a routine bypass using what at the time was the world’s most popular cardiotomy. Shortly into the case, the cardiotomy exploded, causing no apparent damage, although some think there was an increase in white hair among the staff shortly thereafter.

Upon investigation, we discovered that the manufacturer had changed from a ribbed-therefore vented-nipple cap at the top of the reservoir to a smooth-sided one. No notice of this change was communicated. The company did point out that in the Instructions for Use it was recommended the cap be removed. While they were correct in stating that, they were held to be at fault by many perfusionists who had been leaving the cap in place for years and who subsequently suffered incidents similar to my colleague’s. In some cases, the outflow was not clamped and air flowed into the ubiquitous hard shell oxygenators, leading to more serious problems.

A number of years later, desiring to take advantage of membrane oxygenation, I switched to a system using a collapsible bag, the so called “closed” system. It was a difficult and uncomfortable experience for the first case or two, but thereafter both I and my partner at the time realized what huge advantages a closed system offered. We have been recently amazed at the number of people still using hard shell systems, and indeed have begun using them on selected cases ourselves, due to the need for vacuum assist.

Since small cannulae, minimally invasive approaches are gaining in popularity and seem clearly to be the path to the future, I submit Matte et al. have performed a significant service by explaining their adventure to us all. For sure, somewhere, some time, all unknowing, a cardiovascular team will spare a life because they changed their approach due to reading this article.

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