POSITION AND RELATIVE SIZE OF THE COMMON CAROTID ARTERY ACCORDING TO AGE: IMPLICATIONS FOR INTERNAL JUGULAR VEIN ACCESS

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Aim: *The purpose of this retrospective observational study was to investigate the anatomical characteristics of the Common carotid artery in pediatric patients using computed tomography images.*

Methods: *We evaluated anatomical characteristics of the right and left Common Carotid artery at the cricoid level and at a lower level, which was mid-level between the cricoid cartilage and the origin of Common Carotid artery from the subclavian artery. At each level, the cross-sectional areas of the Common Carotid artery and internal jugular vein, the relative size of Common Carotid artery to internal jugular vein, the minimum distance between them, and the extent of overlap between them were investigated.*

RESULTS:

According to the chest computed tomography images of 123 patients, the sizes of internal jugular vein and vertebral artery were found to increase with age. On the other hand, the relative size of the Common Carotid artery to internal jugular vein was found to increase conversely with decreasing age. The distance between the Common Carotid artery and internal jugular vein increased with age at both sides and levels. The Common Carotid artery was mostly located at the medial side of the internal jugular vein, and overlapped with the internal jugular vein in at least 54% of the patients at the cricoid level and in 74% at the lower level.

CONCLUSION:

The theoretical risk of Common Carotid artery puncture is higher in younger children during internal jugular vein catheterization.

Keywords: *central venous catheterization; internal jugular vein; pediatrics; retrospective study; Common Carotid artery.*

DEVELOPING COUNTRY SINGLE CENTER EXPERIENCE IN MINI STERNOTOMY PEDIATRIC CARDIAC SURGERY

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Objective: To evaluate the results recovering patients in partial sternotomy technique (I- incision) vs full sternotomy for correction of congenital septal heart defects in pediatric population.

Methods: Patients with known congenital heart defects, such as ASD, VSD, partial AVSD, TOF underwent corrective surgery by minimal low sternotomy and full sternotomy technique. For low sternotomy technique the skin incision was done in lower part of sternum, for the full sternotomy skin incision was done below 2 sm of upper part. The intracardiac repair was done in usual manner.

Results: A total 103 patients with known ASD, VSD, partial AVSD, TOF underwent corrective cardiac surgery. The age varies from 2 days to 12 years, average 4 years. There were no significant differences in number by gender. The full sternotomy patients' number was 53 vs 50 patients with partial sternotomy. The skin incision in full sternotomy varies from 12.0- 7.0 (±9,4) sm vs 6.4-3.5 (±4,4) sm in low partial sternotomy. There is no quite big difference in ACC and bypass time. The intracardiac repair was done in usual manner-pericardial patch repair technique. The sternal closure was done by surgical steel wiring. The chest tubes were places in pleural spaces. It was not found the evidence of sternal bleeding in both techniques. The final length of surgical scar was 12.2-7.5 (±10,2) sm in full sternotomy technique vs 7.0-4.3 (±5,2) sm in low partial sternotomy. The physical activity of patients between two techniques was significantly different: full sternotomy patients recover in 4th post operative day vs 1st postoperative day in partial sternotomy.

Conclusions: The full sternotomy technique is suitable for small patients with limited pericardial space. The partial low sternotomy is recommended for older patients over 8monthes of age. The recovering of patients with low

sternotomy is much easier and there is no evidence of sternum dehiscence in comparing of full sternotomy patients with 3 cases of sternum dehiscence. This is first single center experience in our country for performing pediatric cardiac surgery with mini incision and low sternotomy.

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