

gists, with whom we work in the strictest co-operation, now perform the cervical approach as we do. *The technique requires an almost surgical level of skill if the really dangerous possible complications are to be avoided. The operator inexperienced in handling major vessels should not try this approach unless properly assisted.*

We have not found that a larger catheter (No. 7 N.I.H.) is a source of greater myocardial irritability (Zimmerman, 1966) or is unduly rigid and dangerous (Banyai and Gordon, 1966). In infants, however, we usually employ a No. 6 N.I.H.

We have often performed a second approach to the vessel of the neck from a few days to several months after the first procedure, and found normal appearing tissues and vessels, the only evidence of a previous cannulation being the silk purse-string knot. Up to one week soft oedema makes a second dissection fairly easy; from 10 days to 3 weeks indurated oedema, which later disappears, makes dissection difficult, and during this period a second approach in the same area is not advisable.

The same approach may be used on the right side of the neck, as in cases of mirror-image dextrocardia. In cases of persistent left superior vena cava, which are always discovered with this technique, catheterization has usually been performed with more patience and caution and with some limitation, but in most cases completed in spite of some difficulty. If the procedure cannot be completed because of this situation, the catheter is withdrawn and the approach repeated on the right side.

### References

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- Zimmerman, H. A. (1966). *Intravascular Catheterization*, 2nd ed. Charles C. Thomas, Springfield, Illinois.

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### Erratum

The Editorial 'Understanding the Atrial Sound', by Bethell and Nixon, 1973, volume 35, page 230, contained a misprint. The third line of the first column should read 'is an inaudible vibration'.