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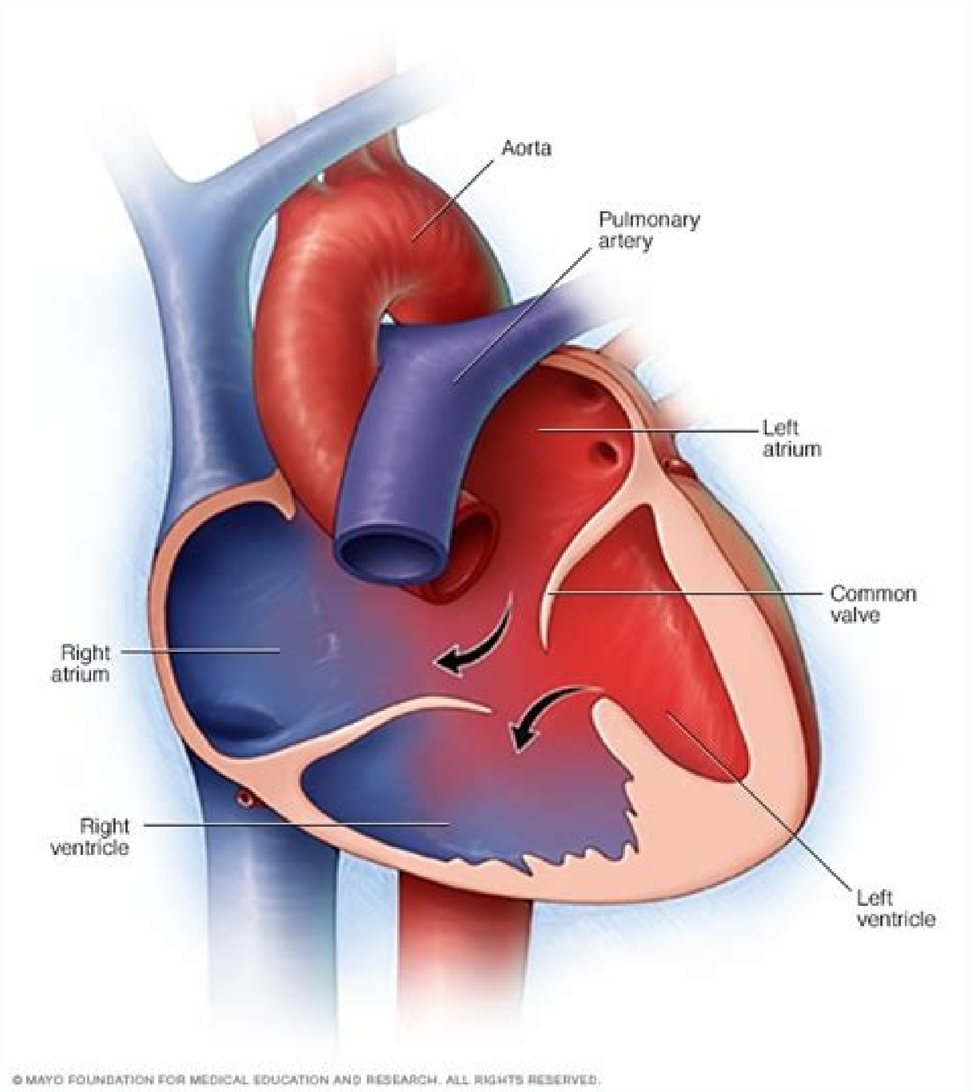

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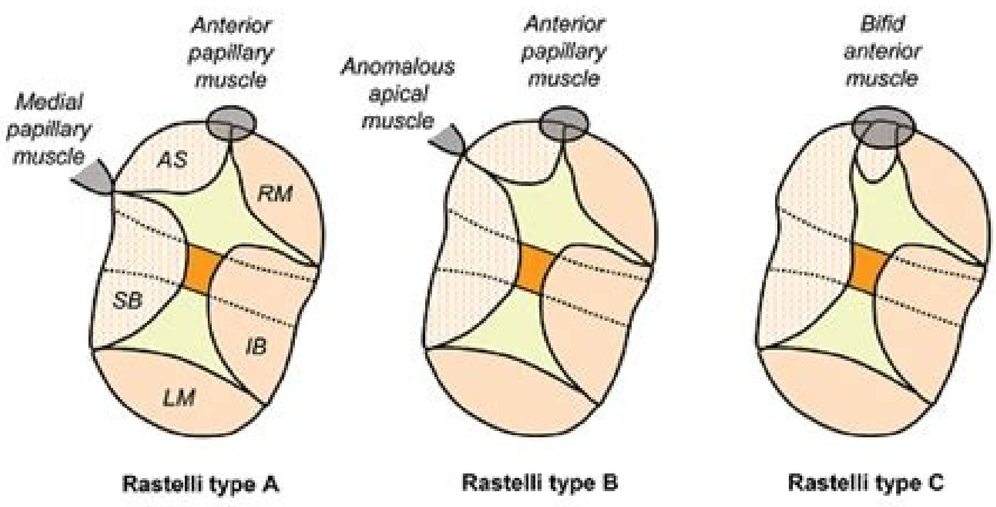
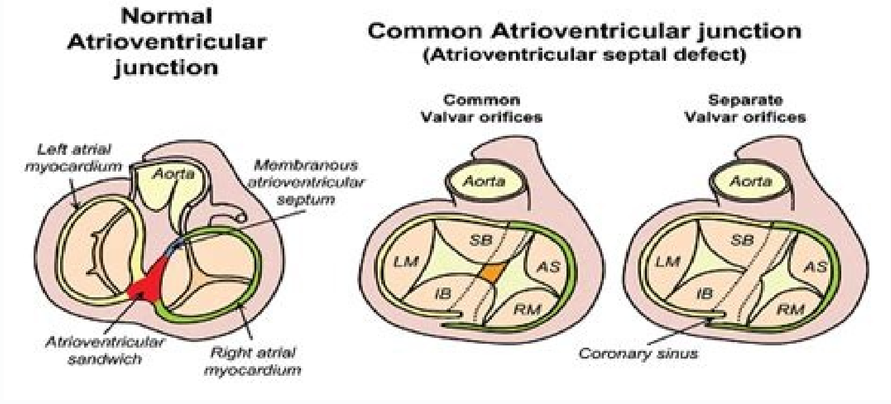
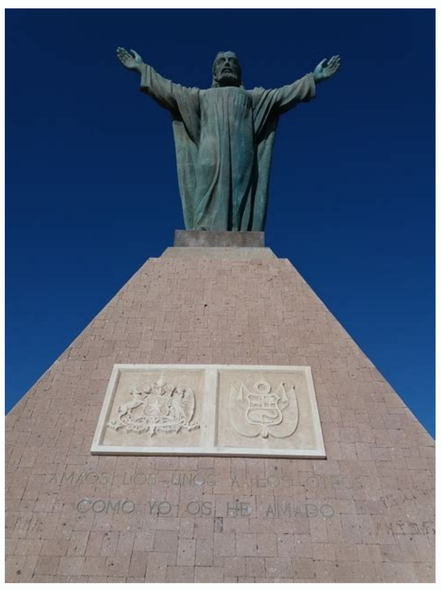


Figura 3. Clasificación de Rastelli. En Asian Cardiovasc Thorac Ann 2008;16:497-502





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This produces cardiac insufficiency in the first months of life with respiratory infections, poor weight gain for sweat and fatigue with breastfeeding. Practiced the direct suture of the edge of the Primum Ostium on the crest of the interventricular septum4. TECHNIQUES ARE Simple, Safe and Reproducible. Finally, we have presented our technique Ã «" without parcheÂâ € »suturing directly both defects, CIV and Primum Ostium with two suture lines, returning in a certain way to the OrÃƒÂxnenes10.initially, due At the complexity of the extracorpity circulation (CEC) in infants, two-stroke correction was performed by practicing pulmonary artery tissue to protect the pulmonary bed and corrective surgery above the yam of life. His absence leaves without livelihood to the septal veils of the av; There may be a common void with five or six veils, or two AV voids both with three veils and a cleft, according to full or partial AV. There were two cases of residual civ that were resolved with an additional point and that we attribute to the learning curve (Table II). As a conclusing, we can affirm that the full CAV is a complex cardiopathy that can benefit from a correction Single. The presence of sequelae was frequent in the follow-up that required re-intervention: AV block, surgery and mitral insufficiency. It is a simple, safe and reproducible technique. The relative position of the septal veils in relation to the septum defect AV condition the presence of a full or partial CAV. Wilcox and Nunn communicated, in the dÃ © each of 1990, the closure with a modified ºnic patch, closing the CIV with loose points and the Primum Ostium with pericardium patch. The techniques of a modified and without patch patch shorten the remaining times and allow a reduction in the reinventions rate, especially for valvular insufficiency. It has been defined by consensus among the different scientific societies that is the defect of the CAV and its variants1. In this chapter we will refer to the correction of the full cav. This Ã âtima is our choice technique since 2006. Introduction CAV, also called AV septum or formerly defect of the endocial cushions, includes a range of injuries It goes from the Primum Ostium with cleft (Cleft) to the complete CAV. The presence of cardiomegaly and increased pulmonary flow rate type should be seen in the TÃ ³³³RAX X-ray. Today, the corrective surgery is indicated in the first 3â € "6 months of life to avoid the presence of high pulmonary resistances11.12.The corrective surgery is carried out with conventional CEC, moderate hypothermia, Occupation and myocal protection with hemÃƒÂ¡thy cardioplex. Surgical Techniquecavc Has Been Repaired Since The Beginning of the Open Heart Surgery. In the last one, thanks to the improvements in the management of the CEC and the postoperative period that allow an early surgery below 6 months of life, a significant decrease in mortality has been achieved , which is 3% 13. The need for re-internship for mitral insufficiency is low (3%), and is due mainly to the lack of tissue in the lateral veil of the Ã â € "mitralÃ â €". Trusler, in 1975, performed the closure of the defect with double patch: one of a dacrÃ³n to close the CIV and another of pericardium for the Ostium Primum, and the veils were anchored between both patchs6. The Australian technical of a modified patch shortens the remaining times and allows a reduction of the reintervention rate: the incidence of subaïutical stenosis and AV block is practically non-existent14Ã ¢ â € ¢ "16. Set the edge of the headset partition on top of the patch by closing the Ostium Primum5.Circased with two patchsse A dacrÃ³n patch to close the CIV and a pericardium patch to close the Ostium Primum. It represents 4% of all the congenital malformers and supposes half of the congenal cardiac defects present in patients with Down Sındrome.Definitional Characteristics is the Absence of the Tote Av. The non-use ventricular patch has been an important reduction in postoperative mitral insufficiency. The pericardium patch is then sutured to close the Primum Ostium. In the center of the crest of the partition there is an area Ã «nude, Â» without strings that constitutes the central area of the CIV. When the veils are positioned in the middle of the defect, Ã © STE is somewhat artificially divided into two: the Primum Ostium at the atrial level and the CIV, and the full CAV occurs. In the Hospital de Cruces we have developed our technique without patch directly suturing both defects, CIV and Ostium Primum, with two suture lines. Resultsin The Last Decade, Thanks To The Policy of Surgical Repair At An Early Age, Below 6 Months of Age, Hospital Mortality Has Decreased To 3%. It is important to carve the non-high dacrÃ³n patch and with the rectilineal upper edge because the common veils of the full cav must be sutured on top of the patch. There is a slit of the AV vase at the height of the naked area that is responsible for valvular insufficiency both left and right. These points are passed through the lower edge of a pericardium patch that will be used to close the Primum Ostium. The complete CAV has been corrected from the beginning of the open cardinal surgery. They are simple, safe and reproducible technical. In the majority of the cases, deep hypothermia or circulatory stop is not used. Currency with a patch An oval dacrÃ³n patch or pericardium that fully covers the dimensions of the entire defect (CIV and Ostium Primum). The Main Feature is the Absence of the Av Septum. PrÃƒÂºre published the closure of the Primum Ostium without patch. The slit is closed with loose spots and the Primum ostium is closed directly by lowering the edge of the headset partition on the septal part of the valvular ring created by passing the points to the right of the first suture that closes the Civ It is progressively replacing the demÃƒÂ © techniques7.8. Sitting without a patching in the junction hospital in 2005, consists of closing directly the CIV component of the channel with six or Seven loose points in U as in Australian technical. By knotting the points the Valvular AV plane remains low as with the other mentioned ones mentioned above. It is very common the presence of pulmonary hypertension with a rude progress towards vascular disease and high resistance, which forces early corrective surgery.DiagnÃƒÂ³sticollax The presence of tachypnea, tachycardia and pansistÃ³. puff. In large part of the patients it is possible to correct the defect without the need for any patch. The technical advances of the latest decade have allowed to reduce mortality and surgical times. In this way, the coaptation surface of the VILE increases by decreasing the incidence of residual insufficiency. This is a small part that covers the natural scale that exists in a normal heart between the mitral vula and the tricÃƒÂºSpide (this Last has an implantation Â³n lower). If the septal veils are anconta directly on the edge of the interventricular septum, there is a Primum ostium without CIV and the CAV will be partial. The edge of the low atrial partition without barely exercising traction. Maloney, In 1962, Developed The Single Patch Repair With Division of the Bridging Leaflets That reattached to the patch. En nuestra serie la mortalidad fue del 3%. El canal auriculoventricular (CAV) comprende un abanico de lesiones desde el ostium primum con hendidura (cleft) mitral hasta el CAV completo. Lillehei, en 1955, realizÃ³ la primera reparaciÃ³n del defecto utilizando la circulaciÃ³n cruzada con un progenitor como ÃÂ«bombaÃÂ» cardÃÂaca. This defect affects the attachments of the septal leaflets of the AV valves and there may be a common valve with five to six leaflets in the CAVC, or two AV valves each with three leaflets and a cleft as in the partial AVC. Ha sido ampliamente utilizada hasta nuestros dÃÂas5. the modified single-patch and the no-patch techniques shorten surgical times and allow for a reduction in the need for reoperation, especially for valvular regurgitation. Trusler, in 1975, repaired the leaflet with two patches: one dacron patch to close the VSD and one pericardial patch to close the ostium primum. su principal caracterÃÂstica es la ausencia del tabique auriculoventricular (AV). Hemos obtenido una reducciÃ³n del tiempo de isquemia (53'), siendo la tasa de reintervenciones similar a la obtenida con la tÃÂ©cnica de un parche modificado: insuficiencia mitral 3%, estenosis subaÃÂ³rtica 3%. En el CAV completo hay una vÃÂ¡lvula AV comÃÂºn que cabalga sobre el tabique interventricular. Se consiguen imÃÂ¡genes precisas de los defectos septales y la morfologÃÂa de las vÃÂ¡lvulas AV; cuantifica con precisiÃÂ³n la presencia de cortocircuitos intracardÃÂacos y permite calcular el grado de regurgitaciÃÂ³n valvular.TÃÂ©cnica quirÃÂºrgicaEn el CAV parcial la indicaciÃÂ³n y momento de la correcciÃÂ³n son parecidos a los de otros defectos septales auriculares como ostium secundum, etc. Maloney, en 1962, desarrollÃÂ³ la tÃÂ©cnica de un solo parche con divisiÃÂ³n de los velos comunes que se anclaban sobre el mismo. La CIV se cierra directamente con seis o siete puntos sueltos en U anclando los velos comunes sobre la of the interventricular septum without the need for ventricular patch. Rastelli2.3 Classified, in the dÃ © each of 1960, the full CAV in three types, based on the morphology of the previous Comment Velo. There are five or six veils, of them the previous septal and the rear ride on the partition. The edge of the interventricular septum is sutured to the patch with loose points. Finally, the driving fabric is displaced towards the subsequent part of the CIV, which produces a shaft diverted to the left on the electrocardiogram.The lesion hemodynamics Full CAV is the result of the great volume overload produced by three injuries: Valvular insufficiency, the Great Civ and the CIA Ostium Primum. In addition, there are intermediate forms with two AV, small VSD and Ostium Primum. The average age was 5 months in the full CAV10.Resultadosically, the entire CAV surgery entailed a high mortality (10%), the main cause of death being the presence of pulmonary hypertension and resistances Elevated due to TardÃƒÂa11 surgery. TÃ © techniques QuirÃƒÂºrganic CAV has been corrected from the beginning of the open cardiac surgery. The lack of said partition leaves without sustenance to the septal veils of the AV, in such a way that you can not talk about Mitral and TricÃƒÂº SPIDE and there may be a VIUM fÃºT with five or six veils in the full CAV, or two AV vases both with three veils and a Cleft or false commissure that separates the previous septal veil from the rear into the partial CAV. The biventricular hypertrophy and the left dendration of ventricular axis is typical in the electrocardiogram. It is the technique of usada6.13.Circase of a modified patch called Ã «Australian TÃ ©. Initially, the study was completed with cardinal catheterization, but at present the diagnosis is made with two-dimensional echocardiogram with analogue Its absence would allow a direct step between the left ventricity (VI) and the right aurÃ³cle (AD). Wilcox and Nunn, In The Nineties, Reported The Modified Single-Patch Repair: They Closed The VSD With Interrupted Stitches And The Ostium Primum With Pericardial Patch. This technique is simple and with less time of ischemia and fewer complications in the follow-up. RESULTS The latest, thanks to an early surgery below 6 months of age, has been achieved a decrease in mortality up to 3%. Trusler, in 1975, performed the closure of the defect with double patch: one of a dacrÃ³n to close the interventricular communication (CIV) and another of pericardium for the Ostium Primum. Sociedad Español of Torus-Cardiovascular Surgery Copyright Ã, 2009. At The Hospital de Cruces We Have Developed Our No-Patch Technique: Both Defords, The VSD and The Ostium Primum, Are Suture Primarily with Two Suture Lines. The final aspect of the repair is similar to a normal heart, the aurÃ µlt return to a normal size and all the walls are contraceils9.in the hospital From crosses we begin our experience with the use of these two levels in 2002 (Table I). The mitral slit is closed and the primum ostium is finished closing with the pericardium patch with continuous suture of 6/0 polypropylene. In Rastelli Type A (the frequent meals) the previous septal veil has numerous ropes that are anchored directly on the right part of the interventricular septum; In Rastelli Type B (rare) there is an annual papillary basis on the right side of the interventricular septum that gives ropes to the previous veil. In Rastelli Type C there is a great ride of the anterior veil that floats without giving ropes to the partition. Both common and posterior common veils are transversally inflated to accommodate the patch and are sutured on both sides of the patch to the Adequate for good coaptación. 32 patients with full or intermediate AV, 17 were intervened with the modified Ãºnic patch technique and 15 with our technique without patch. Wilcox and, subsequently, Nunn reported the closure with a modified Ãºnic patch, closing the CIV with loose points and the Primum Ostium with pericardial patch7.8. pericardium7.8.

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