National Institute for Health and Clinical Excellence

655 – Endoaortic balloon occlusion for cardiac surgery

Comments table

IPAC date: 14 February 2008

Comment no.	Consultee name and organisation	Section no.	Comments	Response Please respond to all comments
1	Individual clinician	**1**	1.1 Agree 1.2 Agree. Expertise in transoesophageal echocardiography is essential and should be a pre-requsite. Additional training is then required in obtaining views, placement and possible complications.	Thank you for your comments.
2	Individual clinician	**2.2**	2.2.3 Continuous echocardiographic monitoring is used but once the heart is asystolic after cardioplegia and the left atrium is opened it becomes extremely difficult to visualise it. Distal migration can be detected by displaying pressure tracing from both radial arteries, however proximal migration is difficult to detect on echo. This can be done by direct inspection in the surgical field or some other method needs to be divised.(a constrast medium or alteration in balloon design to make it detectable on echocardiography)	Thank you for your comment.

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3	Individual clinician	**2.3**	I am not sure about about reduced duration of cardiac arrest. Duration obviously is dictated by the nature of the surgical procedure but in general the arrest period is longer than when the approach is a standard sternotomy.	The word ‘reduced’ has been removed from section 2.3.2 which now reads ‘duration of cardiac arrest’.
4	Individual clinician	**2.4**	In our experience, the complication rates are low and within published figures.	Thank you for your comment.
5	Individual clinician	**General**	Modification to make them echo detectable will be a huge improvement.	Thank you for your comment.