Author`s Reply

To the Editor,

We thank the colleagues for providing feedback on our article regarding lead extraction using the Lead Locking Device

(LLD) system (1) by placing their emphasis on definition standards, which are indeed good communication tools (2, 3) as long as everybody understands the unique meaning that is conveyed. However, these reflect arbitrary playing with words, and each time they are used one needs to explain their meaning. We explicitly stated in the article that "Lead extraction was accomplished using simple traction for 4 atrial, 1 ventricular, and 1 coronary sinus leads (only test stylet inserted); using the locking stylet alone for 60 (47.4%) leads in 39 (58%) patients; using locking stylet aided by unpowered sheaths for 27 leads; and via a femoral approach for 1 ventricular lead", which is a clear description of our results without the need for referring to and/or explaining any definitions (1). Regarding procedural success, without using too many labels, we again explicitly explained that, "Complete removal of all leads was successful in 52 (96.3%) patients for 96 (98%) leads; partial lead removal with the retention of a lead fragment was effected in 2 patients. … The former patient did well conservatively responding to antibiotic therapy, while the other patient preferred elective surgery over a transfemoral approach for the removal of the retained ICD lead fragment." Of course, the authors' relevant remarks and interpretation of all the above issues are welcome.

Regarding endocarditis, we mentioned in the Methods section that 9 patients experienced bacteremia and 4 patients presented with lead vegetations, which is again a clear statement without mingling with "definitions", whether one wants to refer to these 9 cases as systemic CIED infections (4) and retain the definition of lead endocarditis for the 4 cases with vegetations is a matter of semantics. Thus, among the 46 patients with CIED infection, "Positive blood cultures were detected in 9 (19.6%)... Echocardiography revealed small-/moderate-sized vegetations on the right ventricular pacing leads in 4 patients."

Regarding ICDs, 14 patients were implanted with an ICD device and 5 patients with a CRT-D (a total of 19 patients with defibrillating devices), while the count of defibrillating (DF) leads was 20 because there was 1 patient with 2 DF leads (a ventricular and an SVC DF lead). Hence, there were 6 CRT patients (5 CRT-D and 1 CRT-P patient). In response to the comment regarding the use of sedatives, we did not routinely use these, except sporadically for prolonged procedures. Regarding inconsistencies in numerical values, as explained above, there are no discrepancies except for a typographical error spotted in the Discussion section, wherein "47" should be corrected to "46" (infections). The confusion apparently relates to our referring to number of leads and the number of patients in the Tables, and numbers related to the use of tools are not mutually exclusive or additive.

Finally, we concur with the statement included in the colleagues' letter regarding the need for availability of a peripheral balloon for emergency SCV complications, and we wish to thank them for their comments.

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