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MEETING ABSTRACT Open Access

A survey of contemporary usage of epicardial pacing wires among UK cardiothoracic surgeons: A call for a more conservative approach

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Background/Introduction

To determine current practice regarding the use of epicardial pacing wires by cardiothoracic surgeons in the U.K.

Aims/Objectives

To determine current practice regarding the use of epicardial pacing wires by cardiothoracic surgeons in the U.K.

Method

An internet-based survey was distributed via email to all U.K. cardiac and cardiothoracic surgeons. The questionnaire consisted of 18 questions regarding use and management of epicardial pacing wires.

Results

Of 282 questionnaires, 126 responses were received (response rate 44.7%). Around two thirds (68.3%) of respondents routinely used epicardial wires for isolated coronary artery bypass grafts (CABG). Both atrial and ventricular wires were favoured for valve cases: isolated aortic valve(60.3% respondents), isolated mitral valve (63.5%), multiple valves(70%), CABG & valve(63.5%), redo valve(67.5%). The main reasons quoted for not using pacing wires: perception as an unnecessary procedure(22.2%), risk of bleeding(25.4%) and potential for delayed discharge(17.5%). Around half (54%) of surgeons reported practising minimally invasive techniques and 36.8% of these modified pacing wire usage. Two-thirds of surgeons accepted an INR of <2.5 for removal of pacing wires with another 24.6% accepting an INR <3.0 (>91% overall). Seventy percent would not remove pacing wires outside daytime hours although 54% removed them over weekends and holidays. Postoperative day 3 or 4 was the most common day for removal. Forty-five percent of respondent surgeons were comfortable discharging patients the day the wires were removed.

Discussion/Conclusion

Results show considerable variation in practice. Modifications based on peer practice could potentially save bed-days (by increasing pacing wire removal over weekends and out-of-hours and same-day discharge), reduce costs (clarifying indications and reducing routine use) and reduce risk of bleeding (by standardising safe level of anticoagulation).

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