

Primary repair is the ideal strategy for the closure of a complete sternal cleft

Tam bir sternal yarığın kapatılmasında primer onarım ideal stratejidir

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To The Editor

I read with interest the article “Repair of a complete sternal cleft in a five-month-old female infant” by Özyurtkan et al.^[1] I commend the authors for their successful secondary repair in their case report. Most of the complete sternal cleft in infancy are amenable for primary repair due to the elastic nature of thoracic wall structures. This is, of course, the ideal strategy for the closure of such defects to avoid complications associated with secondary closure and the need for foreign material, particularly at such an early age. Luckily, we performed the primary closure of a complete sternal cleft in a 35-year-old female.^[2] The patient was asymptomatic and scared of surgery until her marriage. A direct repair of the congenital complete sternal cleft was performed using titanium plates fixed by predrilled screws to the manubrium and costal cartilage. This provided excellent protective and cosmetic results. The width of the cleft is the most important factor determining the possibility of direct closure. In our case, it was 6 cm on inspiration. Gradual closure over minutes plus opening the left pleural cavity to create more space for the heart helped to avoid cardiac compression. A substitute sternal reconstructive procedure must always be available in case of intolerance to direct closure. Previously reported repairs of complete cleft repair were carried out using synthetic Marlex, Teflon, or Prolene mesh, meth-acrylate sandwich, or autogenous tissues (iliac crest or rib grafts) covered by pectoralis

major myocutaneous flaps.^[3,4] The main drawbacks and hazards of secondary reconstruction are due to the huge amount of foreign material with the potential for untoward reactions, infection, extra weight on the sternum, and the difficulty of future cardiac or mediastinal surgical procedures.

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