

# Letter to the Editor

## Subcutaneous ICD implantation should be considered when confronting anatomically complex cases

Dear Editors,

We read the case report of Fastner et al. with great interest<sup>1</sup>. They presented an ICD implantation case in a patient with complex anatomical conditions. Persistent left superior vena cava (PLSVC) and subclavian vein stenosis association forced the authors to avoid two leads implantation and they clinically succeeded ICD implantation via single chamber lead with additional atrial sensing capacity. We would like to thank to the authors for this contribution to our daily practice.

Infective endocarditis and venous thromboemboli are common and one of the most scarring complications of ICD implantation. Especially in patients such as mentioned with PLSVC and subclavian vein stenosis, venous thrombosis and infective endocarditis risk may be high. Moreover after implantation, if inflammation and mechanical endothelial trauma cause to the stenosis progression, system retraction may be required and this second trauma may worsen clinical outcomes. In order to avoid these results, subcutaneous ICD implantation would have been better for this case. Subcutaneous ICD implantation have various benefits especially avoiding lead complications such as infective endocarditis and venous thromboemboli<sup>2</sup>. It can be implanted with successful rates in experienced centers, with special attention to wound site infections.

Finally, the manuscript of Fastner et al is contributed to our daily practice for approaching the anatomically complex cases for ICD implantation. Beyond this, subcutaneous ICD implantation may be beneficial to avoid complications and better clinical outcomes.

### Conflict of Interest

The Authors declare that they have no conflict of interests.

### References

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- 2) LAMBIASE PD, SRINIVASAN NT. Early experience with the subcutaneous ICD. Curr Cardiol Rep 2014; 16: 516.

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