Specific indications for the operation were as follows:

1. Presence of thymoma (n = 20) or suspected thymic mass (n = 3) on the thoracic computed tomographic or nuclear magnetic resonance scan
2. High titers of acetylcholine receptor antibody (n = 3)
3. Resistance to pyridostigmine therapy or relapse after steroid or immunosuppressive therapy (n = 1)
4. Dependence on a high dosage of corticosteroids (n = 2).

Our mortality rate was nil, and no major morbidity was experienced. That is common to most of the surgical teams skilled in the treatment of myasthenic patients and makes the thymectomy a generally considered safe procedure.

The neurologic results of thymectomy in our overall series of 45 patients with OMG have been recently reported.⁶ The remission rate was significantly higher in patients with stage I myasthenia than in those in the other Osserman categories.

In the more recent series of 29 patients, the neurologic postoperative results were 22 complete remissions, 3 remissions with medication, 3 cases of improved status, and 1 case of unchanged status.

Our experience, general considerations, and results suggest that extended thymectomy might play a role in highly selected patients with OMG, and there is need for further studies to assess its efficacy.

We again congratulate the authors, who have focused and debated on what is considered a highly controversial indication for thymectomy.

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Reply to the Editor:

We appreciate the comments by Lucchi and colleagues at the University of Pisa. Their results are consistent with ours, but they differ in one important respect. In their group of 29 patients, 23 were operated on because of thymomas or suspected thymic masses, and 3 had thymectomies because nonoperative therapy had been ineffective or was not tolerated. This suggests that only 3 of their 29 patients had thymectomies specifically for the treatment of ocular myasthenia gravis (OMG), whereas OMG was the indication for operation in all of our patients. Our findings, supported by those of Lucchi and associates and the University of Pennsylvania group,¹ strongly suggest that thymectomy achieves greater remission rates for OMG than for more advanced forms of myasthenia gravis. Thus we recommend operation as the primary treatment for OMG when the diagnosis is firm.

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Percutaneous valve insertion: A new approach?

To the Editor:

The recently published article on percutaneous aortic valve replacement Lutter and associates¹ strengthens our belief that non-surgical valve replacement will soon become a reality in the replacement of semilunar cardiac valves.

Andersen, Knudsen, and Hasenkam² reported a nonsurgical heart valve replacement as early as 1992, and this was followed by similar attempts by other groups. Many technical problems have been encountered. The size of the vascular access required was too big, the function of the valve after compression and re-expansion could be compromised, and finally the newly implanted valve could obstruct the coronary orifices in aortic implantations. We reported our first experimental studies in 2000 for percutaneous pulmonary valve replacement and, after ethical approval, the first human heart valve implantation was performed by us in September 2000.^{3,4} In parallel, we reported our first successful aortic implantations in an experimental setup without creating coronary obstruction due to a newly designed stent with a two-step deployment strategy.⁵ In April 2002, the French newspapers reported the first successful percutaneous implantation of an aortic valve as an emergency procedure in a 47-year-old man in cardiogenic shock. This came as a result of an ongoing research project by Alain Cribier in Rouen, France.

The article by Lutter and associates reports their experience with aortic implantations. As in our early aortic work, they have experimented with valve implantations in the supravalvular position. In this position, the valve implant does not obstruct the coronary orifices and the pressure difference over the closed valve is significantly smaller. This decreases the force to dislodge the valve after implantation and leads to reduced stress on the functioning valve leaflets. In our experience, implantation in this position was technically easy. However, in contrast to Lutter and coworkers, we had significant problems with cor-