acute aortic dissection with severe aortic regurgitation. Retrospectively, our patient showed no dilatation of the sinuses of Valsalva until 4 years after the operation. The study by Sioris and associates¹ included some patients with aortic dissection or aortic annulus ectasia. And no patient required reoperation for aortic root aneurysm after separate grafting in their follow-ups. As they mentioned, separate grafting might be a perfectly acceptable option for patients with aortic valve disease and a dilated ascending aorta. However, we believe a careful follow-up is imperative for patients undergoing separate grafting because of the possible risk involving dilation of the sinuses of Valsalva, particularly in patients with evidence of gross annuloaortic ectasia or cystic medionecrosis of the aortic wall. Therefore we are looking forward to an additional long-term report by Sioris and associates.¹

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Reply to the Editor:

Drs Misawa, Ohki, and Sakano expressed concerns about our selective approach of aortic valve replacement and supracoronary replacement of the ascending aorta in patients with aortic valve disease, a normal aortic root, and a dilated ascending aorta, as described in our recent article published in the *Journal*.¹ To emphasize their viewpoint, they described a patient who underwent surgical intervention for type A aortic dissection with severe aortic insufficiency and 10 years later required aortic root replacement because of aneurysm of the retained aortic sinuses. I am not surprised that their patient experienced this late complication. Their patient had type A aortic dissection with severe aortic insufficiency, which suggests that the aortic sinuses were involved by the dissection. I believe that the appropriate operation for that patient would have been an aortic valve-sparing procedure, preferably the reimplantation technique, or aortic root replacement to remove the diseased aortic sinuses.

In our series¹ only 5 of 44 patients with type A aortic dissection had aortic valve replacement and supracoronary replacement of the ascending aorta, and none of

the 5 patients had dissection of the aortic sinuses or an aortic root aneurysm. The remaining 39 patients with type A aortic dissection had aortic root replacement, as shown in Table 1 of our article. In addition, no patient with Marfan syndrome or annuloaortic ectasia had supracoronary replacement of the ascending aorta, as shown in Table 1.

Aortic valve replacement with supracoronary replacement of the ascending aorta is a valid and safe operation for patients with aortic cusp disease, normal aortic sinuses, and dilation of the ascending aorta. Although the series described included patients operated on from 1990 onward, and the longest follow-up is 14 years, I have performed this operation during the past 25 years and have never seen late aortic root aneurysm. This means that I have correctly tailored the operation to the surgical pathology.

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