instrumenting a narrow posterior interspace might cause more, and not less, pain, particularly if an endoscopic clamp, a 5-mm video camera, and an 11-mm endostapler are all placed through the same incision.

Furthermore, I anticipate technical limitations with the ability to perform an exploratory thoracoscopy for traumatic injury through a single incision in the midthorax. During the course of elective surgical intervention for bullous disease, interstitial disease, or a pulmonary nodule, a mid-scapular incision is recommended for lesions in the superior or apical segments, and a posterior axillary incision is recommended for lingular or middle lobe lesions.^{1,2} There is no such preoperative target in the case of traumatic injury, and thoracoscopy is a true exploration. The entire pleural cavity must be inspected, and many times the video camera is moved from one port to another to obtain a comprehensive view. I suspect that in all but the most limited injury, it would be unwise to limit the exploration to a single point of view. However, the uniportal technique might be valuable as an initial diagnostic maneuver, and if the entire injury is comfortably visualized and if endoscopic stapled resection is not required, the uniportal technique might suffice.

Because of concerns regarding the anatomic constraints of the posterior approach and the potential for a less than complete trauma exploration, I would only consider the uniportal approach of potential value as an initial diagnostic maneuver, and I would continue to approach most patients with complex penetrating chest injury with a conventional 3-port approach or open thoracotomy.

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Anticoagulation after bioprosthetic aortic valve replacement

To the Editor:

We read with interest the letter by di Marco and associates¹ concerning anticoagulation after bioprosthetic aortic valve replacement. We also performed a survey of such anticoagulation practice among UK consultant cardiothoracic surgeons.² This highlights a similar disparity between the accepted guidelines and actual practice in the postoperative management of patients undergoing bioprosthetic aortic valve replacement, without comorbidities or risk factors that necessitate anticoagulation.

In our survey, only 16% of consultants (16/97) adhered to the comparable American College of Chest Physicians (ACCP)³ or American College of Cardiology/American Heart Association guidelines.⁴ The majority of consultants (51/97 [52%]) never used warfarin at all postoperatively, of whom 40 of 51 (78%) initiated antiplatelet therapy instead. The other 22% (11/51) used neither antiplatelet nor anticoagulation therapy postoperatively.

It is important to note that the ACCP guidelines recommending 3 months of anticoagulation postoperatively are termed a "Grade 2C Recommendation." This means that the evidence for the recommendation came from observational studies or case series. As such, the ACCP accepts that the evidence is of low quality, and that there is uncertainty in the estimates of benefits, risks, and burden. The ACCP is aware this is a very weak recommendation, and other alternatives may be equally reasonable.⁵

Given that so few surgeons seem to be following these guidelines, we await the updated European Society of Cardiology recommendations with anticipation.

Perhaps the prospective randomized clinical trial being undertaken by di Marco and associates¹ will provide stronger evidence and clarify a controversial area in the management of bioprosthetic heart valve replacement.

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