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Reply to the Editor:

We are pleased that Drs Filsoufi and Carpentier enjoyed our article, but they may have misinterpreted our results. We are not aware of other studies of systolic anterior motion (SAM) that include early and late intraoperative echocardiography. Our study also differs from others in that we have included only patients with mitral valve pathologies at risk of SAM development. Some authors do not make this distinction and report an artificially low incidence.¹ The 11% incidence of SAM, which Drs Filsoufi and Carpentier mention, includes all patients with SAM on early intraoperative transesophageal echocardiography. After medical management, the incidence of SAM intraoperatively decreases to 6% and then to 4% by hospital dismissal. Previous investigations that estimate the risk of SAM have reported echocardiographic findings at varying times, and therefore comparisons are difficult.¹⁻³ But the important point is that the risk of SAM appears low and diminishes with time and ventricular remodeling.

Therefore the question of whether prophylactic measures should be used to "prevent SAM" is a bit more complicated than

the correspondents might be thinking. As noted in the article, the risk of development of symptoms related to late SAM using the techniques we describe is extremely low (16/17 patients in New York Heart Association class I, 1 patient lost to follow-up). Also, SAM has been described with all methods of valve repair, including quadrangular resection with a sliding leaflet technique.⁴⁻⁷

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Tricuspid valve repair: Indication and type of repair

To the Editor:

We read with great interest the article by Ghanta and colleagues¹ concerning their results with repair of functional tricuspid regur-

gitation. After the comparison between Kay's annuloplasty versus ring annuloplasty on the tricuspid valve, they concluded that there is not a significant difference in the midterm results. Ghanta and colleagues recommend bicuspidization annuloplasty as an option to ring annuloplasty because it is inexpensive, simple, and reliable.

We do agree with the authors that moderate-to-severe tricuspid regurgitation should be repaired when a concomitant cardiac procedure is performed. At our institution, we are rather liberal in the indication for tricuspid repair. We perform about 50 cases of repair yearly on the tricuspid valve (46–61 per year in the last 3 years) of approximately 1200 total cardiac procedures. Our experiences show that repair of tricuspid regurgitation improves early postoperative outcome and long-term quality of life. Long-term survival after cardiac surgery depends mainly on the postoperative left ventricular performance. Indications for tricuspid valve repair should be decided preoperatively, according to the results of echocardiography. Intraoperative evaluation of tricuspid regurgitation is not reliable enough.

The method of repair on the tricuspid valve is another question. Cohn² recommends use of a ring if the tricuspid regurgitation is severe and suture annuloplasty if it is moderate. We have had good experiences with both de Vega annuloplasty and Kay's suture bicuspidization. In our experience (published in 1980), we found that, in about 70% of the cases, tricuspid repair (de Vega or Kay's) provided good results at a mean follow-up of 4 years.³ Since then, we used mostly de Vega repair with multifilament suture material, and we have had good experiences in several hundred cases. We even used an adjustable half-moon ring for tricuspid annuloplasty in a group of patients with good results.⁴ The ring annuloplasty had no better results compared with those of the suture annuloplasty, it is more expensive, and it takes more time and can reduce annular flexibility. That is why we do not use it routinely.

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