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Reply to the Editor:

With great interest we read the comment by Takagi and colleagues¹ with regard to the analysis of publication bias in our previous report.² Our systematic review carefully assessed the presence of publication bias by Egger's weighted regression statistic and visual assessment of the funnel plot, tools that are generally recommended for assessment of publication bias. As correctly stated by the authors, both tests revealed evidence of substantial publication bias for any of the analyzed outcomes (any atrial fibrillation: $P = .0003$; new-onset atrial fibrillation: $P = .0001$), with visual examination of the asymmetric funnel blot underscoring a small study effect. Consequently, the results of our systematic review showing a 22% reduction in the unadjusted odds for any type of atrial fibrillation in patients with preoperative statin intake are extensively discussed in light of existing publication bias, as presented in the Discussion, Results, and Limitations sections of our article.

Nevertheless, we disagree with the authors' statements that advocate a deliberate use of the trim and fill method by Duval and Tweedie² for assessment of publication bias for several reasons. The basis of the method is to remove the smaller studies causing funnel plot asymmetry and to provide an estimated adjusted intervention effect based on the filled (ie, missing) studies. However, the trim and fill method is built on the assumption that there must be a symmetric funnel plot, which may not always be true. Second, it does not take into account the true mechanisms of publication bias or reasons for funnel plot asymmetry other

than publication bias. Finally, the method is known to perform poorly in the presence of substantial heterogeneity among studies,^{3,4} which was also present in our report. These are the reasons for not using the trim and fill method in our primary analysis. When taking the aforementioned restrictions into account, the "recalculated" odds ratio provided by Takagi and colleagues for the end point "any atrial fibrillation" should be interpreted cautiously and within the limitations of the trim and fill method, because there is no guarantee that the adjusted intervention effect would have been observed in the absence of publication bias.

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TREATMENT OF RECURRENT AORTIC PROSTHETIC DETACHMENT WITH MODIFIED BENTALL PROCEDURE

To the Editor:

I enjoyed the recent article "The Treatment of Recurrent Aortic Pros-

thetic Detachment with Modified Bentall Procedure: Results of Two Cases."¹ The authors described 2 cases of surgical management using a translocated Bentall procedure with a mechanical prosthesis. I have used a similar technique with a porcine or bovine prosthesis in patients with severe endocarditis in whom a valve homograft was not available. A second useful application is in the case of an aortic root that requires replacement and a bioprosthesis is the prosthesis of choice. The technique has the advantage of being more hemostatic because a rigid mechanical or bioprosthetic ring is not positioned on the native aortic annulus at the root. In the event of bleeding at the root, it is much easier to place a suture into the cuff of the conduit rather than the rigid aortic valve prosthesis resting on the annulus.

In addition, if the aortic valve requires replacement, it is easier to change the aortic valve than redo the aortic root replacement.

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Reply to the Editor:

We appreciate the comments by Dr Frank A. Baciewicz on our article, "The Treatment of Recurrent Aortic Prosthetic Detachment with Modified Bentall Procedure: Results of Two Cases." His respectable clinical experiences briefly describe a similar technique with a bioprosthesis in patients with endocarditis or requirement of aortic root replacement and its advantages.

Prosthetic detachment after aortic valve replacement is one of the most frequent complications requiring reoperation.¹ Many factors, including endocarditis, aortitis, anatomic characteristics, and surgical techniques, are thought to predispose a patient to this complication. However, the intrinsic anatomic factor is considered critical for an adverse event of this kind. The aortic annulus between the middle portion of the right coronary sinus and the middle portion of the noncoronary sinus corresponds to the area above the membranous part of the interventricular septum and the right trigone of the cardiac skeleton. This embryologic origin of the aortic annulus may be a reason for its intrinsic weakness. The base of the noncoronary leaflet does not appear to be embedded in the ventricular muscle and seems to be higher in the aortic root plane.² However, the lack of muscular tissues presumes that this sector has hypodynamic properties, transforming it into a point of anchorage because of the greater dynamic energy developed by the other 2 bases. In addition, the mechanical changes start from the lowest point of each sinus of Valsalva during the cardiac cycle.³ Different dynamic characteristics cause the least expansion of this weak sector. The cooperation of the anatomic, mechanical, and pathologic factors may adversely increase to put stress on the base of the noncoronary leaflet, transforming it into a major site of prosthetic detachment: the dissection of the intrinsic weak annulus into the left ventricular outflow tract and a major flail-like rocking motion of the prosthesis.

Taking into consideration the reconstruction with a valved conduit is helpful because the rigid prosthetic valve does not apply direct pressure to the aortic annulus and the flexible tubular prosthesis may cushion the stress. This modified translocated Bentall technique provides better flexibility and elasticity of the aortic annulus than the standard Bentall procedure.⁴ The technique also has the advantage

of being more hemostatic, because it is easier to place a suture into the cuff of the conduit rather than placing the rigid aortic valve prosthesis on the native annulus. Bioprosthesis of a valved conduit is the better choice of reoperation for aortic prosthetic detachment caused by endocarditis. Moreover, the modified Bentall procedure has often been used to prevent valve detachment in prosthetic detachment caused by aortitis.⁵ Thoracic and cardiovascular surgeons may choose to use this technique.

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SILVER NITRATE: TO DISCOVER ALREADY DISCOVERED...

To the Editor:

We read the article by Stratakos and colleagues¹ with great interest inas-

much as the treatment of bronchial fistulas is of utmost importance to both the pulmonary and thoracic surgery divisions. The exact method of silver nitrate (SN) application through the videobronchoscope shown by the authors is very valuable on one hand. However, on the other hand, it is rather evident for us, and we have treated many patients without publishing our experience owing to its obviousness. We appreciate this work as a well-planned scientific trial to prove the application of SN to heal bronchial fistulas, but its use has been known for longer than the 25 years postulated by the authors. Melfi, Schverlich, and Tambornini² in 1954 used SN for endobronchial treatment of tuberculosis cavities. The same method of treating the opened bronchi was described by Guzeev³ in 1965. Worth mentioning is the toxicity induced by SN, sometimes even demanding lobectomy.⁴

In conclusion, we thank the authors for reminding us to use SN for smaller bronchial fistulas, but let us focus on finding new ways to heal the fistulas or preventing this complication during the operation, rather than reminding us of the old known methods.

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