total. In the United Kingdom, approximately 3500 isolated bioprosthetic aortic valve replacements are performed per annum. Assuming 50% of these patients are eligible for the study and all units participate, the study will take more than 4 years to complete.

One of the main difficulties we have encountered in the feasibility phase of this study is recruitment of patients with pure aortic valve disease who do not have any forms of arrhythmia or coronary artery disease, thus already receiving aspirin or warfarin. Ideally, a randomized study is necessary. Unless this is a multicenter international trial, sufficient numbers of patients cannot be recruited. We may then have to rely on antithrombotic therapy in the high-risk groups.

We would like to thank the British Heart Foundation for supporting the feasibility phase of this study.

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doi:10.1016/j.jtcvs.2010.06.058

Reply to the Editor:

We thank the authors for their comments regarding our recent article discussing the necessity of immediate postoperative anticoagulation in patients with bioprosthetic aortic valves.¹ Although this exact topic has been studied repeatedly over the past decade, there continues to be a lack of consensus, primarily owing to the absence of level 1 evidence. As the authors point out, despite strong evidence to advocate for/against antithrombotic therapy after bioprosthetic aortic valve replacement, guidelines from major international cardiology and cardiac surgery societies continue to recommend antithrombotic therapy for 90 days after bioprosthetic aortic valve replacement.

Although there have been attempts at performing a prospective randomized controlled trial to definitively answer this question and establish a standard of care,^{2,3} these studies have been grossly underpowered, containing no more than 150 patients in each group. Depending on the parameters used to perform a power analysis, a conservative estimate for conducting a randomized controlled trial with an effective power ($\beta > 80\%$) would consist of at least 1500 patients in each group. As the authors describe, conducting such a study would require enrollment from multiple high-volume centers.

The controversy and need for level 1 evidence regarding this topic are illustrated by the variability in antithrombotic therapy regimens, which has been documented in the literature (primarily in the United Kingdom).⁴ Anecdotal, in the United States, we know of institutions and surgeons that routinely anticoagulate with intravenous heparin followed by warfarin sodium and those that provide no anticoagulation whatsoever. These varying practices and unclear data should provide incentive to funding agencies to further study this question. On one hand, we may be placing patients at a high risk of major bleeding events and on the other hand, we may not

be adequately protecting patients from the risk of embolism. In the meantime, however, we believe it is important that we use the best available evidence, which is to avoid routine anticoagulation except in high-risk patients.¹

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doi:10.1016/j.jtcvs.2010.07.044

SURGICAL VERSUS ENDOVASCULAR TREATMENT FOR TYPE B AORTIC DISSECTIONS

Supplemental material is available online.

To the Editor:

We read with great interest the manuscript by Xu and associates,¹ in which they presented their early and midterm results of endovascular repair for the treatment of type B aortic dissections.

Although the Stanford classification is frequently used in the current era, the DeBakey classification seems more