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IS EARLIER AORTIC VALVE SURGERY IN REPAIR CANDIDATES JUSTIFIED?

To the Editor:

I read with great interest the report by Sharma and colleagues¹ about their experience with aortic valve (AV) repair and congratulate them on their honest presentation of the long-term data. I believe, however, that the interpretation of some aspects needs additional comments and questions. The authors stated that survival after AV repair in their population was excellent and, with 91%, 80%, and 58% survival at 5, 10, and 15 years, respectively, was indistinguishable from the healthy population. Such a survival of the healthy population with a median age of 54 years seems to be rather low, and this impression could be intensified when looking at the US Life Tables,² which revealed corresponding survival rates of 96%,

90%, and 83% for a 54-year-old population containing 76% men. The authors found (not unexpectedly, because this aspect has already been revealed after AV replacement³) that myocardial impairment (MI) was a significant predictor of mortality. They correctly noted that this is barely avoidable, because the late presentation of symptoms in some patients with aortic insufficiency does not lead to referral for surgery until the development of MI. They suggested, however, earlier surgery for patients with suitable repair anatomy. In this context, 2 questions arise: how reliable is the assessment of AV repair suitability; and are patients with MI proper candidates for AV repair? I believe AV replacement should be preferred for patients with considerable MI because such patients need a fast and safe surgery without the risk of residual or recurrent insufficiency, let alone any intraoperative revisions. The remaining aortic insufficiency, which can never be ruled out after repair, can even be considered as a potential factor that can worsen long-term survival in this special subgroup. However, the authors did not provide the rate of postoperative aortic insufficiency—neither in the entire nor in this special cohort. Thus, I am wondering whether the rate of reoperation alone would be adequate enough for assessment of clinical and, especially, functional results. Furthermore, the number of patients operated at Mayo Clinic, with an average of about 12 annually, does not indicate that a considerable share of aortic valve pathologic entities could be scheduled for the repair. By coincidence, we submitted an abstract for the same American Association for Thoracic Surgery meeting that included 137 repairs performed during a 1-year period, but it was not well received by the reviewers.

It seems that AV repairs are still limited to single centers or, even, surgeons; hence, we can hardly speak about the "expanding relevance of

AV repair." The repair rate, as presented in our abstract, was 40% for all AV surgery patients younger than 70 years or, after excluding patients with contraindications (eg, MI), even greater. Even if the suitability of repair could be assessed with a probability of about 80%, the final decision for AV repair was always performed during surgery. Thus, I am convinced that AV repair is a valuable option; however, the repair candidates must fulfill the same indication criteria as for AV replacement,³ because the need for replacement can never be ruled out.

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COX MAZE III PROCEDURE: THE BEST ALTERNATIVE IN SURGERY FOR ATRIAL FIBRILLATION

To the Editor:

We read with particular attention the article by Stulak and colleagues.¹ After close scrutiny of this report one cannot escape the conclusion that standard cut-and-sew Cox maze III procedure, as first described by Cox and associates,² remains the criterion standard choice for the surgical treatment of any type of atrial fibrillation (AF). Of special interest is the entity of mitral valve (MV) disease with concomitant long-standing persistent