think that the pressure gradient across the aortic valve may be increased after operation as a result of increased preload of the left ventricle after mitral replacement or repair.

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<http://dx.doi.org/10.1016/j.jtcvs.2014.09.068>

ROUTINE AORTIC VALVE REPLACEMENT FOR MILD STENOSIS IS NOT NECESSARY DURING RHEUMATIC MITRAL SURGERY

Reply to the Editor:

We greatly appreciate the interest in our recently published study by Zhang and colleagues in their letter to the Editor.¹ We designed our study with the same question that they raised: should we intervene in the grossly deformed but functionally mild rheumatic aortic valve (AV) to prevent future AV-related events? The answer obtained from our study was “no.” Although rheumatic aortic stenosis (AS) progresses easily as seen in previous studies,² we demonstrated that prophylactic methods such as AV replacement or repair failed to

prevent adverse events after the primary operation. The aortic annulus is often too small to insert a prosthetic AV of sufficient size in patients with mild rheumatic AV lesions and aortic valve repair also does not guarantee favorable outcomes, as shown in previous studies and ours.^{1,3}

Regarding the authors’ first question about inspecting the AV during the primary operation, we have often inspected the AV at the discretion of the operating surgeon during the study period. Unfortunately, however, we could not clearly demonstrate how many patients in the no-treatment (NT) group underwent AV inspection during mitral valve surgery because of the retrospective nature of our study. Their second question came from concerns that the preoperative AS grade might be underestimated in patients with mitral stenosis and the pressure gradient across the AV might increase after mitral valve surgery. Although we did not provide detailed data on this issue in our published article, only 1 of 5 patients who had AS and pure mitral stenosis in the NT group showed moderate AS early after surgery. Among 16 patients (14.2% of the NT group) who showed improved severity of AV lesions, 13 patients had regurgitant AV and only the other 3 had AS. In these 13 patients with regurgitant AV, 9 had mitral stenosis, 3 had mitral regurgitation, and 1 had mixed lesions. In 3 patients with AS, the mitral valve lesion was mixed steno-insufficiency.

As we discussed as a limitation of our study, we believe that the issues on attitude after a mild rheumatic AV lesion should be addressed in future studies with a large number of patients. Once again, we appreciate the comments and questions of Zhang and colleagues.

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<http://dx.doi.org/10.1016/j.jtcvs.2014.09.125>

ANTIPLATELET THERAPY AS SOLE ANTICOAGULANT IN PATIENTS WITH AORTIC MECHANICAL PROSTHESES

To the Editor:

I read the very interesting article by Puskas and colleagues,¹ “Reduced Anticoagulation After Mechanical Aortic Valve Replacement: Interim Results From the Prospective Randomized On-X Valve Anticoagulation Clinical Trial Randomized Food and Drug Administration Investigational Device Exemption Trial.” This article represents part of the Prospective Randomized On-X Valve Anticoagulation Clinical Trial (PROACT), which is intended to answer existing questions about anticoagulation in patients with mechanical aortic prostheses (MAPs).

Puskas and colleagues¹ concluded that the international normalized ratio can be safely maintained at 1.5 to 2.0 in high-risk patients after implantation of the On-X aortic prosthesis (On-X Life Technologies Inc, Austin, Tex) in patients who are monitoring with a home international normalized ratio monitor. Some of the results reported are still worrisome, however, because the issue of thromboembolism in patients with MAPs who are undergoing warfarin anticoagulation has not been resolved. The number of