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LACK OF INFLUENCE OF HETEROTAXY ON ARRHYTHMIA PREVALENCE AFTER INTRACARDIAC VERSUS EXTRACARDIAC FONTAN OPERATIONS

Reply to the Editor:

We thank Dr Rajanbabu for his comments. In response to these comments, we reanalyzed our cohort after removing the heterotaxy patients from both groups and the statistical results were the same. We therefore believe that the difference in the number of heterotaxy patients in the 2 groups did not influence our results.

We do, however, agree with his comment that transvenous pacing and transcatheter ablation are harder to perform after an extracardiac conduit operation. In light of our study results, the intracardiac tunnel may be the better operation from that point of view. Yet we caution that the follow-up in the 2 groups (particularly the extracardiac conduit cohort) in our study was short and that it may be wise to wait for longer follow-up before making definitive recommendations.

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A RECOMMENDATION FOR MODIFICATION OF THE HOURGLASS-SHAPED RESECTION TECHNIQUE FOR REPAIR OF TALL MITRAL VALVE POSTERIOR PROLAPSE

To the Editor:

We have read the article entitled "Hourglass-shaped resection technique for repair of tall mitral valve posterior prolapse" by Sawazaki and colleagues¹ with great interest. They have well described their novel method for repairing a high posterior leaflet of the mitral valve. They have adopted triangular resection for a posterior leaflet of normal height, and an hourglass resection for an excessively high posterior leaflet without annular plication. This simple and reproducible method may indeed improve outcomes of folding plasty and avoid the sacrifice of large amounts of useful leaflet tissue during annular plication.^{2,3} Short-term results of this reproducible technique seem promising.¹

However, when the technical details for this novel method are examined more closely, some questions may arise. For instance, if points B and E, which represent the midpoints of a posterior leaflet, were sutured to the annulus, as shown in Figure 1, such an approach has important drawbacks. We think that this maneuver may pull the annulus and cause narrowing of the leaflet width, resulting in a final shape that impedes formation of a new, normal-sized, and deeply coapted posterior scallop. Thus, we suggest that some refining modifications to improve this technique may aid in achievement of more

satisfactory outcomes and decrease postoperative morbidity and complications.

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ABOUT LEMONS AND LEMONADE

To the Editor:

We read with great interest the article on lung volume reduction surgery (LVRS) published by Decker and coworkers,¹ even though we found the results somewhat disappointing.

On one hand, the study provides a previously unknown nationwide overview on the early outcome achieved with LVRS, taking into account the Society of Thoracic Surgeons database data; Decker and coworkers¹ underline that LVRS continues to be reportedly underused despite its proven efficacy and highlight the need to invest in future analyses to identify determinants of adjusted