of Thoracic Surgeons recently started detailed data collection on devices; the information is incomplete, however, and it will take a long time to achieve enough data and statistical power to detect small differences in valve outcomes. In the interim, we should consider collection of explants and evaluation of autopsy reports to get more information on causes of death and to provide key information for decision making for regulators, patients, and surgeons.

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SURGEONS AND DEVICES IN AORTIC VALVE REPLACEMENT

Reply to the Editor:

Although critical to our understanding of clinical medicine, retrospective study—even with the most refined statistical analysis—is fraught with well-known limitations. Moreover, the limited ability of administrative data to answer clinical questions is legendary. The medical literature is replete with scientifically sound hypotheses supported by robust anecdotal and retrospective data that failed to withstand the scrutiny of prospective randomized evaluation. While our medical colleagues are still trying to sort out the dramatic failures of hormone therapy in postmenopausal women,¹ our own cardiac surgical community is absorbing the failure of statins to affect the progression of aortic valve disease,² and, more recently, the failure of a restrictive blood transfusion strategy to improve

clinical outcomes.³ It is certainly possible that the evolution of devices has rendered earlier prospective, randomized control trials of mechanical versus prosthetic valves irrelevant. However, if it is the valve (or the requisite technical or medical aspects of valve selection) that is specifically driving the observed difference in mortality, then the difference should be reflected specifically in the valve-relatedness of the mortalities observed. In the absence of any such signal, the distinction between valve selection and quality of care will await more convincing data. However, with the emerging success and increasing application of transcatheter aortic valve replacement, the question may well remain unanswered.

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EPIDURALS, INTRAOPERATIVE FLUID ADMINISTRATION, AND HYPOTENSION

To the Editor:

I enjoyed the recent article, “Effect of the amount of intraoperative fluid administration on postoperative pulmonary complications following anatomic lung resections” by Arslantas and colleagues¹ in the January issue of *Journal of Thoracic and Cardiovascular Surgery*.

Our group agrees that all patients undergoing anatomic pulmonary resection should have limited fluid administration because it decreases the number of postoperative pulmonary complications. We have seen substantially greater amounts of fluid administration in patients who receive epidural catheters for pain control, and in recent years have decreased our use of epidural catheters for this reason. Our impression is that the reduced fluid administration as well as the reduced incidence of intraoperative and postoperative hypotension decreases postoperative complication rates.

The study by Arslantas and colleagues¹ noted that epidural use was not significantly different between patients