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for immediate surgery. Vegetation < 10 mm of 1 aortic leaflet or mitral scallop with transesophageal echocardiographic evidence of low embolic risk may not require immediate surgical treatment. Single or multiple vegetations larger than 10 mm involving more than 1 leaflet or scallop indicates immediate surgery. In these cases, despite negative blood culture, surgery should not be deferred while other microbiologic assessments are performed because of the consistent risk of neurocognitive complications or end-organ damage with clinical deterioration. Urgent surgery should be considered in infectious endocarditis of prostheses.

We agree with Bando's¹ conclusions regarding the need for an international project that effectively addresses all the issues related to endocarditis. The goal should be to obtain reliable data and redefine the guidelines and establish the most appropriate strategy to assist these patients.

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OBESITY AS A CONFOUNDING FACTOR IN A STUDY EVALUATING THE ROLE OF M1 POLARIZATION IN AORTIC VALVE CALCIFICATION

To the Editor:

We recently read with interest the great article by Li and colleagues¹ showing that macrophage infiltration and polarization influence the process of calcification in the human aortic valve. In their study, the infiltration of classically activated (M1) phenotype macrophages was more predominant in the calcified aortic valves than in the noncalcified aortic valves.

It is well known that the M1 macrophage infiltration and M1 polarization are increased in patients with obesity, which could induce chronic inflammation.^{2,3} In the study of Li and colleagues,¹ the body mass index of the group with calcified aortic valves was statistically significantly higher than that of the group with the noncalcified aortic valves. Is there any chance that body mass index is working as a confounding factor in the evaluation of whether M1 macrophage infiltration pattern is different between the groups of patients with calcified aortic valves and with noncalcified aortic valves?

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