Author has nothing to disclose with regard to commercial support.

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multicenter registries such as the Society for Thoracic Surgeons database, in which large numbers of baseline, surgical, and outcome variables are collected, commonly have limitations when it comes to detailed data on pathoanatomic descriptions of the primary diseases, which may be very important in surgical decision making in IE. Such variables are difficult to quantify and most of the time are subjective. In this regard, it seems imperative to establish a universally acceptable consensus to define the severity of inflammation and destruction in a way that is clear and practical from surgeon's perspective, ideally with minimum interobserver variations. This may also be challenging, but it should be the starting point.

In the meantime, what do we do? We have argued that there are 2 reasons to consider homografts: technical factors related to the destruction of the annulus and concern for reinfection. There is little debate in our mind concerning the former. The controversy surrounds the latter.

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FIGURE 1. The greater the quality of the data, the more decisions in our surgical community are driven by evidence. Where there are low levels of good data, however, the debates are high, and the impact of opinions on decision making dominates.

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SUTURELESS AORTIC VALVE REPLACEMENT: PROGRESS FOR THE SAKE OF PROGRESS?

To the Editor:

We read with interest the article by Barnhart and colleagues¹ on behalf of the TRANSFORM (Multicenter Experience with Rapid Deployment Edwards INTUITY Valve System for Aortic Valve Replacement) study investigators. The INTUITY valve (Edwards Lifesciences, Irvine, Calif) eliminates the need for complete concentric annular suturing and provides an option for rapid valve deployment, but it is essentially an adaptation of the well-established PERIMOUNT Ease prosthesis (Edwards) for sutureless implantation. The virtues of this technique supposedly include reduced implant times and a possible advantage in minimally invasive approaches, although most implantations in the reported series (60%) used conventional sternotomy.

This study showed a 94.4% implantation success rate with mean crossclamp and bypass times in full sternotomy cases of 49.3 ± 26.9 minutes and 69.2 ± 34.7 minutes, respectively. Our own institutional review of isolated aortic valve replacements exclusively with the comparable Edwards PERIMOUNT and PERIMOUNT Magna Ease

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prostheses in 202 cases from 2008 demonstrated a mean crossclamp time of 59.5 ± 35 minutes and a bypass time of 89.2 ± 41 minutes, with a 100% implant success rate and 4.5% requiring a pacemaker.

Taking into account the significant additional cost of the prosthesis relative to its conventionally sutured siblings, it is hard to be convinced of the advantage to patients of saving 10 minutes of crossclamp time. Given the rate of permanent pacemaker insertion of 11%, compared with our own rate of 4.5% with nearly identical prostheses (for equivalent hemodynamics), one must wonder whether surgeons are best sticking with convention. In doing so, patients will face no difference in outcome, with the benefit of reduced permanent pacemaker insertion rates. Health care costs would be vastly reduced. Is this progress for the sake of progress?

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**THE EDWARDS INTUITY
ELITE VALVE: NOT
TO REPEAL NOR
REPLACE, BUT RATHER
ADDITIVE TO SURGICAL
AORTIC VALVE
REPLACEMENT OPTIONS**

Reply to the Editor:

I thank Booth and colleagues for their comments regarding the rapid-deployment valve concept, concerns, and use of the Intuity valve (Edwards Lifescience, Irvine, Calif). They are correct. This valve design is an adaptation of the current Edwards Perimount valve platform combined with the Edwards Sapien valve that uses balloon-

deployment technology. The Intuity valve has demonstrated improvements in ease of use, particularly in limited-access procedures, and in valve hemodynamics. The major emphasis of this technology is not necessarily “speed” of implantation, but rather ease of implantation and superb transvalvular gradients, specifically in the smaller valve sizes. Because the Intuity valve crosses the annulus and expands subannularly, numerous articles have shown this hemodynamic benefit.^{1,2}

In the Transform Trial, first-generation Edwards Intuity valves were used initially and then the second-generation valves were used, demonstrating an improved delivery system and altered subannular stent coverage. As the trial progressed, experience with sizing and symmetric annular débridement has improved the success in terms of valve implantation and pacemaker rates. In my clinical practice, the Intuity valve has been advantageous in patients with calcified aortic roots or severe “extra-annular” calcification, eliminating the need for complete annular suture placement. Also in limited access incisions and approaches, there is difficulty with exposure for complete annular suture placement, with only 3 sutures used in the nadir of each coronary sinus.

I agree that the Intuity valve is not poised to replace the well-established Perimount platform, but rather to be additive in select cases when indicated. I thank Booth and colleagues again for their correspondence.³

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