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technical aspects of these operations are essential, and this needs to be recognized so that appropriate referrals are made to manage these cases in centers of excellence.

We agree with Bando² and Nappi and Spadaccio³ that there is a need for a study comparing allograft versus prosthetic valve implantation in patients requiring extensive root reconstruction after radical débridement. There is also a need for another review of outcomes after the use of allografts for IE that includes long-term follow-up. For now, we believe that allografts are the best choice for aortic root reconstruction in patients with invasive, destructive aortic valve IE, and we answer in the affirmative the question of Nappi and colleagues¹: “Should we more often apply the maxim ‘do it once, and do it well’ in extensive IE?”

Syed T. Hussain, MD^a

Eugene H. Blackstone, MD^{a,b}

Gösta B. Pettersson, MD, PhD^a

^aDepartment of Thoracic and Cardiovascular Surgery
Heart and Vascular Institute

^bDepartment of Quantitative Health Sciences
Research Institute
Cleveland Clinic
Cleveland, Ohio

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**WEAK EVIDENCE,
STRONG OPINIONS,
AND HIGH
EXPECTATIONS**

Reply to the Editor:

Because of the low incidence of infective endocarditis (IE) requiring surgical therapy, it is unlikely that there will

be many randomized trials to form robust evidence to support specific procedural guideline recommendations. Where there are low levels of evidence, as is the case with IE, the debates in our surgical community are high, and the impact of opinions on decision making dominates (Figure 1). This becomes particularly evident when expert opinions are divided. Limitations in the available evidence necessitate the exercise of considerable degrees of judgment nuanced by opinions expressed among guidelines authors.

We agree with Bando¹ that the lack of solid evidence is the major obstacle in the establishment of consensus of surgical therapy for IE, especially with regard to the materials to be chosen. There is general agreement that either biologic or mechanical prostheses may be used to replace infected valves absent annular involvement; however, debated rages when invading abscess destroy the annulus.² The use of homografts has been regarded as surgical dogma in the setting of surgical IE, but this belief has been challenged by controversial results from recent studies, including ours.^{3,4} We also agree that for those unfamiliar with homografts, it may not have been considered the simplest solution. Indeed, proponents argued not that it is the simplest answer, but rather that it is the best.³⁻⁵ It should be noted, however, that even in the severe forms of root abscess, studies have shown excellent results with a minimum risk of reinfection mechanical or biologic root replacement procedures.⁶

In the presence of conflicting results among observational studies, including ours, it may be a good time to start seeking the answer the right way—through large-scale, prospective studies. Although this is easy to say, and is surely an intellectually defensible statement, the challenges will be frustrating. On the basis of our previous study, we estimated that enrollment of more than 3000 surgical patients with IE would be needed to yield adequate power to test the hypothesis that homografts are better than biologic or mechanical prostheses.⁴ What makes this even more challenging is the heterogeneity of the study group; among patients with surgical IE, those with the most controversial pathoanatomic feature—friable, destructive annulus with abscess formation—are much rarer. This poses the question of whether recruiting such large numbers of patients for such rare conditions is ever possible. This notion may conversely demonstrate that the meaningful differences in the outcomes depending on homograft versus prostheses may not be detectable at the surgeon level, or even in center-level experiences.

Nevertheless, efforts should be continued from our surgical community to get more solid answers, even if they are not randomized trials, which would likely carry an extremely high burden of financial strains and ethical conflicts dealing with these high-risk patients. Collaborating on a multicenter, prospective registry seems a more realistic solution in this regard.

It is also important to have a common language to describe the pathoanatomic features of IE. Large,

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^b*Division of Cardiac Surgery
Massachusetts General Hospital
Harvard Medical School
Boston, Mass*

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.

Joon Bum Kim, MD^a
Thoralf M. Sundt, MD^b

^a*Department of Thoracic and Cardiovascular Surgery
Asan Medical Center
University of Ulsan College of Medicine
Seoul, South Korea*

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