Author has nothing to disclose with regard to commercial support.

VALVE-SPARING ROOT REPAIR: V-SHAPED REMODELING CAN BE PERFORMED IN ALL SINUSES

To the Editor:

I read with great interest the article by Eleftheriades and colleagues¹ about V-shaped noncoronary sinus remodeling. As indicated by Paper in the accompanying editorial commentary,² many surgeons probably perform such or similar techniques (eg, simple plication of the aortic sinus wall³), but the contribution by Eleftheriades and colleagues¹ is very valuable because it clearly describes and illustrates the surgical technique and, maybe even more importantly, reminds readers that the narrowing of the sinotubular junction (STJ) is the easiest, most effective, and most durable valve-sparing repair technique for aortic insufficiency caused by STJ dilatation with unchanged valve cusps.⁴ I completely agree with the authors that this technique is not

suitable in younger, let alone in syndromic, patients, yet aortic regurgitation related to dilated STJ is mostly caused by atherosclerotic aortic aneurysm, and, consequently, occurs in the elderly. In this patient group, an asymmetry of sinus dilatation is very characteristic and the dilatation of STJ frequently limited to the noncoronary sinus, but it can also comprise coronary sinuses, in which identical V-shaped remodeling is possible (Figure 1). However, one should be careful with the use of pledgeted sutures in the proximity of coronary origins. For reapproximation of the sinus wall, I generally use 5-0 or 6-0 polypropylene sutures, depending on the strength of the aortic tissue, and never add any adhesives. In patients with tearable aortic tissue, I would not hesitate to replace the entire sinus or sinuses, as is our routine in younger or syndromic patients.⁵ In the ad-hoc analysis of our database, 62 patients with aortic root repair using V-shaped remodeling of sinuses of Valsalva (performed between 2000 and 2016) could be identified, all presenting excellent surgical and functional outcomes.

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The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should: • Include no more than 500 words of text, three authors, and five references. • Type with double-spacing. • See <http://jtcvs.ctsnetjournals.org/misc/fora.shtml> for detailed submission instructions. • Submit the letter electronically via jtcvs.editorialmanager.com. Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity of offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.

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FIGURE 1. Intraoperative view of a 76-year-old female patient with ascending aortic aneurysm and severe aortic insufficiency related to dilatation of sinotubular junction. V-shaped resection (arrows) was performed in each sinus of Valsalva (left) and sinus wall approximated with 5-0 polypropylene running sutures (right). Coronary ostia are marked with arrowheads. The repair was completed by supracoronary ascending replacement with tube corresponding to diameter of neosinotubular junction.

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VALIDATION OF THE “V” Reply to the Editor:

We appreciate Urbanski's leadership in creative solutions for the moderately dilated aortic root and the kind comments in his letter to the Editor.¹ His still photographs of the procedure are clear and instructive.

We are pleased to learn of his large series of patients (n = 62) who have successfully undergone “V-shaped” remodeling of the aortic sinuses. His experience, reported in the Letter to the Editor,¹ provides substantial validation for the concept of V-shaped resection. It is reassuring that his patients have done well in the short term and subsequently.

With Urbanski's validation, we consider that the V-shaped resection of the noncoronary sinus (Figure 1)² provides the surgeon with a simple, safe alternative for the older patient with moderate (4-5 cm) dilatation of the aortic root. We do not recommend this procedure for younger patients or those with severe dilatation, in whom we would perform some variety of aortic root replacement procedure.

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FIGURE 1. Marking the resection line for the V-shaped remodeling of the noncoronary sinus.

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SIMPLEST SOLUTIONS ARE NOT ALWAYS THE CLEVEREST: CAN WE STITCH IN AN INFECTED ANNULUS? SHOULD WE RETHINK THE CURRENT GUIDELINES?

To the Editor:

The considerations expressed by Dr Bando¹ deserve to find a rapid application so that the surgical treatment of valve endocarditis can be addressed successfully. Although the study by Kim and colleagues² is sustained by a valid statistical analysis supported by a propensity score matched study, the short follow-up makes the conclusions fragile and open to many criticisms that still need to be addressed, as we have pointed out.³ The factors suggested as the drivers in the choice between allograft or conventional prostheses, such as vegetations larger than 10 mm, have proven inconsistent. How many of these are located on a single leaflet with a nonextended annulus involvement? Unfortunately, the general trend seems to have moved toward the use of the “simplest solution,” but the easiest option is not always the one that leads to the best long-term results.

The presence of extensive vegetation is associated with the compromise of the entire valve and rarely is only a single leaflet involved. Moreover, lesions greater than 10 mm involving more than one leaflet often are associated with a severe inflammatory response, also involving the perivalvular tissues, which become extremely friable. The consistency of the annulus in this case as well as of the adjacent regions is not reliable for suturing. Is this the condition described in Class IIa, Level of evidence B of The American Association for Thoracic Surgery guidelines?⁴ What is the limit of a correct debridement without a compromise of the annulus in the presence of an active infective process?

For patients with severe infectious extension, the benefit of an allograft implant is undisputed, provided that the patient has multiple regions significantly affected with compromise of the mitroaortic junction, left ventricular outflow tract, or aortic root. Expert consensus favors correction of endocarditis with allograft when there is substantial annular and periannular tissue destruction, although the question of which surgical