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<http://dx.doi.org/10.1016/j.jtcvs.2017.07.024>

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.

Author has nothing to disclose with regard to commercial support.

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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