Reconstructive aortic valve surgery in the elderly: Another example of better being the enemy of good?

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Central Message

Complex aortic valve and root repair in elderly patients may fulfill the adage that “better is the enemy of good” relative to standard valve and root replacement techniques.

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In this month's edition of the *Journal*, Urbanski and colleagues¹ describe their modifications of operative techniques and long-term results after aortic valve and root repair in patients 75 years old and older. This is another review of their single-center results, which have served to elevate the consciousness of the cardiac surgical community regarding the merits of these operative approaches to aortic valve pathology. Although Urbanski and colleagues¹ clearly stipulate the merits of expeditious, predictable, and reproducible standard valve and root replacement techniques, they still present their rationale that they “believe that elderly patients with suitable pathological and clinical conditions can also profit from the advantages of valve-sparing albeit more complex aortic repair techniques as has been demonstrated for the young.”^{2,3}

Since the advent of transcatheter aortic valve replacement, there probably has been more focus on the subject of valvular intervention in elderly patients than on most other topics in our specialty. Clearly, this debate of open aortic valve replacement versus transcatheter aortic valve replacement eclipses the scrutiny given to another widely debated subject: surgical myocardial revascularization versus percutaneous catheter intervention for coronary artery occlusive disease. As a result of these analyses, the reality is that open aortic valve replacement has been performed in the elderly population with acceptable operative results for mortality and morbidity.^{4,5} Although the postoperative convalescence is clearly more arduous in this elderly cohort, the recognition of satisfactory operative results in the patients undergoing open surgery should be the filter that we use to interpret this article by Urbanski and colleagues.¹

In the discussion section of their article, Urbanski and colleagues¹ repeatedly mention the operative challenges of the repair techniques and state that “even centers with the most extensive experience in the reimplantation technique do not recommend this method in risky or elderly

patients.”⁶ Individual surgeon expertise is also mentioned as critical to the surgical outcomes. This point is further stressed that “the surgeons have to be quite sure about the primary surgical and functional results, because any corrections are connected with a second run and prolonged operative times (ischemia, cardiopulmonary bypass), which are not tolerated as well as by younger patients.”¹

The central issue, therefore, is not whether gifted and experienced surgeons can obtain excellence with these demanding procedures, but whether those surgeons with less experience in centers with lower populations of patients with these pathologies should consider these procedures, rather than the more commonly performed valve replacements with standard stented bioprostheses or composite grafts. The enemy of good may not, in fact, be better in many less-experienced hands attempting these techniques in the higher-risk cohort of elderly patients.

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