Stepping down from the ivory tower: Inviting the patient for mutual responsibility

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How delightful it would be to practice straightforward surgery during a complex clinical scenario of mitral valve endocarditis. The bad tissue is resected, and mitral valve repair or replacement is performed. The sooner the surgery is performed, the better the results, especially with *Staphylococcus aureus*, which accounts for almost a third of the microorganisms during endocarditis.¹ The basic rule includes resecting all infective focus and reconstructing the heart accordingly.

Back to reality. Many rules become controversial, and many seemingly dull clichés may apply; one has to “see the forest from the trees” and “take the patient as a whole.” Clinical details, such as history of embolism, the size of vegetation, and the presence of heart failure, cerebral stroke, sepsis, and microorganisms, interfere with the choice of treatment. Deciding between medical treatment and surgery, the timing of surgery, the choice of prosthesis, all determine the fate of the patient.² In short, one ought to discuss the case before acting; are all safety precautions, consulting measures, and clinical experience provided adequately?

The article in this issue of the *Journal* by Nappi and colleagues³ describes the surgical steps during the operational decision making. Nappi and colleagues³ share their valuable experience in treating patients with mitral valve endocarditis while referring to previous studies. Figures and algorithms are presented to pinpoint the main message. A step-by-step procedure is advised for the evaluation of the disease, and a surgical solution is offered accordingly. Importantly, the article adds to what modern surgery encompasses at its best: a multidisciplinary team works based on a patient-centered approach. Evidently, this review will be helpful to delineate the need for early surgery and the effectiveness of supportive medicine and antibiotics.

The fascination of medicine is based on allowing discussion of which mitral endocarditis is far from spared; does mitral valve repair enhance recovery as opposed to mitral

The ivory tower representing the know-it-all attitude.

Central Message

Surgeons step down from their ivory tower of high expertise in favor of the patient by discussing the complex clinical scenario of mitral valve endocarditis in a collegial multidisciplinary fashion.

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valve replacement? Are we convinced that recurrent endocarditis is related to either mechanical or biologic prosthesis? The implantation of papillary muscles or addition of a supportive mitral ring while using a homograft may add to the complexity of the reconstructive surgery.³ Mechanical valves and anticoagulation may well be tolerated by some. New anticoagulation protocols are currently under rigorous investigation.⁴ Even possible pregnancy may not anymore be an absolute contraindication for receiving a mechanical valve,⁵ and quality of life may be difficult to argue objectively after surgery for endocarditis.⁶ Today, it seems absurd to discuss mini-invasiveness of surgery for endocarditis, but in the future, this may become the reality. Does the elderly patient favor a limited approach in the hope of an instant recovery while accepting the risk of recurrent infection instead of undergoing a demolition surgical operation together with a homograft, possibly leading to an early stenotic valvular disease? It definitely matters for decision making how competent the surgeons prove to be technically, but some patients may still choose differently from what experts recommend. After being shown all options openly, the enlightened patient may decide individually, sometimes even against our own ethics and experience. The multidisciplinary, patient-centered approach to decision making offers shared responsibility.

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