Authors have nothing to disclose with regard to commercial support.

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The Society of Thoracic Surgeons adult cardiac surgery database. *Ann Thorac Surg.* 2014;98:806-14.

3. Byrne JG, Rezai K, Sanchez JA, Bernstein RA, Okum E, Leacche M, et al. Surgical management of endocarditis: the Society of Thoracic Surgeons clinical practice guideline. *Ann Thorac Surg.* 2011;91:2012-9.
4. Byrne JG, Rezai K, Sanchez JA, Bernstein RA, Okum E, Leacche M, et al. Surgical management of endocarditis: the Society of Thoracic Surgeons clinical practice guideline. *Ann Thorac Surg.* 2011;91:2012-9.
5. AATS Surgical Treatment of Infective Endocarditis Consensus Guidelines Writing Committee Chairs, Writing Committee. 2016 the American Association for Thoracic Surgery (AATS) consensus guidelines: surgical treatment of infective endocarditis: executive summary. *J Thorac Cardiovasc Surg.* 2017; 153:1241-58.e29.
6. Nappi F, Spadaccio C. Simplest solutions are not always the cleverest: can we stitch in an infected annulus? Should we rethink the current guidelines? *J Thorac Cardiovasc Surg.* 2017;154:1899-900.
7. Nappi F, Spadaccio C, Acar C. Use of allogeneic tissue to treat infective valvular disease: has everything been said? *J Thorac Cardiovasc Surg.* 2017; 153:824-8.
8. Moon MR, Miller DC, Moore KA, Oyer PE, Mitchell RS, Robbins RC, et al. Treatment of endocarditis with valve replacement: the question of tissue versus mechanical prosthesis. *Ann Thorac Surg.* 2001;71:1164-71.
9. Flameng W, Daenen W, Jashari R, Herijgers P, Meuris B. Durability of homografts used to treat complex aortic valve endocarditis. *Ann Thorac Surg.* 2015;99:1234-8.
10. Svensson LG, Pillai ST, Rajeswaran J, Desai MY, Griffin B, Grimm R, et al. Long-term survival, valve durability, and reoperation for 4 aortic root procedures combined with ascending aorta replacement. *J Thorac Cardiovasc Surg.* 2016; 151:764-74.e4.
11. Perrotta S, Jeppsson A, Frojd V, Svensson G. Surgical treatment of aortic prosthetic valve endocarditis: a 20-year single-center experience. *Ann Thorac Surg.* 2016;101:1426-32.

<https://doi.org/10.1016/j.jtcvs.2018.11.024>

NO, WE SHOULD NOT LOSE THE OPPORTUNITY, BUT WE NEED ADDITIONAL RESEARCH

Reply to the Editor:

The letter of Nappi and colleagues¹ in response to my editorial commentary² on their article³ is entitled “Aortic Homografts: Should We Really Lose the Opportunity?” My answer to their question is “No, we should not.” Cryopreserved aortic homograft should be in the armamentarium of every surgeon who treats patients with endocarditis. But the real question is “Are we benefiting patients with aortic root endocarditis by replacing the root with a cryopreserved homograft?” My answer to this question is “We don’t know, additional evidence to support the theoretic advantages associated with its use is needed.” The original report of Nappi and

associates³ on 210 patients is an important contribution to the field. As Nappi and colleagues¹ point out in their letter, the evidence for or against the use of cryopreserved aortic allografts comes from nonrandomized, retrospective, observational studies (level of evidence B). Although many prestigious authors advocate their use, others have found no benefit relative to prosthetic valve conduits in terms of cure rate, infection recurrence, durability, and reoperation.^{4,5} My impression is that the key concept for the treatment of endocarditis is radical débridement of all the infected tissue, with the reconstruction method likely less important.⁶ Some of the advantages of homograft relative to prosthetic valve conduits are technical and difficult to quantify in a clinical trial, such as the use of the anterior leaflet of the mitral valve for root reconstruction. Other claimed advantages, such as improved cure rate and increased resistance to infection, need to be demonstrated conclusively. Additional research on tissue preservation strategies is also necessary to prevent calcification and prolong homograft durability. This necessary evidence will prevent us from “losing the opportunity” and advance our knowledge on the best reconstruction strategy for extensive aortic root endocarditis.

Juan A. Crestanello, MD

Department of Cardiovascular Surgery

Mayo Clinic

Rochester, Minn

References

1. Nappi F, Spadaccio C, Chello M. Aortic homografts: should we really lose the opportunity? *J Thorac Cardiovasc Surg.* 2019;157:e245-6.
2. Crestanello JA. Aortic homografts: unrealized expectations and hard reoperations at the end. *J Thorac Cardiovasc Surg.* 2018;156:1351-2.
3. Nappi F, Nenna A, Petitti T, Spadaccio C, Gambardella I, Lusini M, et al. Long-term outcome of cryopreserved allograft for aortic valve replacement. *J Thorac Cardiovasc Surg.* 2018;156:1357-65.e6.
4. AATS Surgical Treatment of Infective Endocarditis Consensus Guidelines Writing Committee Chairs, Pettersson GB, Coselli JS; Writing Committee, Pettersson GB, Coselli JS, et al. 2016 the American Association for Thoracic Surgery (AATS) consensus guidelines: surgical treatment of infective endocarditis: executive summary. *J Thorac Cardiovasc Surg.* 2017;153:1241-58.e29.
5. Byrne JG, Rezai K, Sanchez JA, Bernstein RA, Okum E, Leacche M, et al. Surgical management of endocarditis: the Society of Thoracic Surgeons clinical practice guideline. *Ann Thorac Surg.* 2011;91:2012-9.
6. David TE, Gavra G, Feindel CM, Regesta T, Armstrong S, Maganti MD. Surgical treatment of active infective endocarditis: a continued challenge. *J Thorac Cardiovasc Surg.* 2007;133:144-9.

<https://doi.org/10.1016/j.jtcvs.2018.11.082>