Author has nothing to disclose with regard to commercial support.

ALLOGRAFT AORTIC VALVE REPLACEMENT: DEFINITELY, STILL AN OPTION FOR SOME PATIENT GROUPS AND PATHOLOGIES

Reply to the Editor:

In an article recently published in the *Journal*, Nappi and colleagues¹ discussed their experience of the long-term outcomes of cryopreserved allograft for aortic valve replacement, with particular emphasis in young patients with infective endocarditis. Nappi and colleagues¹ then came to the conclusion that “the cryopreserved allograft is a valid option especially in complex infective endocarditis and in women of child-bearing age.”

As it is now customary, this paper was accompanied by two editorial commentaries, invited by the Editor-in Chief, one by Crestanello² and another by me.³ In these two commentaries, somewhat different, although not antagonistic, personal views of this problem were expressed. Mine was a little bit more sympathetic of the use of aortic allografts in children and adolescents, women of child-bearing age, and aortic endocarditis, especially prosthetic endocarditis, while Crestanello felt that “the benefits of aortic homografts relative to bioprostheses and mechanical valves are limited and need to be weighed against the unavoidable and significant risk of reoperation.”

In a letter to the Editor published in this issue of the *Journal*, Nappi and colleagues⁴ respond to Crestanello's editorial commentary² and reinforce their original opinion and conclusions,⁴ and I was again invited by the Editor to participate in the discussion (as certainly was also Crestanello). Although Nappi and colleagues⁴ and I agree

that reoperation remains a significant long-term problem associated with the use of allografts, in the subgroups indicated previously, this is outweighed by the advantage of avoiding the use of anticoagulation therapy in the case of mechanical prostheses (I am still a strong supporter of mechanical prostheses in the young). There is also no evidence of a difference in the rate of biodegradation leading to reoperation in comparison with bioprostheses. On the other hand, in my group's experience, there has been a significantly better freedom for recurrent endocarditis with the use of allografts in the treatment of aortic valve endocarditis, especially in prosthetic endocarditis with extensive disruption of the aortic annulus. This was also reported recently by Perrotta and associates⁵ from Gothenburg, Sweden. As correctly pointed out by Nappi and colleagues,⁴ the use of allografts in these cases is now supported by the most recent guidelines.

Finally, in the hands of experienced teams, reoperation for a failed bioprosthesis or allograft, which does not necessarily pass through a new aortic root reconstruction, is now relatively safe, and degeneration of both these valve substitutes may in the future be good indications for percutaneous treatment.

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