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Dr Gillinov serves as a consult to Edwards Lifesciences, Medtronic, CryoLife, Abbott, AtriCure, and ClearFlow and has the right to equity in ClearFlow. Drs Mick and Wierup serve as consultants to Medtronic and CryoLife.

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RINGS AND THINGS: CONTROVERSIES IN MITRAL VALVE REPAIR Reply to the Editor:

There is more than one way to skin a cat. As cat owners, Drs Gillinov and Mick take exception to this statement; however, they do embrace its meaning. This principle—that there are many ways to achieve success—applies to mitral valve repair. When operating on the patient with isolated degenerative mitral valve disease, the surgeon has a variety of choices: complete ring versus band, flexible annuloplasty versus rigid device, resection versus artificial chordae, robotic approach versus sternotomy, and so on. There are many pathways to a competent mitral valve. Each of these approaches has been proved successful by institutions that have expertise in mitral valve surgery. There are few truly reliable comparative data (ie, randomized, controlled trials), however, that directly pit one approach or technique against another.

Where does this leave us? No surgeon can claim to have the single best approach to mitral valve repair. All a surgeon can say is that a specific technique works well in his or her hands. It is particularly important that surgeons know their results so that they can state with confidence and knowledge which techniques actually work for them. If the operation ends with excellent valve function on transesophageal echocardiography, and long-term durability is good, the surgeon can conclude that successful repair techniques were used.

Surgeons have great interest in (and loyalty to) particular annuloplasty devices. In their letter, Tomšič and colleagues¹ suggest that the type of annuloplasty is less important than surgical details, such as annuloplasty sizing. In general, we agree. At the

Cleveland Clinic, we favor a flexible posterior band for virtually all patients with degenerative mitral valve disease; our short- and long-term results are good.² At the Mayo Clinic, surgeons use a one-size-fits-all annuloplasty approach that relies on a premeasured, restrictive, flexible posterior band; their results are also good.³ No doubt, at Hôpital Européen Georges-Pompidou, cardiac surgeons rely on a complete, rigid or semirigid annuloplasty ring and, of course, have a long history of good results.⁴ While each of these institutions uses a different annuloplasty device, they have something in common: excellent outcomes. Until and unless we have randomized, controlled trials comparing annuloplasty devices, we can only conclude that in skilled hands, all of them work well.

Our rationale for choosing a flexible posterior band for nearly all patients with degenerative disease is simple: it is easy, and it works. A complete ring would require additional sutures in the anterior annulus, with the attendant (albeit small) risk of distortion or damage to the aortic valve. In addition, we have no doubt that a complete ring is more likely to be associated with both systolic anterior motion and elevated postrepair gradients. Given these potential drawbacks, we choose a posterior flexible band for patients with degenerative mitral valve disease.

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