that increased bleeding rates may be a consequence of NCS replacement is interesting, but it is not supported by our subgroup analysis. Within 30 days after the index operation, 10% of patients with NCS replacement (N = 12) had a reoperation for bleeding, compared with 13% of patients without NCS replacement (N = 36; $P = .41$). In summary, on the basis of our clinical experience and new subgroup analysis, we continue to support NCS replacement in selected patients with a baseline aortic root diameter smaller than 45 mm.

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WHAT'S IN A NAME? THAT WHICH WE CALL A ROSE BY ANY OTHER NAME WOULD SMELL AS SWEET

Reply to the Editor:

I have enjoyed reading the dialog between Drs Vallabhajosyula and Ouzounian^{1,2} on the management of the sinuses of Valsalva in the setting of bicuspid aortic valve in what seems to be competitive conservatism. It would appear that they are in violent agreement on the safety of leaving the left and right sinuses alone but differ perhaps on the management of the noncoronary sinus, or at least on inclusion of those with resection in their data sets. The topic appears to be what one might term “a hearty perennial.” I have been interested for many years in the place of what I would call “separate valve and graft” operations in the treatment of bicuspid aortic valve and associated aortic

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dilatation.³ Ouzanian calls it “AVR and RAA” (aortic valve replacement and replacement of the ascending aorta),¹ whereas the group from Penn appears to be suggesting application of the term “Wheat procedure” as an alternative to “AVRSCAAR,” as referenced in their 2017 publication,² a more readily enunciated if less historically accurate moniker; the operation Wheat and colleagues⁴ reported excised all sinus tissue down to the annulus, apart from 2 small tongues around the coronary ostia themselves. To be fair, the confusion invited by use of my own term is obvious as well.

Irrespective of the name, for my part, I am, like Juliet, a pragmatist. If implanting a tissue prosthesis, I am inclined to extend a tongue of graft down into the noncoronary sinus, reasoning that such will simplify a subsequent reoperation if necessary by making a hockey-stick incision possible without crossing an old proximal suture line. Still I cannot argue with those who prefer to leave the noncoronary sinus intact if not significantly dilated. What does matter, I think, is leaving the sinuses surrounding the coronaries alone. It is in my experience the reimplantation of the coronaries that can create problems for the surgeon and the patient alike. Bleeding, twisting, kinking, and tension can all lead to trouble, especially if the ostia are not particularly displaced in the first place.

So, to do or not to do? With reference to the noncoronary sinus, I really do not mind. It is the coronary buttons that are the question!

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