treat patients with increased surgical risk who are unsuitable for transfemoral valve implantation.

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Commentary: Transapical aortic valve replacement: There are other fish in the sea

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The choice of treatment for patients with symptomatic aortic valve stenosis at the beginning of this new transcatheter era was controversial; however, the guidelines as well as the large numbers of prospective randomized trials are progressively clarifying the ideas around it. At the same time, the transcatheter aortic valve replacement (TAVR) technique has expanded widely in recent years, and femoral access has become the gold standard and first-choice access for TAVR procedures.¹ Nevertheless, 10% to 15% of patients still require a different access route due to unfavorable anatomy or extreme calcification of the femoral/iliac arteries.²

Transapical (TA) access was the first option at the beginning of this new TAVR era, but it was progressively overcome by the “less-invasive” femoral access, becoming an alternative second choice. Some says that the “necessity is the mother of invention,” and therefore new surgical access routes were studied to reduce the drawbacks of TA-TAVR, avoiding the chest opening (pleura and pericardium) and to possibly maintain an antegrade access to the aortic annulus. Transaortic, trans-subclavian, or transaxillary and transcarotid accesses

CENTRAL MESSAGE

Transapical access is an unconventional site for transcatheter aortic valve replacement; however, might have comparable outcomes compared with standard aortic valve replacement.

were much appreciated and became the first alternative surgical routes to percutaneous approaches.^{3,4}

In this issue of the *Journal*, Stachon and colleagues⁵ identified and compared 19,016 isolated surgical aortic valve replacement (SAVR) and 6432 TA-TAVRs performed in Germany between 2014 and 2016. The authors concluded from their analysis that patients younger than 75 years and patients at low operative risk benefit from SAVR compared with TA-TAVR and the others might have comparable or even better (in case of chronic renal failure) results. Nevertheless, the study presents several limitations that should be pointed out. First, these are 2 distinct patient populations who underwent the respective procedures largely for very specific and very different clinical reasons (logistic EuroSCORE 5.3% vs 17%).

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Also, procedures are much different in many technical aspects (access sites, extracorporeal circulation support, operative times, postoperative management, etc), which greatly impacts on outcomes. Finally, for TAVR, this approach should now rarely be necessary and is largely of historical interest. Therein lies the main weakness of this study.

According to this limitation, the reported mortality rate for the TA-TAVR group was 5.7% and was significantly greater compared with the SAVR group; however, this result has to be considered as a logical consequence.

Recently, the FRANCH TAVI group (French Transcatheter Aortic Valve Implantation) reported among 21,611 patients treated with TAVR, 1616 (7.5%) had nonfemoral TAVR (transcarotid, $n = 914$ or trans-subclavian, $n = 702$). The results of their prospective registry showed excellent and comparable outcome between the 2 access routes (3.97% vs 2.91% $P = .211$), demonstrating a noninferiority to transfemoral access.⁶

Even if Stachon and colleagues consider the TA-TAVR a feasible and safe alternative access to the transfemoral approach, we should consider that this option provides a valid alternative only if other different peripheral accesses

are not available. Moreover, such a large population of TA-TAVR should better have been compared with other TAVR access sites to demonstrate a superiority or inferiority in terms of postoperative outcomes.

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Commentary: Surgical or transapical aortic valve replacement? Does the answer matter if you are asking the wrong question?

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CENTRAL MESSAGE

Contemporary transcatheter aortic valve replacement should rarely require transapical access for valve delivery.

Beginning with the premise "...[trans-apical transcatheter aortic valve replacement] is the most established alternative

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