See Article page 1502.

Commentary: Just do it?

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In this issue of the *Journal*, a group from the Mayo Clinic investigates the impact of early septal reduction therapy (SRT) on survival in patients with obstructive hypertrophic cardiomyopathy (HCM).¹ Patients who underwent septal myectomy or alcohol septal ablation within 6 months of initial evaluation at the Mayo Clinic (early SRT group, not early in their clinical symptomatology) were compared with those who received only medical management during the initial 6-month period, regardless of whether SRT was performed at a later point. As expected, the early SRT group had more advanced symptoms and more likely failed medical therapy at the time of index evaluation when compared with the early medical treatment group. The authors demonstrated improved survival with early SRT after adjusting for age and comorbidities.

Although current guidelines recommend SRT for patients with persistent symptoms despite maximal medical therapy and significant left ventricular outflow tract obstruction,^{2,3} the optimal timing of SRT is uncertain. A previous study showed increased adverse cardiovascular events and disease progression when SRT is delayed more than 5 years from initial diagnosis, despite successful gradient reduction and symptom relief.⁴ The present study sheds additional light on the optimal timing of SRT in patients with symptomatic obstructive HCM.

Although this observation was not the main focus and might be confounded by indication, SRT improved survival compared with medical management in the present study, challenging the current understanding that SRT improves

Should we “just myectomize it?”

CENTRAL MESSAGE

Mayo Clinic data show a survival advantage with early SRT over medical management, shedding light on the optimal timing of SRT in obstructive HCM.

symptoms and quality of life. In fact, even delayed SRT was shown to have a survival benefit over medical management. Additionally, early SRT yielded a survival advantage in female patients, those in New York Heart Association functional class III and IV, and nondiabetic patients. Prior data indicate that women with HCM generally tend to be older and more symptomatic at presentation compared with men.⁵ Therefore, the early SRT strategy for women and the benefit of that approach observed in this study may avoid worse clinical outcomes because women likely have greater diastolic dysfunction and more advanced cardiac remodeling at the time of referral.

Procedure mortality is 1% or less in recent studies for both interventions at experienced centers.⁶ With advances in management and improvement in technique, the authors appropriately question whether the benefits of watchful waiting outweigh the risks of SRT. This is particularly important in minimally symptomatic patients, because the presence of significant left ventricular outflow tract obstruction adversely affects outcomes, irrespective of symptoms, and has been shown to be a predictor of mortality in this subset.⁷ Overall, a reiteration of the current guidelines favoring earlier SRT may be warranted to mitigate the known time-dependent risks of obstructive HCM.

Although external validity of the findings from a tertiary referral center with extremely high volume may be limited and additional confirmatory evidence from outside of the Mayo Clinic is warranted,⁸ we trust that our colleagues at the Mayo Clinic, who have already contributed so much to the field on this topic, will continue to

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spearhead the pursuit to optimize management in this heterogeneous disease.

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See Article page 1502.

Commentary: Invasive therapy for hypertrophic obstructive cardiomyopathy: Is it time to reexamine the guidelines?

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Hypertrophic obstructive cardiomyopathy (HOCM) is associated with reduced life expectancy and quality of life,^{1,2} even in asymptomatic or mildly symptomatic patients.³ Previous observational studies have shown that septal reduction therapy (SRT) in the form of surgical septal myectomy restores long-term survival in HOCM patients to that of the age- and sex-matched general population.⁴ Nonetheless, both European and American practice

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CENTRAL MESSAGE

In experienced centers, early septal reduction therapy is associated with improved long-term survival in women and symptomatic patients with hypertrophic obstructive cardiomyopathy.

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guidelines recommend that SRT be reserved for patients whose symptoms are refractory to medical treatment (class I; level of evidence, B in European guidelines and C in American guidelines).^{5,6} Furthermore, there remains a paucity of data to guide the optimal timing of invasive treatment of patients with HOCM.

In this issue of the *Journal*, Cui and colleagues⁷ attempt to address this gap in knowledge and challenge the existing paradigm of treating only those with refractory symptoms. This article represents another important contribution from the Mayo Clinic on the treatment of HOCM. In this