subsequent valve-in-valve options, coronary access, and the risks of reoperation and valve explant, with much of the data needed to make these decisions still in the future. Is there a role for the Perceval valve in this paradigm? The results thus far are encouraging; however, longer-term follow-up, particularly regarding valve durability for this and other catheter-based devices, is clearly needed.

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Commentary: The truth is out there

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We are focusing on the new, we are distracting from the old. The rapid development of transcatheter devices and the subsequent flourishing of randomized clinical trials and large registries have shown not only the feasibility and good results of new technologies but have also brought to light that something is missing, rigorous data on surgical aortic valve replacement (SAVR).^{1,2} A critical appraisal of recent randomized clinical trials can suggest that incidence of end

CENTRAL MESSAGE

The 5-year outcomes of sutureless aortic valve bioprostheses are a key point for remodulating the reference points for benchmarking of aortic valve treatment.

points in the SAVR arm are abnormally high compared with the real world; nonetheless, looking for high-quality data supporting this hypothesis, we stay with a fistful of flies in hand as there are no strong updated mid- and long-term outcomes confirming surgery as the gold standard for the treatment of aortic valve disease, until proven otherwise.

The 5-year follow-up presented by Fischlein and colleagues³ adds new information on the outcomes of sutureless aortic valve bioprostheses and can permit us to make

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some considerations on reference points for benchmarking. First of all, the study is proof that technology in aortic valve replacement is still evolving and it is not slowed down by transcatheter aortic valve implantation (TAVI); emerging evidence of outcomes' decay of TAVI at mid-term are corroborating the viability of surgical option, and companies are still investing resources in surgical device research, despite potential future changes in indications that are not still predictable, lacking long-term evaluations.

These results can also serve as a reference point in benchmarking for sutureless aortic valve bioprostheses. As soon as safety and effectiveness have been demonstrated, the main key points of any implanted device are durability and long-term performance. However, their evaluation requires time (at least 5-10 years), which often counterposes to the pushing need of market rules. Moreover, most of existing studies are biased by high rate of withdrawal from trial follow-up and loss to follow-up, and their results can be of little use.⁴ The completeness of the presented data gives robustness to the very low 5-year incidence of major adverse cardiac and cerebrovascular events compared with previous analyses, with a particular focus on structural valve deterioration and reintervention.⁵

But that's not all. This sponsored trial can also be considered a good reference point for benchmarking the surgical arm in the TAVI versus SAVR trials. Its mid-term outcomes favorably compare with those of the surgical arm of

intermediate-risk trials, with a gap of more than 10% in all-cause mortality (29.3% vs 40.5%, respectively), among others.¹ Also, the Kaplan-Meier graphs do not show the steep ascent of the curve, representative of a high incidence of events in the first months, that we are used to see in the TAVI trials.

In the transcatheter era, updated follow-up on SAVR is needed as benchmark for transcatheter procedures and to support the definition of old and new gold-standards for the treatment of aortic valve disease. A weighted evaluation cannot prescind from updating our knowledge on SAVR and new technologies employed in surgery—the truth is out there.

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