Letters to the Editor

To the Editor:

I read with great interest the article by Lawrance and colleagues,1 for this fine and great effort. Unfortunately, cardiopulmonary bypass remains a crucial aspect to perform this kind of procedure. The most important point is that we are going on the right direction, each moment getting closer to the goal. I really congratulate Lawrance and colleagues1 for this fine and great effort.

Ovidio A. Garcia-Villarreal, MD
Department of Cardiac Surgery
Hospital of Cardiology UMAE 34
Instituto Mexicano del Seguro Social
Monterrey, Mexico

MINIMALLY INVASIVE FULL BIATRIAL COX MAZE IV: WE ARE GOING IN THE RIGHT DIRECTION

To the Editor:

I read with great interest the article by Lawrance and colleagues,1 and I congratulate them on this very interesting and well-written article. They have shown that the Cox maze IV procedure, with its inherent variations, can be performed by means of a less invasive right anterolateral minithoracotomy with excellent outcome. My personal preference is for the classic standard “cut-and-sew” Cox maze III procedure. Once the surgeon has acquired technical expertise, this procedure is both easy and safe to do. What is truly important is not the complexity of the procedure, but rather the aortic crossoff clamp time. This is the rub, and this is why alternative energy sources for atrial fibrillation surgery have mushroomed in recent years. Since 2002, this has been termed as Cox maze IV procedure. Damiano and his working group2 have been pioneers in this technology. The idea proposed by Lawrance and colleagues1 looks promising. In addition to the minimally invasive surgery, they used the only 2 energy sources that have been proved to be successful achieving full transmural lesions in the atria, bipolar radiofrequency and cryoablation. This great effort by Lawrance and colleagues1 in this article highlights that the trend is now toward the idea conceived by Cox3 11 years ago. He stated that surgery for atrial fibrillation should meet the following conditions: (1) the procedure should preferably be epicardial by nature; (2) the energy source should be capable of penetrating epicardial fat and ablating all types of atrial tachycardia; (3) cardiopulmonary bypass must be avoided; (4) the procedure should be amenable to endoscopic or minimally invasive techniques; (5) it should be performed in less than 1 hour; and (6) hospital discharge should be possible on the first postoperative day. Although it is true that not all these objectives have been achieved, we must recognize that we are on the right track. Novel devices are being developed4,5; as yet, however, transmural lesions have not been safely produced on the beating heart by epicardial ablation. Unfortunately, cardiopulmonary bypass remains a crucial aspect to perform this kind of procedure. The

References


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RUPTURE OF EXPANDED POLYTETRAFLUOROETHYLENE-LENE NEOCHORDAE USED FOR MITRAL VALVE REPAIR: DOES SIZE MATTER?

To the Editor:

In a report published in another journal in 2007,1 we reported 2 cases of rupture of synthetic chordae tendineae (expanded polytetrafluoroethylene [ePTFE]). We also analyzed the possible causes of what was then considered an extremely rare finding, which had first been reported by Buttany and