Authors have nothing to disclose with regard to commercial support.
permanent pacemaker (PPM) placement within the combined mitral tricuspid group. More specifically, the incidence of our secondary clinical endpoint was 47% (16 of 34) in the patients who received a Carpentier Edwards Classic ring and 35.2% (19 of 54) in those who received a “less rigid” Carpentier Edwards Physio ring ($P = .18$). Understanding the true influence of the implanted prosthetic material rigidity on the occurrence of PCA will require further studies.

Although we reported a high prevalence of PCA after concomitant tricuspid annuloplasty, we found at the end a much lower incidence of PPM placement than that previously reported in the literature for isolated tricuspid valve annuloplasties. This was due mainly to the effect of our strategy to extend the observation period after PCA. Nonetheless, Mestres and Suri believe that these results challenge the 2012 European Society of Cardiology/European Association for Cardio-Thoracic Surgery recommendations and the 2014 American College of Cardiology/American Heart Association guidelines, which encourage preventive surgical correction of tricuspid annular dilatation, even with mild valve dysfunction, at the time of left-sided heart valve surgery. In addition, they emphasized that prophylactic tricuspid annuloplasty has not been shown to diminish the risk for subsequent reopening on the tricuspid valve. However, in our own experience, this prophylactic approach has been responsible for a significant decrease in the incidence of late severe isolated functional tricuspid regurgitation (TR) over the last decade (see Central Figure). Furthermore, Goldstone and colleagues recently identified indexed tricuspid annular diameter as the sole risk factor for late TR in patients undergoing mitral valve surgery for degenerative disease with no TR or only mild TR preoperatively. Moreover, Desai and colleagues showed that the ability of mitral valve correction alone to improve functional TR is of short-term duration, and that even moderate residual TR has an adverse effect on mortality. Finally, late severe functional TR is rarely addressed surgically, mainly because of an associated operative mortality as high as 30%. Therefore, a low long-term tricuspid valve reoperation rate could not be the only criteria to promote the strategy of isolated mitral valve surgery.

We fully agree with the remark of Mestres and Suri on the ethical importance of informing patients about the risk of postoperative PPM before concomitant prophylactic tricuspid annuloplasty in the setting of mitral valve intervention. Nevertheless, one can also argue that patients should be informed about the risk of developing severe functional TR late after correction of a left-sided heart valve disease, an evolution that carries a risk of severe right ventricular dysfunction with poor survival.

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http://dx.doi.org/10.1016/j.jtcvs.2016.02.025

PREVENTIVE TRICUSPID ANNULOPLASTY: WHEN BENEFIT JUSTIFIES THE RISK. WHAT ELSE?

Reply to the Editor:

We were happy, pleased, and honored to discuss the contribution by Jouan and colleagues published in the Journal. The main issue was whether rigid ring annuloplasty has an influence on outcomes, especially when related to permanent

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