In this issue of the Journal, Dr Useini highlights some of the variables of interest missing from the TC Transcatheter Valve Therapy (TVT) report, including rates of paravalvular leak, degree of internal carotid stenosis, stroke risk, and questions the appropriateness of TC TAVR. Although there are many factors impacting paravalvular leak (device type and generation, appropriate sizing, distribution of annular calcification, etc.), access site is unlikely to significantly impact the rate or degree of paravalvular leak. As such, this should not be a deciding factor in access site for most patients. Risk of stroke has not been found to be significantly different in TC TAVR compared with other delivery methods, with experienced centers having stroke rate <2%, despite a greater degree of other comorbidities in the TC patient population.

Although we do not have direct insight to the degree of internal carotid stenosis, level of expertise of the TAVR teams with carotid access, preprocedure evaluation, technical details, or specific factors involved in the decision to perform TC TAVR from the TVT report, it is evident that this report reflects the initial experience and learning curve with these procedures. As with all surgical procedures, experience and a systematic and reproducible approach are critical for improving outcomes. It is therefore not surprising that with increasing experience, stroke rates are lower than in the TVT report. In our practice, we evaluate the diameter, degree of calcification, and tortuosity of the common carotid and innominate arteries and the angulation by duplex ultrasound and then select to access the side with the greater degree of internal carotid stenosis to preserve cerebral perfusion via the contralateral carotid artery. We believe the small surgical incision of TC TAVR is associated with less morbidity than the transthoracic TAVR approaches (thoracotomy or median sternotomy) with shorter duration of hospitalization, and similar length of stay to standard transfemoral approach.

Insights from both the national and institutional experiences suggest multiple factors supporting the use of TC TAVR, including low stroke rates, less morbidity, and faster recovery compared with other alternative access strategies. Accordingly, cardiovascular surgeons should continue to gain experience with TC TAVR in an era with increasing demand for alternative TAVR access.

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