The authors reported no conflicts of interest.

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To the Editor:

We read with great interest the article by Starnes and colleagues1 that showed excellent 10-year results of the wrapped vs unwrapped Ross procedure in adults with a bicuspid aortic valve. We also believe that using the inclusion technique with an artificial external vascular conduit can stabilize the pulmonary autograft to prevent late dilation and pulmonary autograft reinvention, and this has become part of our current Ross policy in young adults scheduled for this operation.

However, the authors state that the inclusion technique was adopted in 2001, yet this assumption is only partially true. In fact, almost 20 years ago, we reported a retrospective analysis on the clinical outcomes of pulmonary homograft in the aortic position, comparing the subcoronary and the Ross technique.2 In the latter, the pulmonary homograft was inserted as a short cylinder with lower interrupted sutures and a continuous upper line inside the patient’s aortic root, which wrapped the pulmonary homograft. At a maximum follow-up time of 39 months, none of the wrapped pulmonary homografts required reoperation for root dilation or valve regurgitation. Conversely, in the subcoronary implantation group (61 patients), 4 patients required reoperation (P = .04). This study is surely limited by the fact that we analyzed pulmonary homografts (rather than autografts), which are more prone to immunological failure. Indeed, the homograft was not included in an artificial vascular prosthesis, but within the original aortic root of the patient. However, to the best of our knowledge, Gerosa and colleagues,3 and in the same year, Pacifico and colleagues,4 were the first to introduce the concept of a wrapped pulmonary graft, showing its successful clinical results and performance. Since the beginning, the Ross procedure has been widely adopted for adult patients with excellent results at long-term follow-up. Unfortunately, compared with infants (in whom the unwrapped inclusion technique is the technique of choice because of its physiological adaptation properties),4 adults are more prone to Ross dilation due to the pulmonary autograft wall characteristics that make it weaker when switched into an aortic position. The use of an artificial vascular conduit rather than the patient’s own aorta to wrap is technically easier and might be safer (especially in cases of bicuspid aortopathy). However, its long-term benefits must still be ruled out, as well as the prosthesis of choice (eg, Valsalva or normal tubular conduit).1,5

We congratulate Starnes and colleagues1 for their impressive results. However, it is important to highlight that the concept of a wrapped pulmonary wall is older than this recent study, but it might still become the gold standard for the Ross operation in adults.

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References

Reply to the Editor:

We would like to thank Drs Gerosa and Pradegan from Padova, Italy, for their thoughtful letter to the editor in response to our recent manuscript in the Journal1 describing our experience with...