Reply to the Editor:

We thank Drs Vendramin, Bortolotti, and Livi for their interest in our work.

In the era of transcatheter aortic valve replacement, the concept of a “biological lifelong strategy” has become a key issue for cardiac surgeons, particularly in young patients with aortic disease who choose a bioprosthesis. Therefore, it is crucial to understand the durability of one of the most widely implanted prostheses worldwide. Our study provides one of the longest clinical and echocardiographic follow-ups of the Perimount Magna Ease (PME) valve (Carpentier-Edwards), which has been the most commonly used pericardial valve in the past decade. We found a low overall risk of moderate to severe structural valve degeneration, as well as low rates of endocarditis and reoperations at 10 years. These findings validate the good 10-year durability of the PME and compare favorably with other former and contemporary biological prostheses, as we discussed. We understand that patients with life expectancy exceeding 10 years may require longer follow-up periods. However, it is widely accepted in the medical literature that a 10-year observation is considered long-term follow-up. Furthermore, although Bourguignon and colleagues reported a “very long-term” follow-up of the previous Carpentier-Edwards valve extending to 20 years, the average follow-up duration in their study was only 6.7 ± 4.8 years, which is shorter than the average follow-up time of 7.9 ± 2.5 years in our study. Therefore, we believe it is fair to maintain that the present study reports long-term data on PME valves, demonstrating good durability over a period of at least 10 years. Clearly, an international consensus on reporting follow-up results of biological valves would be appropriate, especially in the coming years, because we will be dealing with younger patients who have received bioprostheses.

Regarding the second issue raised by the authors, we were unable to present data on patient-prosthesis mismatch due to the inconsistent reporting of effective orifice area in echocardiographic examinations during follow-up. As noted in the article, the main limitation of the study is the absence of standardized echocardiographic protocol examination, inherent to the retrospective nature of the study. The echocardiographic follow-up was conducted by cardiologists at referring hospitals, and the effective orifice area was reported in less than 10% of the examinations. Nevertheless, a subgroup analysis stratified by group size found no statistically significant differences in terms of structural valve degeneration greater than 2, endocarditis, or reoperation when comparing small-sized (19-21-23 mm) with large-sized (25-27-29 mm) bioprostheses. Despite its limitations, our study provides valuable insights into valve-related events and structural valve degeneration grading, aiding clinical decision-making based on long-term durability. Of course, ongoing follow-up is essential to further validate the use of this prosthesis in patients with a life expectancy exceeding 10 years.

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Conflict of Interest Statement
The authors reported no conflicts of interest.

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References

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