progression bearing the risk of aortic rupture, branch vessel occlusion resulting in visceral and/or leg ischemia, refractory hypertension or pain. Aortic replacement for acute aortic dissection showed significant mortality (29–50%) and paraplegia rate (30–36%) [5]. The 30-day mortality rate following endovascular type B dissection repair is acceptably low at 8.4%. There was and is a clear need for less invasive techniques. Better patient selection, precise stent-graft deployment, and the avoidance of balloon dilatation whenever possible may help to prevent these complications.

The growing body of evidence for such patients confirms that aggressive comprehensive risk factor management improves survival, reduces recurrent events and the need for interventional procedures, and improves the quality of life for these patients. In such patients, controversy remains regarding the optimal dose of aspirin with/without statins or clopidogrel to prevent postoperative complications.

While offering the advantage of being easily available at medium cost, statin therapy is a preventive measure of subclinical atherosclerosis, but at the same time it is not a predictive factor of postoperative cardiovascular events.

There are a number of recent studies, unfortunately the author cited only one, that suggest statin therapy may reduce the risk of perioperative complications [2–4]. This evidence, whilst promising, is not conclusive. Many of these studies are small and the data collected over a long period during which practices have changed significantly. This is an area in which the results of large randomized control trials are required to guide therapy.

Furthermore, data from medical patients suggest that the withdrawal of statin therapy may itself be associated with adverse consequences.

For that reason and the purposes of possible world-wide comparisons of recent studies representing data, serum cholesterol in patients with cardiovascular diseases should be evaluated and treated according to guidelines of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. Interestingly cessation of statins pre-event was associated with significantly poorer outcomes when compared to those patients who continued on statin therapy or those who had never been on a statin. Moreover, for the real-world practice it is important to be cautious in extrapolating from medical to surgical patients but these data mitigate against withdrawing statins from patients undergoing cardiovascular surgery.

The doubtful conclusion offered by the author that statins should become an essential component of the therapeutic approach of the cardiovascular patients is mainly based on retrospective or small studies. Nevertheless, no definitive evidence has been proved and this conclusion needs to be confirmed by a multicenter, prospective randomized trial.

If the main feature of the article had to be emphasized in a title and speaks for itself [5] two statements could or must be emphasized. Patients presenting for cardiovascular surgery have a complex array of medical problems. The careful management of these problems can improve outcome for these patients and is part of the fascination of this specialty. The cardiovascular teams are asked to address pre-, peri- and postoperative management issues relating not solely but predominantly to the statins in combination with scoring systems, beta-blockers, anti-platelet therapy, etc.

Put simply there is more to cardiovascular surgery than cardiovascular surgery.

The extraordi

**References**


**Letter to the Editor**

**Statins and perioperative management of patients undergoing cardiovascular surgery**

**Narcis Hudorović**

Department of Endo and Vascular Surgery, University Hospital “Sestre Milosrdnice”, Vinogradска 29, 10000 Zagreb, Croatia

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**Keywords:** Cardiovascular disease; Risk factors; Statins

The extraordinary actuality of the article of Paraskevas [1] is my excuse for this letter. Patients presenting for major cardiovascular surgery represent a dynamic challenge for the surgeon that extends beyond the intricacies of the planned operation. These patients frequently suffer from other significant comorbidities such as diabetes, respiratory, renal disease and elevated cholesterol. The management of these patients has to address not only immediate perioperative management issues but also prevent the deterioration of coexisting disease.

The growing body of evidence for such patients confirms that aggressive comprehensive risk factor management improves survival, reduces recurrent events and the need for interventional procedures, and improves the quality of life for these patients. In such patients, controversy remains regarding the optimal dose of aspirin with/without statins or clopidogrel to prevent postoperative complications.

While offering the advantage of being easily available at medium cost, statin therapy is a preventive measure of subclinical atherosclerosis, but at the same time it is not a predictive factor of postoperative cardiovascular events.

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Put simply there is more to cardiovascular surgery than cardiovascular surgery.

**References**


Reply to the Letter to the Editor

Reply to Hudorovic
Would a randomized controlled trial testing the effects of statins on patients undergoing cardiothoracic surgery be ethical?

Kosmas I. Paraskevas\textsuperscript{a, b, *}

\textsuperscript{a}Department of Clinical Biochemistry (Vascular Disease Prevention Clinics), Royal Free Hospital, London, UK
\textsuperscript{b}Department of Vascular Surgery, Red Cross Hospital, Athens, Greece

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Keywords: Statins; Cardiothoracic surgery; Perioperative mortality

Unfortunately, the comments by Dr Hudorovic [1] are inaccurate and incorrect. Dr Hudorovic states that ‘there are a number of recent studies, unfortunately the author cited only one, that suggest statin therapy may reduce the risk of perioperative complications [2—4]’. This statement is not true; of the ‘recent studies’ he mentions [2—4], two [2, 3] are actually cited in my article [5]; one is reference number 183 [2] and the other is reference number 17 [3]. The third ‘recent’ reference he mentions [4], is not so ‘recent’ (5 years old); instead of this, two more recent, comprehensive reviews by the same group are cited (references 20 and 21).

Regarding the part when Dr Hudorovic mentions that ‘unfortunately, the author cited only one (study)’, it may be of interest that the ‘study’ cited, is actually an extensive review we published on the effects of statin therapy on perioperative (and long-term) morbidity and mortality rates in patients undergoing non-cardiac vascular surgery (reference number 184). Two of the ‘recent’ studies mentioned by Dr Hudorovic [2, 3] are also cited in this review; the third [4] could not be cited, as it was published 6 months after our article.

The next comment by Dr Hudorovic is also incorrect (‘statin therapy is a preventive measure of subclinical atherosclerosis, but in the same time it is not a predictive factor of postoperative cardiovascular events.’). For example, in reference number 181 of my article [5], statin use was associated with a 2.5-fold reduction in the risk of all-cause mortality and a more than three-fold reduction in the risk of long-term cardiovascular mortality in 510 patients undergoing abdominal aortic aneurysm repair after a median follow-up of 4.7 (range: 2.7–7.3) years.

Dr Hudorovic claims ‘no definitive evidence has been proved and this conclusion needs to be confirmed by a multicenter, prospective randomized trial’; this statement is correct. However, due to the uniform positive results of observational studies, there may now be ethical restrictions when designing double-blind placebo-controlled trials to assess the effects of statins on patients undergoing cardiothoracic surgery. It may also be difficult for an ethical committee to approve of such a randomized controlled trial due to the reported benefits of statin therapy [2—5]. In light of the current evidence [2—5], would Dr Hudorovic prefer his patients to quit taking their statin preoperatively? I doubt any surgeon would!

References


Letter to the Editor

Injury to the circumflex coronary artery following mitral valve repair: a rather opposite strategy

Walter J. Gomes\textsuperscript{a, b, §}

\textsuperscript{a}Pirajussara General Hospital, Cardiovascular Surgery, Federal University of São Paulo, São Paulo, Brazil

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Keywords: Mitral valve repair; Annuloplasty; Circumflex coronary artery; Myocardial ischemia

The letter from Acar [1] on the management of circumflex artery injury after mitral valve repair, as well as the original report from Zegdi et al. [2], were both very instructive and definitely life-saving.