compared to a mechanical prosthesis [3] and, therefore, bioprostheses and PPM could be suggested to be closely linked. However, one cannot rule out that PPM could be considered a ‘catalyst’ variable for other risk factors and, as such, even multivariate analysis may have difficulties in discriminating between patient-related and prosthesis-size confounding factors. In terms of the beneficial impact on outcome with the use of stentless valves, results are disparate, and no clear clinical advantage of one valve type over another has been demonstrated. In a meta-analysis, Kunadian et al. [4] concluded that stentless aortic valves provide an improved level of left ventricular mass regress (LVMR), reduced gradients and improved effective orifice areas (EOAs), but longer cardiopulmonary bypass time is required. In contrast, in a recent publication by Cohen et al., long-term outcomes of patients randomised in a previous study were evaluated [5] and the authors reported that stentless valves offered improved haemodynamic outcome, but not superior LVMR or improved clinical outcome up to 12 years after implantation.

In light of current and similar reports, in assessing the benefits of a particular valve design, the goal should be a comparison of clinical outcomes, such as survival, freedom from valve-related morbidity and functional capacity rather than EOAs, gradients, and PPM since the latter seem to be of inferior clinical importance.

References


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Letter to the Editor

What else could be done beside aortic repair?

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Congratulations to the authors for this valuable study [1]. We wanted to emphasise some issues that we think are important: Was it not necessary to correct the bicuspid aorta when aortotomy was already made? This is because the bicuspid aorta has its own unique anatomy and physiology causing turbulent flow.

Another issue was that the prolapsus of aortic leaflet that caused deterioration in the leaflet microscopy. Was another option possible to correct it other than plication?

Could it be more convenient to increase the durability of normal tissues during the repair? For example, dilation of ascending aorta may be caused by increased stroke volume due to aortic regurgitation. The peak value of rate of rise of left ventricular pressure (dp/dt) is reached around the non-coronary cusp, possibly to lead to aortic dissection. Could a graft be interposed to the ascending aorta while the patient is already being operated and, if so, could this be a preventive measure in an ageing population with prolonged life expectancies?

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Reply to the Letter to the Editor

Reply to Kestelli et al.

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We appreciate the comments of Kestelli et al. [1] to our publication 'Aortic valve repair leads to a low incidence of valve-related complications'.