also be found in other large reports [3]. The extremely low rate of \( \approx 10\% \), as mentioned by Numata, is more likely an extraordinary exception.

Secondly, Numata et al. should not suppose that the majority of arch surgeries in our series consisted of hemiarch replacements. We clearly provided the number of complete arch repairs in our cohort and emphasized that the rate of 22% matched the ratio in other large studies reporting arch surgery. It is correct that performing distal arch anastomosis and/or anastomoses with supra-aortic arteries can be difficult and time-consuming in particular arch pathologies, and therefore, for such cases and/or less-experienced surgeons, we recommended a technique of gradual reperfusion for shortening both the circulatory arrest and unilateral cerebral perfusion times. I refer Numata et al. to this issue, extensively described and illustrated in our article.

REFERENCES


LETTER TO THE EDITOR

Transcatheter aortic valve and aortic homograft reintervention

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I read with interest the article by Drews et al. [1] about the use of transcatheter aortic valve implantation (TAVI) after homograft valve surgery. Surprisingly, I realized that both the authors and the manufacturing company are not aware that the TAVI valve was already implanted in the case of homograft degeneration [2].

Aortic valve replacement in patients with a previous homograft implantation remains a technical challenge, above all in extremely calcified aortic roots. The traditional surgical approach has a perioperatively reported surgery mortality of between 3 and 8%.

TAVI represents a valid alternative in the case of homograft valve reintervention.

Considering the homograft insertion technique, it could be useful to slowly deploy the balloon valve twice, thus permitting the gentle displacement of the valve [2, 3].

TAVI represents a very interesting option compared with the traditional surgical approach in patients with valve redo and is a safe and successful alternative.

REFERENCES