We are happy to reply to the letter from Tavlasoglu et al. [1] to further elucidate our position on transcatheter mitral valve therapies.

Dr Tavlasoglu has questioned the title of our recently published paper [2]: in the author’s opinion, mitral repair for functional mitral regurgitation (FMR) is not confined to undersized annuloplasty alone. Undersized annuloplasty is universally considered the standard procedure for treating FMR. We do agree that there are other options, but these are neither proven nor standardized. This was the reason for restricting the inclusion criteria to this technique alone, with the aim of comparing a new therapy (MitraClip) to the most proven surgical therapy (undersized annuloplasty) [3].

Tavlasoglu et al. question the value of the EVEREST trial in supporting clinical decision-making. The EVEREST addressed low-risk surgical candidates, mostly with degenerative aetiology [4]. Currently, most patients undergoing the MitraClip procedure are non-surgical candidates with FMR.

The surgical patients were very carefully selected, to keep the risk profile low and preserve the chance of clinical success. On the contrary, patients who underwent MitraClip had a higher risk profile. This message should not be missed: patients treated by transcatheter interventions today are patients who have been denied surgery.

Transcatheter interventions offer the unique opportunity of staging interventions to mitigate risk. However, most of the associated procedures performed in the surgical cohort, although being recognized as risk factors for early mortality, are associated with long-term benefit. Therefore, if the comparison could be unfair against surgery in the early term, it is in favour as far as the longer follow-up is considered. In addition, we are reluctant to believe that associated procedures like revascularization have a negative impact on early outcomes in patients with FMR. In fact, the guidelines support associated procedures with a higher level of evidence when compared with isolated mitral valve surgery [5]. There are other important issues related to the amount of reverse remodelling achievable by MitraClip when compared with surgery. Future studies should address this issue in a more effective way. Regarding the durability of the technique, surgical experience has demonstrated that annuloplasty improves durability [6], and we expect transcatheter techniques to implement annuloplasty.

Finally, in the opinion of Tavlasoglu et al., the MitraClip should not be considered an alternative option in FMR. Two European Society of Cardiology guidelines committees had a different opinion when they included the MitraClip as a treatment option in high-risk and inoperable patients with FMR and severe symptoms despite optimal medical therapy [5]. The guidelines suggest a class IIb indication (evidence C). This reflects the scarcity of data supporting stronger statements. However, it should be recalled that surgery in isolated FMR has exactly the same level of evidence and class of indication as the MitraClip, reflecting the similar lack of evidence.

Our opinion is that we, surgeons, should focus on collecting evidence to further support surgical techniques before rejecting novel therapies, and be more open to incorporating technological innovations in our practice to be able to judge their value based on direct experience.

REFERENCES


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LETTER TO THE EDITOR RESPONSE

Reply to Tavlasoglu et al.

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