LETTER TO THE EDITOR RESPONSE

Reply to Cikirikcioglu et al.

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We thank Dr Cikirikcioglu et al. [1] for their comments, and interest in our work [2]. Guidelines are, by their nature, general in concept and application and should normally be taken to represent the ‘default’ position: what should be ideally done when there is no clinical reason to do the contrary.

The evidence from which our guidelines were constructed undoubtedly points to the possibility of the occurrence of venous thromboembolism being a real risk in cardiac surgery, and also to the benefit in reducing this risk by prophylactic intervention. If patients with aortic dissection and other categories are to be excluded from this, then we would ideally like to see robust evidence supporting such exclusion. Of course, clinicians should always have the freedom to act outside the guidelines when their own clinical evaluation of the patients mandates this. For example, it would be wrong to persist in anticoagulating a patient who has a life-threatening gastrointestinal haemorrhage in order to reduce the much smaller risk of venous thromboembolism.

Guidelines are produced by collating the best evidence available at the time. We share Dr Cikirikcioglu’s concern about the relative lack of sufficient and high-quality evidence in this and many other fields, but it is better to be guided by the best evidence available than by no evidence at all. A feature of any evidence-based guideline is that it will necessarily contain evidence that is dated. Furthermore, as a result of continuing developments, the guidelines themselves are subject to obsolescence. That is why all guidelines should be reviewed in a timely fashion, so that the latest evidence can be taken into account and the guidelines themselves can be modified as appropriate if new evidence mandates such a modification.

REFERENCES


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Does the anatomy of mitral paravalvular leakage increase the risk of device embolization in percutaneous treatment modalities?

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