LETTER TO THE EDITOR

Challenging valve replacement in posterior mitral annular calcification

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The ‘How-to-do’ paper by Nezic et al. [1] was truly interesting. These authors resolve, by a simple technique, a really challenging surgical problem: the method of implanting a valve prosthesis when the posterior mitral annulus is heavily calcified, sometimes involving the posterior left ventricular myocardium. The only drawback of the above-mentioned technique appears to be the calcification of the anterior mitral leaflet (AML). I successfully adopted this technique to perform a mitral valve replacement on a 74-year old man with aortic bioprosthesis failure and calcified mitral valve stenosis. I performed the operation with a minor modification that I think further simplifies the proposed technique. Briefly, the AML was removed from its insertion and brought posteriorly. It was first sewed by two 4/0 polypropylene sutures starting bilaterally where the AML crossed the mitral annulus out of its calcification area. The two running sutures were also brought up to the left atrial posterior wall, avoiding the placement of any sutures on the ventricular posterior wall (personal modification). At the time of bioprosthesis insertion, a 2/0 pledgeted subannular mattress stitch was passed bilaterally through the posterior annulus, overriding the AML where it crossed, then to the prosthetic sewing ring. The remaining ‘posterior’ stitches were passed only through the transposed AML in a kind of ‘subannular’ fashion, without securing them to the calcified area of the posterior left ventricular wall (personal modification), avoiding the need for partial decalcification. Finally, the bioprosthesis was secured to the anterior annulus in the usual manner. Both the postoperative and 3-month follow-up echocardiography revealed the regular function of the bioprosthesis. Neither perivalvular leakages nor rocking mobility of the bioprosthesis ring, which appeared well fixed in the proper position, was detected. The patient is still in good clinical condition 6 months after the operation. In conclusion, I had a satisfactory surgical experience with the suggested technique, and therefore I recommend its use whenever indicated.

REFERENCE


LETTER TO THE EDITOR RESPONSE

Reply to Da Col

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