Touch or keep away: big debate on mitral regurgitation in patients with hypertrophic obstructive cardiomyopathy

Safak Alpat* and Mustafa Yilmaz

Department of Cardiovascular Surgery, Hacettepe University School of Medicine, Ankara, Turkey

* Corresponding author. Department of Cardiovascular Surgery, Hacettepe University School of Medicine, 06100 Sihhiye, Ankara, Turkey. Tel: +90-537-2419710, e-mail: salpat@hacettepe.edu.tr; safakalpat@gmail.com (S. Alpat).

Received 23 March 2013; accepted 19 June 2013

Keywords: Hypertrophic obstructive cardiomyopathy • Systolic anterior motion • Mitral regurgitation

We have read the manuscript by Borisov [1] with great interest. In this article, the author described a new surgical technique for patients with simultaneous obstruction of the left ventricular (LV) midcavity and right ventricular outflow tract (RVOT), combined with extreme LV hypertrophy, in which classical surgical techniques are not effective. It is an innovative paper but several issues have to be addressed.

It is well known that systolic anterior motion (SAM) of the mitral valve is observed in 31–61% of patients with hypertrophic obstructive cardiomyopathy (HOCM). It is associated with resting LV outflow tract obstruction in 25–50% of these patients. SAM is now recognized as one of the important determinants of outcomes after HOCM surgery [2]. Since its pathophysiological features are a result of the complex relationship between ventricular phenotype of septal hypertrophy and anatomical characteristics of the mitral valve, a multifaceted surgical approach is required. Several repair techniques have been reported in literature [3]. However, as we observed in our clinical practice, these patients will eventually need valve replacement. For that reason, we look forward to seeing long-term follow-up of patients that had been operated on with the new technique, as regards mitral regurgitation.

Furthermore, authors divide right ventricular anterior wall since free wall hypertrophy exists in patients with RVOT obstruction. However, it was not reported if a patch had been used to enlarge the RVOT. We wonder whether enlarging the RVOT will add further benefit or compromise the postoperative haemodynamic status of patients.

Management of HOCM is one of the most controversial areas in cardiac surgery. Several surgical techniques exist with different results from various centres. It is obvious that we need new techniques to get better long-term outcomes. However, with a better understanding of the impact of SAM in HOCM, techniques combining the surgical relief of HOCM and surgical correction of SAM will be important.

REFERENCES

