I thank Alpat and Yilmaz [1] for their interest in my article published in the journal. It is my pleasure to respond. In our hypertrophic obstructive cardiomyopathy (HOCM) group with severe hypertrophy and obstruction of the right ventricular outflow tract (RVOT), we had no cases with severe mitral incompetence [2]. A systolic anterior movement of the mitral valve (SAM) after surgery was noted only in 2 patients (to a mild degree) and moderate mitral regurgitation present before the operation was successfully eliminated. The follow-up echocardiography showed a reduction in the atrial size and low gradients and mitral regurgitation was minimal.

Recently, a group from the Mayo Clinic reported on 198 patients undergoing transaortic extended myectomy alone without plication of the anterior leaflet of mitral valve and mitral valve repair. They documented that outflow gradients were abolished and the systolic anterior motion resolved, as did residual mitral insufficiency. Despite minor structural abnormalities in the mitral apparatus associated with hypertrophic cardiomyopathy, intervention on the mitral valve is not necessary after complete relief of left ventricular outflow tract (LVOT) obstruction with septal myectomy when mitral regurgitation is due to SAM [3]. In our HOCM group with RVOT obstruction and moderate mitral regurgitation not due to independent mitral valve disease, there were no indications for surgical correction of SAM and additional mitral valve repair after surgical relief of obstruction.

Concerning mitral valve replacement, we never used this technique for HOCM patients. The advantages of mitral valve repair compared with prosthetic replacement are well established [4] and replacement can be avoided in most patients with HOCM and concomitant degenerative mitral regurgitation [3]. In HOCM patients with significant mitral insufficiency we usually perform myectomy and mitral valve repair. However, it is another group of HOCM patients and there was no RVOT obstruction.

Finally, the authors are concerned about using the patch to enlarge the RVOT during the operation. We never used patches for surgical correction of HOCM in patients with RVOT obstruction. For the widening of the RVOT and normalization of the RV cavity size, it was sufficient to excise hypertrophic tissue in the asymmetrical area of the septum from the right side and divide additional trabecules and attachments that exist between the anterior part of the ventricular septum and the RV anterior wall. The adequate resection of hypertrophied tissue from the right side resulted in elimination of obstruction, increase in the RV and LV cavity sizes and improvement in RV function. Based on our clinical experience, it is not necessary to use patches for surgical correction of HOCM in patients with simultaneous obstruction of left ventricular mid-cavity and RVOT, simultaneous LVOT and RVOT obstruction or isolated RVOT obstruction.

REFERENCES