After reading the eComment by Hernandez-Vaquero et al. [1] on our original article [2], we would like to express our gratitude to the authors for their nice feedback and their interest in our paper.

Before answering the cited criticism, we remind that the missing data regarding geriatric evaluation, namely frailty and poor mobility, have already been acknowledged in the Limitations section of the article [2]. We completely recognize the importance of vulnerability of the senile patient, but the earliest patient enrollment dates back from 2001, when the concept of frailty was not so clearly linked to the patient’s outcomes in cardiac surgery. Mainly, it was not before the introduction of transcatheter valve procedures that inoperability of a patient due to frailty or comorbidities was extensively investigated [3]. It would be interesting to analyze the impact of minimally invasive heart valve surgery on the postoperative recovery of frail patients, but unfortunately it was not possible within the limits of this retrospective study [2]. However, we continue to investigate the effects of minimally invasive approaches on the immediate recovery after heart surgery, and our centre is actually a contributor to a multicentre study dedicated to preoperative poor mobility.

The data presented in the original study clearly favour the minimally invasive approach, with shorter times of mechanical ventilation and hospital stay and a greater proportion of patients discharged to the rehabilitation facility or directly home. We interpret these findings as a direct consequence of the less invasive character of the right anterior minithoracotomy, with less biological harm, or less biological price to pay, associated with minimal access aortic valve replacement (AVR).

As demonstrated on Figure 1 of the original article, since 2009 there was a distinct trend to a numerical reduction of conventional sternotomy AVR in our centre (octogenarian patients), so that already in 2013 all isolated AVR procedures were performed through a right anterior minithoracotomy in the elderly. It was a conscious option to provide a better service to our patients and to avoid full sternotomy whenever it was possible, because the advantages of a right minithoracotomy were already well known. That is why we deem inappropriate an eventual future study with randomization between full sternotomy and right anterior minithoracotomy in our centre. However, we strongly advocate the hypothesis that minimally invasive AVR could benefit also frail patients versus full sternotomy AVR.

Nobody is perfect, and no article is ideal: even the sun has spots!

We are happy to concede the right of the future study organization to the University Hospital of Asturias!

Conflict of interest: none declared.

References