

## Aortic valve reconstruction using autologous pericardium for patients aged less than 60 years

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**Objective:** We have performed an original aortic valve reconstruction using autologous pericardium. The feasibility for patients aged less than 60 years is reviewed.

**Methods:** From April 2007 to April 2013, aortic valve reconstruction was performed in 108 patients aged less than 60 years. A total of 51 patients had aortic stenosis, 7 patients had annuloaortic ectasia, 7 patients had infective endocarditis, and 43 patients had aortic regurgitation. Fifty-seven patients had bicuspid valves, and 11 patients had unicuspid valves. There were 75 male and 33 female patients, with a mean age of  $47.8 \pm 11.2$  years. Preoperative echocardiography showed an average peak pressure gradient of  $86.1 \pm 35.1$  mm Hg with aortic stenosis. The surgical procedure is based on the independent tricuspid replacement using autologous pericardium. First, the distance between the commissures is measured using an original sizing apparatus, and then the pericardial cusp is trimmed using an original template and sutured to the annulus.

**Results:** There was no conversion to prosthetic valve replacement. There were no in-hospital mortalities. Postoperative echocardiography showed an average peak pressure gradient of  $14.8 \pm 7.8$  mm Hg 1 week after surgery and  $12.8 \pm 3.1$  mm Hg 4 years after surgery. One patient required reoperation because of infective endocarditis. The other 107 patients showed less than mild aortic regurgitation. No thromboembolic events were recorded. The mean follow-up period was  $34.2 \pm 15.7$  months. Freedom from reoperation was 98.9% with 76 months of follow-up.

**Conclusions:** Original aortic valve reconstruction was feasible for patients aged less than 60 years. Long-term data will be disclosed in the future. (*J Thorac Cardiovasc Surg* 2014;148:934-8)

Aortic valve reconstruction is the gold standard of surgical treatment for various aortic valve diseases, especially for adults. Bioprosthetic valves are used increasingly because of the complications with inevitable postoperative anticoagulation of mechanical valves.<sup>1,2</sup> However, despite the progress of the design and construction of prosthetic valves, hemodynamic performance is not yet comparable to that of native aortic valves. Moreover, replacement with a bioprosthesis can cause accelerated degeneration in young patients because of fibrosis and calcification.<sup>3</sup> Immune reaction may play a role in the degeneration of the implanted bioprosthesis, especially in younger patients.<sup>4,5</sup>

Aortic valve repair, the Ross operation, and balloon aortic valvuloplasty are the other surgical treatment options

for aortic valve disease, but they have been performed in only a select group of patients by a limited group of well-experienced surgeons or interventionists.

Our original aortic valve reconstruction has been performed since April 2007. The initial report of 88 patients undergoing this operation was published in 2011.<sup>6</sup> This is a unique operation that consists of independent replacement of 3 aortic valve cusps by glutaraldehyde-treated autologous pericardium and that preserves the natural motion of the aortic annulus during the cardiac cycle. In the current study, we inspected the feasibility of our original aortic valve reconstruction for patients aged less than 60 years.

### METHODS

Our original aortic valve reconstruction and the clinical study of this operation were approved by the institutional review board of Toho University Ohashi Medical Center. All patients underwent this operation after written, informed consent had been obtained.

Our original aortic valve reconstruction was performed between April 2007 and April 2013 in 108 patients aged less than 60 years. We retrospectively reviewed our clinical data of all 108 patients and evaluated their short- and midterm results.

There were 75 male and 33 female patients, with a mean age of  $47.8 \pm 11.2$  years. The age distribution of all 108 patients of the current study group is shown in [Figure 1](#). A total of 51 patients had aortic stenosis (AS), 43 patients had aortic regurgitation, 7 patients had annuloaortic ectasia, and 7 patients had infective endocarditis. A total of 57 patients had bicuspid aortic valves, and 11 patients had unicuspid valves.

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### Abbreviation and Acronym

AS = aortic stenosis

Preoperative echocardiography showed that the peak pressure gradient through the aortic valve averaged  $86.1 \pm 35.1$  mm Hg in 51 patients with AS.

### Surgical Technique

The surgical technique of our original aortic valve reconstruction has been reported.<sup>6,7</sup> Preparation of the autologous pericardium began with cleansing fat and other redundant tissue on the outer surface of the pericardium using the Harmonic scalpel (Ethicon Endo-Surgery, Inc, Cincinnati, Ohio). The pericardium was excised to approximately  $7 \times 8$  cm and treated with 0.6% glutaraldehyde solution with buffer for 10 minutes. The treated pericardium was rinsed 3 times using a sterilized physiologic saline solution, with a duration of 6 minutes per rinse. All of the aortic valve reconstructive procedures were performed during cardioplegic arrest on cardiopulmonary bypass.

First in the procedure, the diseased cusps are excised meticulously. In the case of thick calcification along the aortic annulus, the Cavitron Ultrasonic Surgical Aspirator (SonoSurg, Olympus, Tokyo, Japan) is helpful in removing it without damaging annular tissue. The distance between each commissure is measured using our original sizing apparatus. From the glutaraldehyde-treated autologous pericardium, the new cusp with the size corresponding to the measured value is trimmed using our original template. Last, the annular margin of the pericardial cusp is sutured with running 4-0 monofilament sutures to each annulus. The running suture should be performed to make a nice gather, creating a 3-dimensional natural bulge of the cusps. Each pericardial cusp is sewn all the way to the top of the commissure. The reason behind this design is to have a longer coaptation zone, up to the same horizontal plane as the commissures. Commissural coaptation is secured with additional 4-0 monofilament sutures. The coaptation of the 3 new cusps is always ensured with direct vision under negative pressure made by a left ventricular vent before aortotomy closure. In patients with aortic regurgitation or bicuspid/unicuspid valves, we encircle the aorta at the commissural level with a 5-mm-wide felt strip after de-clamping the aorta to prevent the future dilatation of the aorta and eventual recurrence of regurgitation (Figure 2).

### Follow-up

All patients were followed up at the outpatient clinic of Toho University Ohashi Medical Center or at the referral hospital. Echocardiographic evaluation was performed 1 week, 1 month, 3 months, and every 6 months after surgeries.

### Statistical Analysis

Data are presented as mean  $\pm$  standard deviation. Survival and freedom from reoperation rate were calculated by the Kaplan–Meier method.

### RESULTS

There were no conversions to prosthetic valve replacement. There were no in-hospital mortalities recorded. Postoperative echocardiography showed an average peak pressure gradient of  $14.8 \pm 7.8$  mm Hg 1 week after surgery and  $12.8 \pm 3.1$  mm Hg 4 years after surgery. No cusp calcification was recorded during the entire follow-up period. One patient required reoperation because of infective endocarditis. The other 107 patients showed less than

mild aortic regurgitation. No thromboembolic events were recorded even without anticoagulation. The mean follow-up period was  $34.2 \pm 15.7$  months. Survival and freedom from reoperation were 96.9% and 98.9%, respectively, at 76 months follow-up (Figure 3).

Because our technique is tricuspid reconstruction for all patients, including those with bicuspid or tricuspid aortic valves, we held the comparative study in subgroups of patients who originally had tricuspid, bicuspid, or unicuspid aortic valves. Furthermore, the transition of averaged peak pressure gradient through the aortic valves showed no significant differences in the 3 subgroups (Figure 4).

### DISCUSSION

The choice of strategy among variable aortic valve surgical procedures is still controversial, especially for younger patients. The available surgical treatments of aortic valve disease are repair and replacement of the aortic valve. Valve-sparing operations can be categorized broadly into interventions on the aortic valve itself and those aimed at repairing the proximal aorta.

Aortic valve reconstruction is now acknowledged as a safe and effective operation for aortic valve disease. The recent large-scale study of aortic valve reconstruction with 7883 Japanese patients from 2005 to 2008 showed an operative mortality of 3%.<sup>8</sup> Conventional aortic valve reconstruction presents complications resulting from prosthetic valves. Mechanical valves require lifelong anticoagulation, and bioprosthesis is associated with high rates of structural valvular degeneration.<sup>9,10</sup> The stented bioprosthesis showed progressive calcification at the base of each cusp, notably near the commissure.<sup>11</sup> Even with a stentless prosthesis, calcification may be present along the aortic wall.<sup>11</sup> During the follow-up of all 108 patients aged less than 60 years in the current series, we found no signs of calcification. The following case is a good example. We performed our original aortic valve reconstruction on a 14-year-old boy with a failed unicuspid aortic valve (Figure 5, A). Echocardiographic follow-up 3.5 years

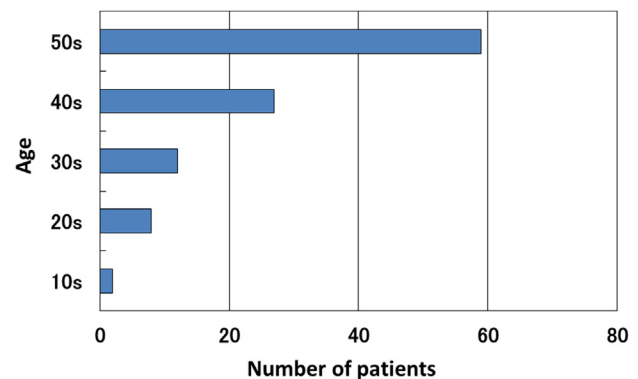


FIGURE 1. Age distribution of all 108 patients in the current study.

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