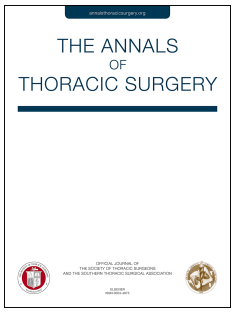
Accepted Manuscript



Ischemic Mitral Regurgitation Treatments After Mitral Annuloplasty (Reply)

Wobbe Bouma, MD, PhD, Inez J. Wijdh-den Hamer, MD, Joseph H. Gorman, III, MD, Robert C. Gorman, MD

PII: S0003-4975(18)30144-9

DOI: 10.1016/j.athoracsur.2018.01.029

Reference: ATS 31323

To appear in: *The Annals of Thoracic Surgery*

Received Date: 26 December 2017

Accepted Date: 6 January 2018

Please cite this article as: Bouma W, Wijdh-den Hamer IJ, Gorman JH III, Gorman RC, Ischemic Mitral Regurgitation Treatments After Mitral Annuloplasty (Reply), *The Annals of Thoracic Surgery* (2018), doi: 10.1016/j.athoracsur.2018.01.029.

Ischemic Mitral Regurgitation Treatments After Mitral Annuloplasty (Reply)

Reply to the Editor:

We appreciate Dr Bademci's [1] interest and careful reading of our article [2]. Dr Bademici addresses two important issues in the current discussion on surgical treatment of ischemic mitral regurgitation (IMR): annuloplasty ring type and concomitant coronary artery bypass grafting (CABG).

Annuloplasty ring type selection was left at the surgeon's discretion in our study, which can be considered a limitation. We did, however, use a standardized approach of annular downsizing (two sizes down). In addition, Table 1 shows that there were no significant differences in ring types used among groups with and without recurrent IMR after repair [2]. In the majority of patients (86%) a Profile 3D or Physio II ring was used. Both ring types are saddle-shaped, semi-rigid, complete rings.

The relevance of ischemic mitral valve repair in the setting of CABG has been a major source of debate. Although this is a very interesting discussion, it was, however, not the focus of our study. In Table 1 we showed that the frequency of concomitant CABG (or any other concomitant procedure for that matter) did not differ significantly between groups [2].

Both annuloplasty ring type and frequency of concomitant CABG did not differ significantly between groups and therefore both parameters cannot be considered predictors of repair failure based on our study results.

Dr. Bademici argues that our mitral valve repairs might not be considered acceptable, because we did not show in our paper if complete coaptation was achieved. However, neither a clear definition of complete coaptation nor a reference to a clear definition are mentioned in his letter to the editor. Our paper was a three-dimensional geometric study to identify preoperative predictors of mitral valve repair failure. We do not see how intra-operative coaptation depth can aid in preoperative prediction of repair failure. However, in addition to preoperative parameters we are in need of intraoperative parameters that can predict repair failure (or success).