

Letter to the editor: Mitral valve repair with the edge-to-edge technique: A 20 years single-center experience

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Letter:

To the Editor,

"Mitral valve repair with the edge-to-edge technique: A 20 years single-center experience" by Konstantinos Sideris et al.¹ provided remarkable information regarding the surgical intervention of mitral valve defects by illuminating its essential components. In-depth details support the article as a result of the authors'

pronounced knowledge of their respective disciplines. Transcatheter Mitral Valve Repair utilizing the Edge-to-Edge MitraClip is a modern, minimally invasive therapy of equal significance, despite the fact that open surgical surgery is emphasized in this paper. This alternative approach, a closed heart surgery, reduces the chance of postoperative infection, hence reducing the iatrogenic danger. Consequently, we believe that the study should have included a percutaneous intervention comparison model.²

In addition, it was also observed that the article's position regarding the severity of Barlow's disease was very ambiguous. The severity of Barlow's illness substantially impacts mitral valve structure, which may necessitate a modified edge-to-edge procedure called "The Triple Orifice Technique".³ However, no attention was discovered addressing this issue, which we believe would enhance the edge-to-edge approach experience. Furthermore, the author regarded the edge-to-edge technique by Alfieri et al.⁴ as the preferred procedure for bi-leaflet and anterior leaflet prolapse, but somehow failed to reveal a procedure for posterior leaflet prolapse, despite the inclusion of patients with posterior leaflet prolapse in this study. Respect rather than resect (RRR) has been identified as an appropriate method for posterior leaflet prolapse, hence reducing the likelihood of reoperation.⁴ Therefore, we believe that postoperative treatment and rehabilitation should be incorporated into surgical approaches to lessen the possibility of reoperations. Nonetheless, neither rehabilitation nor antithrombotic management were mentioned.⁵ Lastly, the investigation revealed that the cause of death for 19 patients could not be determined, although cardiac causes were identified in 40% of the evaluated deaths. Which statement would have been crucial in determining the postoperative treatment issues.¹

As each of the aforementioned factors adds to the foundation of the study that elucidates the edge-to-edge technique in considerable depth, we feel that focusing on these factors could enhance the retrospective analysis of the event. In individuals with end-stage DCM, MV repair is feasible, with a low inpatient mortality rate and significant relief in symptoms. The combination of the edge-to-edge approach and undersized annuloplasty can considerably enhance the longevity of the repair.⁴ Left ventricular (LV) failure is often accompanied with functional mitral regurgitation in ischemic or idiopathic dilated cardiomyopathy (DCM) (FMR). FMR has been treated using undersized ring annuloplasty. However, mitral insufficiency can return in a substantial number of patients. Patients with mild to moderate annular dilatation, significant tethering, and complex jets appear to be particularly unreliable candidates for this type of surgery. However, the majority of unfavorable outcomes have been reported when the edge-to-edge approach has been utilized without simultaneous annuloplasty or in conjunction with only a posterior flexible band, neither of which could prevent the advancement of annular dilatation in the presence of DCM.⁵

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