

Concomitant Tricuspid Annuloplasty in Mitral Valve Surgery for Degenerative and Rheumatic Valve Diseases: Balancing the Benefits.

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Abstract

The article published in this edition of Journal of Cardiac Surgery, Arafat and colleagues discuss the results of their ten year clinical experience of concomitant tricuspid annuloplasty (TA) for moderate to severe tricuspid regurgitation (TR) during mitral valve surgery in patients with rheumatic (RMVD - n= 345; 61% had mitral regurgitation and 39% mitral valve stenosis) and degenerative (DMVD n= 135) mitral valve diseases, The objective of the observational non-randomized trial was to identify predictors of durability of TA for moderate to severe TR in patients with RMVD and DMVD undergoing mitral valve repairs and replacements. Valve repair was feasible in 12% in the RMVD group as compared to 52% in DMVD group (1). The TA was performed with flexible, rigid prostheses and the de Vega suture technique.

Editorial

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The article published in this edition of Journal of Cardiac Surgery, Arafat and colleagues discuss the results of their ten year clinical experience of concomitant tricuspid annuloplasty (TA) for moderate to severe tricuspid regurgitation (TR) during mitral valve surgery in patients with rheumatic (RMVD - n= 345; 61% had mitral regurgitation and 39% mitral valve stenosis) and degenerative (DMVD n= 135) mitral valve diseases, The objective of the observational non-randomized trial was to identify predictors of durability of TA for moderate to severe TR in patients with RMVD and DMVD undergoing mitral valve repairs and replacements. Valve repair was feasible in 12% in the RMVD group as compared to 52% in DMVD group (1). The TA was performed with flexible, rigid prostheses and the de Vega suture technique.

The mean ages of the two groups (RMVD and DMVD) were 51 and 56 years, respectively. The demography of the RMVD group represents an age shift from juvenile rheumatic heart disease (RHD) to a stage of a burn-out RHD in which structural deterioration process of the rheumatic mitral valve has ceased and stabilized. The pathology of the mitral valve apparatus is presented with annular dilatation or mixed lesion. In absence of calcification valve repair is feasible in experienced hands, otherwise replacement is inevitable (2)

It is reported that 65–85% of the population present with trivial to moderate TR which remain asymptomatic until it is discovered in an echocardiogram for preoperative cardiac evaluation or routine cardiovascular checkup (3). Moderate to severe TR occurs in patients with right- and left-sided congenital and acquired diseases and may be associated to bi-ventricular failure, increased risk for associated morbidity such as pulmonary arterial hypertension (PAH), hepatorenal syndrome and mortality (2,3).

It is recognized that 14-35% of the patients with RHD have mild-to-moderate functional TR who have an incremental risk of developing severe TR. The patients have a low survival at a mean follow up of 5 years if they remain untreated without concomitant TA during mitral valve surgery (4-8).

Tricuspid annuloplasty for moderate to severe TR (Class I, IIb) is the current standard of practice to restore the normal tricuspid annular dimension and function (2,9). The current controversy in atrioventricular surgery concerns the indication for concomitant TA in patients with moderate TR and significant annular dilatation of at least > 40 mm or at least 21 mm/m² indexed for body surface area (Class IIb) during mitral valve surgery proposed by the American Heart Association/American College of Cardiology and European Society of Cardiology (2,9,10).

The endpoints of the study by Arafat and colleagues were 30-day mortality, long-term survival, freedom from grade II or higher tricuspid valve regurgitation, change in the degree of tricuspid regurgitation during follow-up and tricuspid valve re-interventions. The Kaplan-Meier method was used to calculate survival at 1, 5, and 7 years, cumulative incidence for recurrent TR and reintervention. Follow-up was 97.8% complete. The median follow-up time was 53 months (25-85 months).

The cumulative incidence of death at 7 years was 4.8% (1). Progression of moderate TR from the baseline was similarly observed in rheumatic and degenerative populations at a median follow-up of 53 months at 1, 5 and 7 years. It was 15.6% 33.8 and 39.3% in RHD group and 16.1%, 30.4% and 36.02% in degenerative group, respectively. In contrast to mitral valve repair vs replacement plus TA, progression of moderate TR was less in the MV repair group (SHR: 1.69(1.03-2.78); P= 0.038). Results of the recently reported randomized controlled trial by Gammie and colleagues showed much lesser progression of moderate TR at two years (0.6% vs. 6.1% control group, relative risk, 0.09; 95% CI, 0.01 to 0.69) (1,10).

The authors should be congratulated for their laudable clinical studies and for sharing the results with the global cardiovascular community. Although it is a single centre observational trial, which they admit, their data provide valuable information that stimulates discussions in the clinical practice, which encourages early aggressive approach for concomitant tricuspid annuloplasty (TA) plus mitral valve surgery (MVS) in rheumatic populations. A multi-centre randomized controlled trial to provide predictive power of the resultant data is required for developing a surgical strategy for TA and MVS in rheumatic patients (1,2,5,6,7). Pacemaker implantation was not an issue in their series, but it is a global concern as indicated by a recent multicenter trial that TA carries an additional risk of pacemaker (PM) implantation at a rate of up to 14% as compared to 2.5% for mitral valve surgery alone (rate ratio, 5.75; 95% CI, 2.27 - 14.60) (9). The risk for procedural related PM implantation needs to be addressed. It can be reduced or eliminated by refined TA techniques (9,10,11).

In conclusion, concomitant TA and mitral valve surgery in patients with burn-out rheumatic mitral valve disease will remain a challenge in the next half century. Intensive patient screening program in RHD endemic regions is required to capture reparable burn-out rheumatic mitral valve disease for early valve repair plus TA for moderate TR. The paper by Arafat and colleagues has stimulated timely discussion and incentives for a multicenter randomized

controlled trials in rheumatic patients to provide further evidence for supporting the current surgical practice. We are looking forward to the five-year follow up results of MVS plus TA in patients with degenerative mitral valve disease.

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Disclosure Statement

The authors declare that no conflicts of interest exist.

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