prosthesis and holder minimizes the chance of contact between the stent post of the bioprosthesis and preserved tissue such as extended calcification and the posterior leaflet. Two 25-mm MOSAIC bioprostheses were successfully seated down on the calcified mitral valve after excision of the anterior leaflet. For the last patient, we implanted a 27-mm Carpentier-Edwards Perimount (CEP) bioprosthesis with a Tricentrix Holder (Baxter Healthcare Corp., Edwards Division, Santa Ana, CA, USA), but postoperative echocardiogram showed mild mitral regurgitation. This might have been caused by the geometrical change of the leaflets on both sides of one stent post, which was tilted inside by marble-preserved calcification. This reinforces that the relationship between the stent post and the preserved marble tissue must be calculated carefully when a bioprosthesis needs to be implanted. Postoperative echocardiogram revealed no evidence of paravalvular leakage or valve dehiscence in any of the patients.

References


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Letter to the Editor

Preoperative prediction of intensive care unit stay following cardiac surgery

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We have read the interesting article by Cocker et al. about a risk-model analysis for prolonged stay in the intensive care unit (ICU) [1]. The study is well designed and is an important contribution for everyday practice. Prolonged stay in the ICU poses important risks not only for mortality but also for the economic and ethical factors [2]. Various studies have also focused on this subject [3,4]. The risk factors are mostly common to every physician in this area; one of the factors is the presence of diabetes mellitus (DM) [3]. We have previously analyzed the determinants of mortality in this group of patients [2]. We found that DM is also a risk factor for mortality. I would like to ask about the patients with DM in this group. It can be seen that their analysis did not result similarly [1]. The resultant risk factors, however, are common for DM patients. Is there a possible explanation for this result? We would like to thank the authors for their study and would like to know their comments on the subject.

References


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Reply to the Letter to the Editor

Reply to Polat and Polat

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As mentioned by Polat and Polat, diabetes mellitus is an important risk factor for adverse outcomes in cardiovascular disease [1]. Initially, we too were surprised to observe that diabetes came out of the analyses as a non-significant risk factor [2]. Even in the univariate analysis, where no adjustment for the possible confounding effects of other