(ii) In patients with active infective endocarditis, valve replacement with aortic and mitral allografts is successful in the early postoperative period.

Conflict of interest: none declared.

REFERENCES


eComment. Preoperative computed tomography scan for the proper planning of surgery for heart valve endocarditis

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This nice report has presented a successful implantation of valve homografts for aortic and tricuspid valve infective endocarditis [1]. It has to be noted that an anomalous communication between the aorta and the right ventricle (probably at level of the membranous part of the interventricular septum) is a quite unexpected finding during surgery. This fistula could have been detected preoperatively by a multidetector computed tomography (CT) scan. As reported by Nishimura et al. recently in the published 2014 AHA/ACC Guidelines for the Management of Patients With Valvular Heart Disease [2], the use of a preoperative CT scan has a level of evidence Ila, B class of recommendation in this clinical setting.

This recommendation has two main practical implications: 1) screening for any perianular access, erosions and fistulae, which may well occur, 2) screening for any concomitant coronary artery disease if suspected by presence of any atherosclerosis risk factors. The relevance of the latter issue has been endorsed by us and others [3, 4]. We believe that in order to get correct surgical planning and have the homografts needed ready, a CT scan has to be preoperatively performed as a routine examination, both in elective and emergency cases of patients affected by infective endocarditis.

Conflict of interest: none declared.

References

eReply. Re: Preoperative computed tomography scan for the proper planning of surgery for heart valve endocarditis

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We are very grateful to Dr Gaeta for his interest in our article and for the comment. We would like to clarify several points regarding a preoperative computed tomography (CT) in this case. Firstly, the preoperative echo clearly showed us a communication between periarterial abscess and right ventricle and we were aware of this during surgery – it was not an intraoperative finding. Secondly, our patient was young (25 years old), so we had no reasons to perform CT in order to assess the patency of the coronary arteries. These were the only reasons why we did not perform a CT, which is without doubt a very valuable and potent diagnostic tool in patients with infective endocarditis, especially with periannular abscess and extensive tissue destruction. It should be mentioned that we now perform routine CT scans for patients receiving allografts, in order to assess the preoperative calcium scoring and also the calcification rate in the aortic tissue during the follow-up period.

Conflict of interest: none declared.

References