to normal, which many times is possible. And once we have done that, we split the papillary muscles down to its base, and that helps improve the movement of the anterior and posterior leaflet. We have not used artificial chordae in these patients except in one or two, and in those patients it was quite satisfactory, but we have not used it in a large number of patients to comment on that.

Dr G. Sami (Cairo, Egypt): We see a lot of those cases back home. I don’t know if I missed it or not, but if you have 100 of those cases you are going to do or you are planning to do mitral valve repair, what is the percentage in whom you are going to replace the valve that you find the repair will not be feasible?

Dr Kumar: I did not mention that in this particular presentation because of time, but it doesn’t exceed 3% in whom we have made an attempt despite the fact that some of these valves are really not repairable, because in patients who have noncalcific mitral stenosis or mitral stenosis and regurgitation, we attempt this repair. In patients with calcific regurgitation, it is practically impossible to repair them.

Dr Sami: You see the disease at an early stage of its development in order to repair like 97% of those cases and replace only 3%?

Dr Kumar: Not likely. In India the patients don’t present early and they come very late. They come in a moribund state. And as you have seen, many of these patients require surgery for other comorbid lesions, particularly of the aortic valve and tricuspid valve, and many of them have huge hearts. So it is not that they come early. It is just that our ability to repair is not 100%.

ICVTS on-line discussion A

Author: Mohammad Ali Yousefnia, Farideh Roshanali, M.H. Mandegar, Day Hospital, Tehran 19389, Iran
doi:10.1510/icvts.2005.121590A

eComment: Are the techniques you used [1] enough for all forms of pathology in rheumatismal mitral valve? If you had tissue loss, what technique would you use?

References