boembolic events, seven were TIs without major sequelae, two patients had permanent deficit and one patient died. Eighty-eight patients remained on long-term anticoagulation because of AF. There were six reported haemorrhagic complications, for an actuarial rate of 95.6 ± 1.97% patients free of anticoagulation related haemorrhage at 15 years for the total series and 91% for the 88 patients receiving anticoagulation.

7. Clinical bottom line

The current European Society of Cardiology guidelines support the use of warfarin for 3 months post-mitral repair, citing an absence of studies supporting the safety of omitting warfarin. They acknowledge that this is based on expert consensus and that many surgeons do not follow this guideline. The longest follow-up studies of patients post-mitral repair report excellent results using short term warfarin, and they also show that a third of patients discharged in sinus rhythm will have an episode of atrial fibrillation shortly after. In addition, the highest risk of thromboembolism occurs in the early months post surgery. Therefore, until studies demonstrate the safety of omitting warfarin for patients undergoing mitral valve repair 3 months of anticoagulation should remain the standard of care.

References


ICVTS on-line discussion A

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eComment: The authors deal with a very interesting topic of oral anticoagulation after mitral valve repair [1]. Although most of us would agree to use warfarin in patients with atrial fibrillation, the most frequent type of repair is quadrangular resection of P2 due to fibroelastic deficiency. Most of these patients are relatively young and in normal sinus rhythm. Is it justified to give warfarin to these patients? Present indication to do so is based on consensus and only by the European Society of Cardiology. Up to 40% of surgeons do not use anticoagulation in this low-risk population. There are no randomized controlled trials to support the safety of omitting warfarin in this setting, but there are no such trials to support the need for oral anticoagulation either. We studied 31 mitral repair patients treated with ticlopidine or warfarin and found a statistically significant difference in prevention of thromboembolism favoring ticlopidine [2]. The study had some limitations, mainly the absence of randomization, but served as a pilot study in this topic. We reported the first randomized controlled trial [3] on the use of antiplatelet treatment after aortic tissue valve replacement in 2005. Antiplatelet treatment was as useful as warfarin in preventing thromboembolism but proved to be safer reducing the rate of bleeding problems. In the ACC/AHA guidelines published this year [4], aspirin is the treatment of choice in aortic bioprosthesis with no risk factors, class I, being the use of oral anticoagulation a second choice, class IIa. With the present refinements in surgical technique and medical therapy, patients having a quadrangular resection of P2 or equivalent mitral repair with no associated risk factors could benefit from the same treatment approach as aortic bioprosthesis. Therefore, we believe that there is a place for controlled trials on this topic in the near future, so that we can satisfy the need for evidence of those surgeons who are using alternatives to oral anticoagulation.

References

