

# The best never rests

José Daniel Espinoza-Hernández, MD, FACS, FCCP

Department of Cardiothoracic Surgery. Hospital General Regional # 1, Instituto Mexicano del Seguro Social, Tijuana, Baja California, MEXICO.

*Any time you have an opportunity to make a difference in this world and you don't, then you are wasting your time on earth.*

~ Roberto Clemente. ~

**Key words:** Aortic valve replacement; Guidelines for clinical practice; MitraClip; Mitral valve repair; Mitral valve replacement; TAVR; Transcatheter edge-to-edge valve repair (TEEVR).

**Palabras clave:** Reemplazo valvular aórtico; Guías para la práctica clínica; MitraClip; Reparación valvular mitral; Reemplazo valvular mitral; TAVR; Reparación valvular mitral edge-to-edge transcáteter.

*Cir Card Mex 2021; 6(3): 61-2.*

© 2021 by the Sociedad Mexicana de Cirugía Cardíaca, A.C.



At the end of last year, the update to the guidelines for heart valve disease was published by the American Heart Association and the American College of Cardiology [1]. This has caused a surprising reaction in cardiac surgeons specifically regarding aortic stenosis and functional mitral regurgitation. The Latin American Association of Cardiovascular and Endovascular Surgery (LACES) has recently expressed disagreement with these topics [2-4] which has been a highly effective action. We surgeons must show disagreement with grounds to provide the patient with a real option for their treatment.

But, operationally, what should cardiac surgeons do about it? Historically, it has always been commented (by cardiologists) that with this or that percutaneous procedure, cardiac surgery will be obsolete, but it is also true that it has not been the case, the cardiac surgeon has always had, has and will have a fundamental space in the cardiovascular medicine.

In 2006, during the annual meeting of the Society of Thoracic Surgeons (STS), Dr. David Taggart gave the Thomas B. Ferguson Lecture [5]. In this talk he emphasized, with scientific evidence, on the use of indiscriminate use of percutaneous treatment of coronary artery disease and listed some important points in making decisions about the best treatment, also demonstrated the existing unilateral decision (Cardiologist - Patient) to grant

"the best" treatment of this pathology. It also clearly mentions the options of cardiac surgeons in the face of this technological advance: off-pump revascularization surgery and the use of total arterial revascularization. In summary, he makes a scientific review of the therapeutic options according to each case and ends by saying: "But the patient must know it." I dare to add: "and the surgeon too" Why? Being honest, on many occasions we become very practical and put aside the fundamental theoretical information to expand our therapeutic armament, practically in many cases, we become dependent on cardiologists.

Every time a surgeon writes something about the benefits of surgery or cardiologists publish on a challenging topic, a proactive surgical spirit is born in the surgeon, trying to show that what we do on many occasions has better long-term results, but it lasts a short time, and we return to theoretical apathy and pragmatism. For example, regarding coronary surgery there are reports of the long-term benefits of total arterial revascularization [6], but in daily life it is not performed routinely. In our country there is only one recent publication of revascularization with double mammary artery [7], they analyzed a total of 178 patients with a total of 45 consecutive cases of bilateral mammary artery procurement and 133 patients of unilateral mammary artery procurement, in their report they found a 2.2 % sternal dehiscence, results like other reported series. This shows that the results are good offering a double arterial graft with low risk and in the long term the benefit is better, and the freedom of reinterventions will be low, the surgeon must believe it, reproduce it, and inform the patient. As this group has done, we must publish more what we do emphasizing the long-term surgical benefits.

Corresponding author: Dr. José Daniel Espinoza Hernández  
email: jdehcardiotx@gmail.com

In 2018 Repossini et al. [8] published their twenty-year experience on minimally invasive coronary artery bypass, in the discussion, Dr. Terragosa told him: How has your patient population changed throughout these 20 years? You currently work in Brescia, which is less than 1 hour door to door from the hospital of Antonio Columbo to which Dr. Repossini replied: Yes, we live close to an aggressive interventional cardiologist, so we are forced to give the patient the maximum minimally invasive procedure possible in competition with PCI stenting. This is a clear example of what surgeons should do, carry out innovative procedures by following up and most importantly: publish it.

In a baseball game, the pitcher offers what he wants to the hitter and he will have to swing with the intention of hitting. This could be an analogy with cardiovascular medicine, where the pitcher could be the cardiologist and send the hitter (surgeon) whatever he sees fit, situation that we must change, the question is: Why not change positions? I believe that surgeons should be more participatory in generating our own patients, orthodoxly we are doctors who treat cardiovascular disease, by this I mean to encourage cardiac surgeons to be more in the medical consultation of first time and with this give more referrals to the cardiologists emulating what the pitcher and catcher do in a baseball game, between the two of them are working as a team to dominate the hitter (disease).

With the above, I want to clarify that i am not against percutaneous technological advance, if it appears that I am hostile to current cardiology practice or interventions, let me emphasize that this is not the case. If used appropriately, the outcome will be effective and prove to be a worthwhile intervention. However, I want to repeat once more that cardiac surgeons must continue to be active in theory and practice, in other words: "The cardiac surgeon must be a cardiologist who performs surgery", even though, the cardiologist currently considers that surgeon has less participation in the treatment of cardiovascular diseases, a cardiac surgeon must always be ready (theoretically and surgically) and prepared in the bullpen to go in to solve a complex case or some complication, because as the legendary Lawrence Peter "Yogi" Berra said: "It ain't over till it's over".

**FUNDING:** None

**DISCLOSURE:** The author has no conflicts of interest to disclose.

#### REFERENCES

- Otto CM, Nishimura RA, Bonow RO, et al. 2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation* 2021;143:e72-e227. DOI: 10.1161/CIR.0000000000000923.
- Dayan V, García-Villarreal OA, Escobar A, et al. The Latin American Association of Cardiac and Endovascular Surgery statement regarding the recently released 2020 ACC/AHA Guidelines for the Management of Patients with Valvular Heart Disease. *Eur J Cardiothorac Surg* (2021). doi: 10.1093/ejcts/ezab027.
- Dayan V, García-Villarreal OA, Escobar A, et al. The Latin American Association of Cardiac and Endovascular Surgery statement regarding the recently released 2020 ACC/AHA Guidelines for the Management of Patients with Valvular Heart Disease. *Ann Thorac Surg* (2021). doi: 10.1016/j.athoracsur.2021.02.001.
- Dayan V, García-Villarreal OA, Escobar A, et al. The Latin American Association of Cardiac and Endovascular Surgery statement regarding the recently released 2020 ACC/AHA Guidelines for the Management of Patients with Valvular Heart Disease. *J Thorac Cardiovasc Surg* (2021). doi: 10.1016/2021.01.139.
- Taggart DP. Coronary Artery Bypass Grafting is Still the Best Treatment for Multivessel and Left Main Disease, But Patients Need to Know; *Ann Thorac Surg* 2006;82:1966-75. doi: 10.1016/j.athoracsur.2006.06.035.
- Taggart DP, D'Amico R, Altman GD. Effect of arterial revascularization on survival: A systematic review of studies comparing bilateral and single internal mammary arteries. *Lancet* 2001; 358: 870-5. doi: 10.1016/S0140-6736(01)06069-X.
- Heredia-Delgado JA, Chable-Medellin H, Aguilar-García AL, Quezada RC. Sternal wound complications after coronary artery bypass grafting with bilateral internal mammary artery grafting. Report of a tertiary referral hospital in northern Mexico. *Cir Card Mex* 2020; 5: 110-5.
- Repossini A, Di Bacco L, Nicoli F, et al. Minimally invasive coronary artery bypass: Twenty-year experience. *J Thorac Cardiovasc Surg* 2019; 158: 127-38. doi: 10.1016/j.jtcvs.2018.11.149.