

IS THERE A PLACE FOR OPEN MITRAL VALVOTOMY?

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Rheumatic Heart disease is one of the common cardiovascular ailments in the Middle East. The mitral valve is affected in almost all cases of cardiac involvement and mitral stenosis is the most common valve lesion.

Since the introduction of non surgical mitral valvuloplasty (Percutaneous Transvenous Mitral Commissurotomy PTMC) by Inoue et.al. in 1984¹, the procedure has become the first choice in treating severe mitral valve stenosis with favorable anatomy. Patients with unfavorable anatomy such as severe calcified valve, moderate/severe mitral regurgitation, left atrial thrombi, and concomittant moderate to severe aortic valve disease are not suitable candidates.

In Qatar, the number of patients with mitral stenosis with favorable anatomy is small, hence the number of PTMC performed is also small. However, the number of cases is expected to rise especially with the increasing number of expatriate population from the Indian subcontinent and Southeast Asia. In Libya (my country), I used to do one PTMC per week because the population of Libya is quite large, about six million, as compared to Qatar, which is about one-a-half million. In addition, rheumatic heart disease is prevalent in Libya. The five year follow-up data from our Libyan series, which included a wide range of mitral valve morphology showed that our acute complication rate was low (significant MR 1%, no cardiac tamponade, and no deaths) and the event free survival in patients with low mitral valve score was 96% (no deaths, restenosis 7%, redo PTMC 10%, mitral valve replacement 2%). The majority in our series were young, 15-35 years.

Several studies have shown that the result of PTMC is quite comparable to closed and open surgical procedure²⁻⁴.

In this issue of Heart Views, Fawzy M. et. al., described the results of their single center 18-year experience with Mitral Balloon Valvuloplasty. The authors had a total of 531 cases. Their study is one of the few long-term follow up series. In the article Fawzy et al included a wide spectrum of patients: patients with low and high mitral echo score, atrial fibrillation, pregnant patients, wide age range (10-61 yrs) and even patients with previous surgical commissurotomy. Their event free survival (death, redo PTMC, mitral valve

replacement) in patients with low mitral valve score at 10, 15, and 18 year was $93 \pm 2\%$, $65 \pm 5\%$ and $38 \pm 8\%$ respectively, which is comparable to open surgical commissurotomy.

This paper and several previous papers with similar intermediate and long term follow up, raise the question whether we should do more PTMC even in patients with left atrial thrombi. Silaruks et.al.⁵, used intensive anticoagulation regimen in such group, (INR range of 2-3 for 6 months) and achieved a 24% success rate in dissolving these thrombi. His study showed that safe PTMC can be performed in such group. Furthermore, the use of neuro-embolic protection device in internal carotid arteries (e.g. filter wire) during PTMC in patients who were turned down for surgery⁶ because of co-morbidity was shown to be safe. All these new techniques will reduce the number of referral for open mitral commissurotomy. ?

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