

The author reported no conflicts of interest.

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REPLY: ROSE-COLORED GLASSES

Reply to the Editor:

We have a responsibility in academic surgery to dissociate objective findings with the personal impressions we have gathered related to our clinical practice. Among the most important

recurring lessons I have tried to impart to trainees relates to the importance and responsibility of investigators to present just the facts and to provide ample opportunity for potential readers to derive valid conclusions from the information presented. Kattach and colleagues¹ have identified concerns with a presentation by Lehmann and colleagues² regarding clinical outcomes after the implantation of the Trifecta bioprosthesis (St Jude Medical, St Paul, Minn). I will go so far as to suggest that the original authors' use of the word *excellent* as an adjective triggered, perhaps appropriately, the ensuing criticism of the proposed conclusions. Selective identification of supportive studies regarding comparative bioprosthesis degeneration in the Carpentier-Edwards Perimount Magna Ease (Edwards Lifesciences, Irvine, Calif) population contributed to their skepticism with regard to the authors' conclusions in the original article. This is an important lesson for all of us. The use of adjectives must be carefully considered because they impart merely opinions in terms of the consolidation of the data before us. When mentoring in the art of manuscript preparation, I teach my trainees to focus on the question, the methodology, and the results; keeping the conclusions concise, perhaps humble, and unbiased to ultimately allow reviewers to help shape the message of the article but

always leaving space for a reader to draw his or her own conclusions.

There is strong evidence that the Trifecta valve produces superb early hemodynamic parameters; however, I agree with Kattach and colleagues¹ that there is growing evidence of premature bioprosthetic degeneration in this valve. There is still an appropriate place and patient in which this valve is best suited, such as in elderly female patients with very small left ventricular outflow tracts. However, in those patients with a reasonable prognosis of long-term survival, alternative valves may be more appropriate. I disagree with the conclusion that degeneration of the Trifecta, even in small sizes (21 mm), cannot be approached with valve-in-valve technology. We have had several cases at our institution in which this strategy was successful even though the annular ring is rigid and cannot be fractured. We need to take into context the understanding that in patients in whom a 21-mm Trifecta valve was originally inserted, the alternative would have been a small or smaller alternative pericardial valve that produces worse hemodynamic parameters and potentially patient–prosthesis mismatch. Are we certain that the original operation would not have resulted in a more challenging outcome?

Distancing results from the conclusion to provide readers with more flexibility in drawing their own inferences calms the waters. Academics are responsible for presenting data. We have to be clear that our conclusions are merely opinions and provide the space for readers to bring their own interpretations to the table.

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References

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