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Commentary: “Don’t put off until tomorrow what you can do today”

S. Adil Husain, MD

Techniques for the correction of partial and common atrioventricular canal defects are wide ranging and highlight perhaps the most tangible example of how proficiency for congenital cardiac surgeons is the product of accurate intraoperative anatomic assessment and subsequent surgical decision-making. Weingarten and colleagues¹ from the Cleveland Clinic present a manuscript and associated surgical video that outlines their approach for an infant with a right dominant partial atrioventricular canal defect made more complex by a double orifice left atrioventricular valve (LAVV) and Ebsteinoid right atrioventricular valve (RAVV).

In particular, the authors present 6 valuable surgical pearls to help the reader best understand their technical approach. These included formal division of the superior and inferior bridging leaflets, use of a pericardial patch for LAVV leaflet augmentation, commissuroplasty for the double-orifice LAVV, division of all subvalvular attachments, except primary chords, to increase valve tissue mobility, approximation of RAVV papillary muscles to improve leaflet coaptation, and, finally, left atrial line placement for postoperative hemodynamic monitoring.

The quality of their attached surgical video is excellent and offers visual insights into the techniques described. A thorough review of the manuscript and video will allow the reader to see many technical options that may indeed be used in isolation or combination for complex atrioventricular canal defects they may encounter in the future.

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Benjamin Franklin

CENTRAL MESSAGE

Repair of complex atrioventricular canal defects often requires aggressive and multifaceted approaches. Surgical video platforms are an ideal for tool for understanding technical options.

In addition to the significance of the authorship contribution to one of our subspecialty technical journals, the case and surgical outcome highlight another valuable message. The decision to pursue a complete repair versus placement of a palliative pulmonary artery band is discussed. In addition, the approach to employing a patch for augmentation of leaflet tissue rather than its use as a “bail-out” for postoperative LAVV repair is described. Finally, the concomitant performance of a cut-and-sew isthmus ablation from the inferior vena cava to the RAVV is outlined. The authors share their decision to employ this technique rather than cryoablation secondary to greater accuracy and the child’s size of 2.6 kg. In doing so, the authors describe their surgical approach as one that addresses potential challenges from the outset rather than as a result of a poor outcome, postoperative complication, or new-onset dysrhythmia. The decision to pursue aggressive early complete repair as well as an open ablative surgical intervention for concerns of dysrhythmia highlight an aggressive approach to address known challenges rather than a “wait-and-see” approach that many others may have pursued.

The utility of sharing surgical videos in our subspecialty continues to gain traction. The power of this educational platform in comparison to text book or diagram learning is clear. This group should be applauded not only for their contributions towards this form of education but also for their approach to this case which would make Benjamin Franklin quite proud. Procrastination in congenital heart

surgery is often associated with significant consequences. Repairing what you can today although filled with risks and anxiety often provides the best opportunity for a longer-term favorable outcome.

Reference

1. Weingarten N, Karamlou T, Ahmad M, Erenberg F, Najm HK. Double-orifice left and Ebsteinoid right atrioventricular valve repair in right dominant partial atrioventricular canal defect. *J Thorac Cardiovasc Surg Tech*. 2021;8: 172-4.