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Commentary: Effective source control in endocarditis sometimes requires unique surgical approaches

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Multiple-valve endocarditis can be a challenging entity for the cardiac surgeon. Uncommon pathology patterns require rare and technically advanced procedures. One notable example is the commando procedure. The commando procedure, which consists of combined aortomitral valve replacement with reconstruction of the intervalvular structure, is technically demanding and infrequently applicable. However, rarity does not denote irrelevance. This procedure, among others, should absolutely be in the cardiac surgeon's armamentarium. We do not always have the liberty of preselecting the pathologies present in our patients and the concomitant operative technique required to achieve the best outcome.

In this edition of the *Journal*, Jahanyar and colleagues¹ describe a combined aortic and tricuspid valve repair for endocarditis performed via a transaortic approach. The case presented is a young male patient with a bicuspid aortic valve and combined aortic and tricuspid valve endocarditis. At operation, the authors entered the left ventricular outflow tract and encountered an annular abscess with involvement of the membranous septum, which was debrided. This allowed for convenient entry into the right atrium with exposure of the diseased tricuspid valve. Debridement of the tricuspid valve commenced with bovine pericardial tissue used for the valvular repair and closure of septal defects. Per the authors, the patient is doing well years after the procedure.

The authors are to be congratulated on the successful outcome of a challenging case. In this scenario, adequate source control

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CENTRAL MESSAGE

Endocarditis is frequently encountered by cardiac surgeons. Innovative surgical techniques may be required to achieve adequate source control.

required thorough debridement of the membranous septum and creation of a septal defect. The authors skillfully used this to their advantage and successfully addressed the tricuspid pathology without the need for a separate atriotomy. Cardiac surgery does not come with ready-made instructions, and improvisation is sometimes required to achieve the best outcome for our patients. While the widespread applicability of this approach is low, for the specific situation presented by the authors it appears to be a viable option. The authors acknowledge that in their large valve practice they have performed only several of these approaches and often do not have preoperative findings demonstrating that this approach will be applicable. Regardless of the frequency of pathology requiring this approach, it is the rare cases in which the utility will be more readily apparent. This approach, had it been published previously, would have been applicable in one of our cases this past year. A surgeon may only see 1 or 2 patients in their career in whom this specific approach will be suitable, but in that moment, it may make a difference. Records of rare approaches such as these are important. For the specific patient with similar pathology in the operating room, the successful performance of a once in a career surgery is of paramount importance.

Reference

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