Annuloplasty for Mitral Insufficiency

A Five to Six-Year Clinical and Hemodynamic Follow-Up

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WILFRED G. BIGELOW, M.D.

ANNULOPLASTY of an incompetent valve
by plication of one or both commissures
under direct vision was the only available
surgical treatment for mitral insufficiency
5 to 6 years ago. At that time, suitable prosthesis
valves for the mitral area were not readily available. The simplicity of annuloplasty
presented an attractive surgical approcach to the correction of mitral insufficiency
provided that there was no undue
rigidity or calcification of the valve leaflets
or loss of valve tissue. While fluoroscopy was
of help in excluding significant valve calcification, loss of valve tissue could only be
accurately determined on inspection of the
valve at operation. While the simplicity of
this operation made this an attractive procedure, the long-term results determine whether
annuloplasty still has a place in the surgical
treatment of mitral insufficiency at a time
when prosthetic valves are readily available.

Seventy-three annuloplasties have been
done at the Toronto General Hospital. The results in the first 20 consecutive cases on
follow-up for 1 to 2½ years were reported by
Bigelow and associates. This early follow-up
suggested that annuloplasty usually led to an
acceptable correction of the insufficiency
with symptomatic improvement in selected
patients. It is now 5 to 6 years since these
patients were operated upon. Their assessment
at this time forms the basis of this report.

Methods

In the previous report preoperative and postoperative studies were presented on 11 patients
with mitral annuloplasty. Two of the patients
with good results were subsequently killed in
automobile accidents and lost to follow-up.

The present report thus deals with nine pa
tients, who were clinically assessed 5 to 6 years
after surgery. Eight patients had a second postoperative cardiac catheterization study from 3 to
6 years after surgery, and one patient was studied
at autopsy. The New York Heart Association
classification was used to grade the clinical disabilify. Preoperative cardiac catheterization data
were obtained by transthoracic left-heart catheterization using the Björk technique. The mitral
insufficiency was assessed by indicator dye-dilution technique. The second postoperative
hemodynamic studies were obtained by transseptal left heart catheterization combined with
percutaneous retrograde aortic catheterization. Insufficiency at mitral, aortic, and tricuspid valves
was assessed by indicator dye-dilution technique. Aortic and mitral insufficiency was also assessed
by cineangiography.

Results

This 5 to 6 year follow-up of nine patients
following mitral annuloplasty showed a sig
significant return of mitral insufficiency in six
patients, or two thirds, as might have been
expected. Three, or one third, of the patients
were still in grade I or II at the time of fol
low-up. Seven of nine patients were still
alive. Two patients died in the fifth year
following operation.

Functional Status

One to two years after operation, eight pa
tients were improved to class I or II; at 3 to
4 years five of these patients remained
improved in class I or II; at 5 to 6 years three
patients were still improved in class I or II,
four patients were in class III or IV, and
two patients had died (fig. 1). Thus one
third of the patients who were in class III or IV before operation were still improved 5 to
6 years after operation.

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Cardiac Catheterization and Autopsy Data

(Table 1)

Left Atrial Pressure

The mean left atrial pressure was increased from 5 to 10 mm Hg above the preoperative level and ranged from 7 to 33 mm Hg in seven of eight patients catheterized after operation. In all patients except one, there had been a decrease in the mean left atrial pressure 1 to 2½ years after operation.1

Left Ventricular End-Diastolic Pressure

The preoperative values ranged from 6 to 15 mm Hg being elevated above the normal (10 mm Hg) in five of the nine patients. Four of the five patients had shown a fall in the end-diastolic pressure at the first follow-up.1 Three patients that had shown no fall in the end-diastolic pressure at the earlier follow-up had further elevation above the preoperative level at 5 to 6 years.

Figure 1

Clinical status of nine patients followed 5 to 6 years after mitral annuloplasty.

Fate of Annuloplasty

The hemodynamic assessment and autopsy data showed that four of the nine patients had recurrence of severe, and two of moderate, mitral insufficiency. Three patients had developed severe mitral stenosis. Valve calcification was a complicating factor in one of these patients. Two of the three patients showing progression to stenosis had a mixed stenosis and insufficiency lesion preoperatively.

Associated Lesions at Other Values

Three patients developed severe tricuspid insufficiency, and one severe tricuspid stenosis. The patient with severe tricuspid stenosis also developed severe aortic (and mitral) stenosis. Two patients developed moderate or severe aortic insufficiency while two had mild aortic insufficiency. In all, five of the nine patients had developed both aortic and tricuspid valve lesions (table 1).

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## Table 1

**Hemodynamic and Autopsy Data in Nine Patients Three to Six Years After Mitral Annuloplasty**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Time of catheterization or autopsy</th>
<th>Mean left atrial pressure (mm Hg)</th>
<th>Mitral end-diastolic gradient (mm Hg)</th>
<th>Left ventricular end-diastolic pressure (mm Hg)</th>
<th>Assessment of mitral insufficiency</th>
<th>Associated lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.T.</td>
<td>Preop</td>
<td>24</td>
<td>8</td>
<td>12</td>
<td>Moderate</td>
<td>MS, mild; mitral calcium, mild</td>
</tr>
<tr>
<td>49 F</td>
<td>5-6 yr postop</td>
<td>33</td>
<td>11</td>
<td>17</td>
<td>Trivial</td>
<td>AI, trivial; mitral calcium, marked; TI, severe</td>
</tr>
<tr>
<td>J.D.</td>
<td>Preop</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>Severe</td>
<td>AI, mild; TI, trivial</td>
</tr>
<tr>
<td>42 F</td>
<td>5-6 yr postop</td>
<td>18</td>
<td>3</td>
<td>10</td>
<td>Severe</td>
<td>AI, mild; TI, trivial</td>
</tr>
<tr>
<td>E.O.</td>
<td>Preop</td>
<td>19</td>
<td>0</td>
<td>10</td>
<td>Severe</td>
<td>AI, mild; TI, trivial</td>
</tr>
<tr>
<td>26 F</td>
<td>5-6 yr postop</td>
<td>23</td>
<td>18</td>
<td>8</td>
<td>Nil</td>
<td>AI, trivial; mitral calcium, mild</td>
</tr>
<tr>
<td>D.R.</td>
<td>Preop</td>
<td>22</td>
<td>0</td>
<td>15</td>
<td>Severe</td>
<td>AI, moderate; mitral calcium, mild; TI, severe</td>
</tr>
<tr>
<td>38 F</td>
<td>5-6 yr postop</td>
<td>27</td>
<td>0</td>
<td>17</td>
<td>Severe</td>
<td>AI, moderate; mitral calcium, mild; TI, severe</td>
</tr>
<tr>
<td>M.C.</td>
<td>Preop</td>
<td>16</td>
<td>2</td>
<td>12</td>
<td>Severe</td>
<td>AI, moderate; mitral calcium, mild; TI, severe</td>
</tr>
<tr>
<td>39 M</td>
<td>5-6 yr postop</td>
<td>24</td>
<td>4</td>
<td>19</td>
<td>Severe</td>
<td>AI, moderate; mitral calcium, mild; TI, severe</td>
</tr>
<tr>
<td>D.L.</td>
<td>Preop</td>
<td>12</td>
<td>0</td>
<td>10</td>
<td>Severe</td>
<td>AI, moderate; mitral calcium, mild; TI, severe</td>
</tr>
<tr>
<td>22 F</td>
<td>3½ yr postop</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>Moderate</td>
<td>AI, severe; TI, severe</td>
</tr>
<tr>
<td>L.B.*</td>
<td>Preop</td>
<td>22</td>
<td>4</td>
<td>14</td>
<td>Severe</td>
<td>MS, mild</td>
</tr>
<tr>
<td>17 F</td>
<td>3 yr postop</td>
<td>32</td>
<td>4</td>
<td>14</td>
<td>Moderate</td>
<td>MS, mild</td>
</tr>
<tr>
<td>M.P.</td>
<td>Preop</td>
<td>17</td>
<td>3</td>
<td>6</td>
<td>Severe</td>
<td>MS, mild</td>
</tr>
<tr>
<td>F</td>
<td>3 yr postop</td>
<td>22</td>
<td>5</td>
<td>12</td>
<td>Severe</td>
<td>MS, mild</td>
</tr>
<tr>
<td>C.D.</td>
<td>Preop</td>
<td>19</td>
<td>7</td>
<td>12</td>
<td>Severe</td>
<td>MS, mild</td>
</tr>
<tr>
<td>F</td>
<td>Autopsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5½ yr postop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Now has Starr-Edwards prosthesis in mitral area.

Abbreviations: MS = mitral stenosis; TS = tricuspid stenosis; AS = aortic stenosis; TI = tricuspid insufficiency; AI = aortic insufficiency.
Late Complications

Subacute Bacterial Endocarditis

In two patients subacute endocarditis developed 2½ to 3 years after annuloplasty. This resulted in breakdown of the annuloplasty with recurrence of moderate insufficiency in one. The infection responded to antibiotic treatment in both.

Systemic Embolization

A cerebral embolus occurred in one patient while clinically well, in class I or II 4 years after operation. Presumably this was of the result of thrombus on the valve or in the left atrium. No residual neurological defect persisted.

Reactivation Syndrome

Two patients presented clinical and laboratory evidence of reactivation of the rheumatic process. This was only partially controlled in one patient with bed rest, long-term steroid and prophylactic penicillin therapy. This patient developed severe mitral, aortic, and tricuspid insufficiency and died 5½ years after operation (see “Late Deaths”). The second patient, a girl, 17 years old, developed recurrence of mitral insufficiency with progressive dilatation of the mitral valve ring. This necessitated further operative intervention and a Starr-Edwards ball-valve prosthesis was inserted 3 years after the annuloplasty. She has been much improved since.

Late Deaths

Two late deaths both occurred 5½ years after operation. In one patient a myocardial factor appeared to be primarily involved with recurring reactivation syndrome, and the development of severe mitral, aortic, and tricuspid insufficiency. The other patient was well, in grade I or II until the onset of atrial fibrillation, following which rapid deterioration occurred and she died within 3 weeks. At autopsy, severe mitral, aortic, and tricuspid stenosis was demonstrated.

Discussion

This follow-up study shows that mitral annuloplasty can provide long-term symptomat-
of foreign body material (Teflon pledgets) and vulnerability of the valve to infection. The infection resulted in the breakdown of repair in one patient, who is still improved in class I or II.

Although this operation was available to only a small percentage of patients with mitral insufficiency, in all cases reported herein the operations were performed before the mitral Starr-Edwards valve or other valve replacements were available. Studies at this center and other centers of patients in whom the mitral valve has been replaced by the Starr-Edwards ball valve have shown satisfactory hemodynamic correction. However, the incidence of late complications associated with the use of this prosthesis has been disturbing. These complications include systemic embolization necessitating lifetime anticoagulation with its associated morbidity and mortality, sudden death due to ventricular arrhythmia, an increased incidence of bacterial endocarditis, and residual regurgitation between prosthetic ring and mitral annulus, sometimes murmurless, leading to failure of patients to improve and necessitating reoperation.

The late problems in mitral valve replacement, the number of survivors of 5 to 6 years following annuloplasty and the percentage of patients with maintained symptomatic improvement suggest that there is still a place for annuloplasty in the correction of mitral insufficiency. A final assessment of the value of mitral annuloplasty cannot be made until a 5 to 6 year study is available in a comparable group of patients in whom the mitral insufficiency was corrected by prosthetic valve replacement.

Summary

Nine patients were followed from 5 to 6 years after mitral annuloplasty. Seven of the nine patients were alive at follow-up, and three of nine, one third of the patients, were still improved in class I or II (New York Heart Association classification). All patients were severely disabled in class III or IV before operation.

Cardiac catheterization and autopsy data at 3 to 6 years showed some progression in the pathology of the mitral valve in all patients including the third who maintained symptomatic improvement.

Severe lesions at tricuspid or aortic valve, or both, had developed in four of the nine patients.

Annuloplasty probably still has a place in the surgical treatment of selected patients with mitral insufficiency.

Acknowledgment

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References


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