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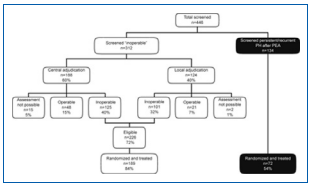

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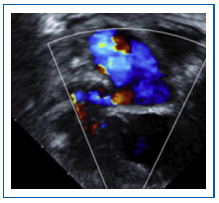
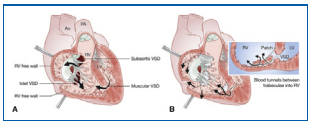
Congenital (CONG): Ventricular Septal Defect



688 **Accuracy of transesophageal echocardiography in the identification of postoperative intramural ventricular septal defects**

Jyoti K. Patel, MD, Andrew C. Glatz, MD, MSCE, Reena M. Ghosh, MD, Shannon M. Jones, MD, Chitra Ravishankar, MD, Christopher Mascio, MD, and Meryl S. Cohen, MD, Philadelphia, Pa

Intraoperative TEE has modest sensitivity but high specificity for identifying intramural VSDs after repair of conotruncal anomalies.

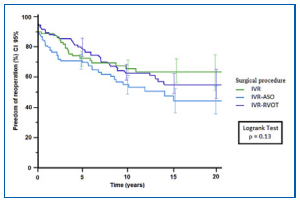


696 **Editorial Commentary:** Intramural ventricular septal defect after repair of conotruncal anomalies: Is there light at the end of the tunnel?

Edward Buratto, MBBS, Philip S. Naimo, MD, and Igor E. Konstantinov, MD, PhD, FRACS, Melbourne, Australia

Precise echocardiographic evaluation is essential for successful closure of intramural ventricular septal defect.

Congenital (CONG): Double-Outlet Right Ventricle



698 **Impact of anatomic characteristics and initial biventricular surgical strategy on outcomes in various forms of double-outlet right ventricle**

Olivier Villemain, MD, Emre Belli, MD, Magalie Ladouceur, MD, Lucile Houyel, MD, Zakaria Jalal, MD, Virginie Lambert, MD, PhD, Mohamed Ly, MD, Pascal Vouhé, MD, PhD, and Damien Bonnet, MD, PhD, Paris, Le Plessis Robinson, and le Kremlin Bicetre, France

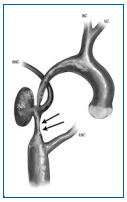
The initial surgical strategy did not influence late outcomes of DORV with biventricular repair.

707 **Editorial Commentary:** Is there a limit to how far we should push the envelope in pediatric cardiac surgery?

Bahaaldin Alsoufi, MD, Atlanta, Ga

The highest mortality risk following biventricular repair of double-outlet right ventricle is seen in patients with a noncommitted ventricular septal defect and small children requiring arterial switch. Alternative management approaches might be indicated.

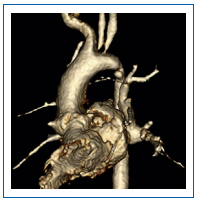
Congenital (CONG): Aorta



709 **Aortic arch repair in children with PHACE syndrome**

Seamus P. Caragher, BS, John P. Scott, MD, Dawn H. Siegel, MD, Michael E. Mitchell, MD, Peter C. Frommelt, MD, and Beth A. Drolet, MD, Milwaukee, Wis

PHACE syndrome is associated with unusual aortic arch obstructions, requiring complex surgical solutions for repair.



718 **Editorial Commentary:** Aortic arch anomalies in PHACE syndrome: An individualized approach to an unusual problem

Carlos M. Mery, MD, MPH, Houston, Tex

Aortic arch and brachiocephalic vessel anomalies in PHACE syndrome are widely heterogeneous. An individualized approach is needed for surgical repair of aortic coarctation in these patients.

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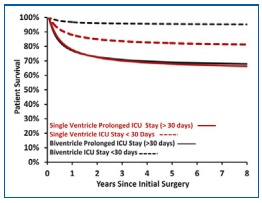
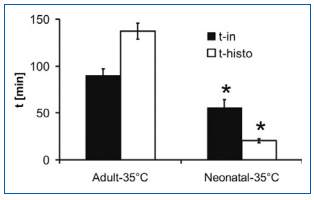
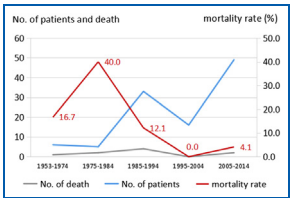
Congenital (CONG): Perioperative

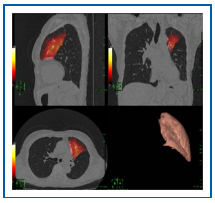




Thoracic (THOR): Lung



Thoracic (THOR): Lung Cancer



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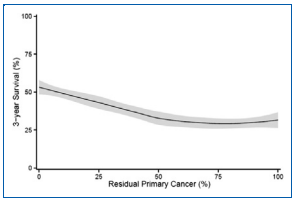
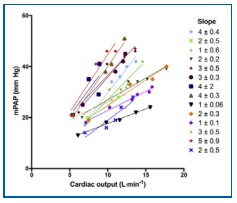
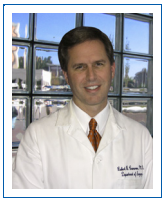
Thoracic (THOR): Esophageal Cancer



Thoracic (THOR): Pulmonary Embolus





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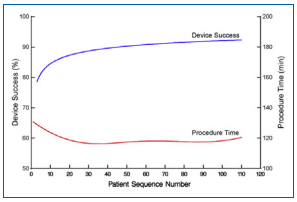
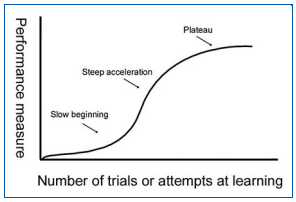
Acquired (ACQ): Aortic Valve



773 **Learning curves for transapical transcatheter aortic valve replacement in the PARTNER-I trial: Technical performance, success, and safety**

Rakesh M. Suri, MD, DPhil, Sa'ar Minha, MD, Oluseun Alli, MD, Ron Waksman, MD, Charanjit S. Rihal, MD, Lowell P. Satler, MD, Kevin L. Greason, MD, Rebecca Torguson, MPH, Augusto D. Pichard, MD, Michael Mack, MD, Lars G. Svensson, MD, PhD, Jeevanantham Rajeswaran, PhD, Ashley M. Lowry, MS, John Ehrlinger, PhD, Stephanie L. Mick, MD, E. Murat Tuzcu, MD, Vinod H. Thourani, MD, Raj Makkar, MD, David Holmes, MD, Martin B. Leon, MD, and Eugene H. Blackstone, MD, Cleveland, Ohio; Zerifin, Israel; Birmingham, Ala; Washington, DC; Rochester, Minn; Plano, Tex; Atlanta, Ga; Los Angeles, Calif; and New York, NY

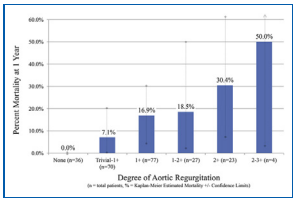
The learning curve for TA-TAVR did not compromise patient safety.



781 **Editorial Commentary:** Navigating the s-curve of transapical therapy

Mohamad A. Alkhouli, MD, Bryan D. Raybuck, MD, and Vinay Badhwar, MD, Morgantown, WVa

One must consider technology and technique evolution when interpreting early transapical learning curve estimates. These timely lessons provide insights for transcatheter mitral valve replacement.

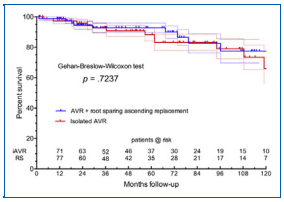


783 **Prognostic significance of mild aortic regurgitation in predicting mortality after transcatheter aortic valve replacement**

Brandon M. Jones, MD, E. Murat Tuzcu, MD, Amar Krishnaswamy, MD, Zoran Popovic, MD, Stephanie Mick, MD, Eric E. Roselli, MD, Sajjad Gul, MD, Jasneet Devgun, BS, Sohi Mistry, Wael A. Jaber, MD, Lars G. Svensson, MD, and Samir R. Kapadia, MD, Cleveland, Ohio

A more granular characterization of mild AR after TAVR is effective in predicting long-term mortality and will hold increasing importance as the technology transitions to low-risk populations.

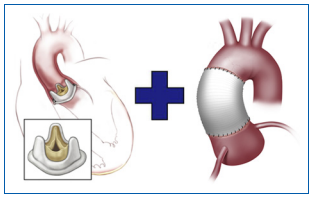
Acquired (ACQ): Aortic Root



791 **Aortic valve disease with ascending aortic aneurysm: Impact of concomitant root-sparing (supracoronary) aortic replacement in nonsyndromic patients**

Sven Peterss, MD, Paris Charilaou, MD, Julia Dumfarth, MD, Yupeng Li, BS, Rohan Bhandari, MD, Maryann Tranquilli, RN, John A. Rizzo, PhD, Bulat A. Ziganshin, MD, and John A. Elefteriades, MD, New Haven, Conn; Munich, Germany; Stony Brook, NY; and Kazan, Russia

Proximal aortic replacement with the RS technique is a safe approach and can be performed with excellent operative results.



799 **Editorial Commentary:** Concomitant replacement of the ascending aorta is free—for some

Nicholas D. Andersen, MD, and G. Chad Hughes, MD, Durham, NC

Concomitant ascending aorta replacement can be performed with trivial incremental risk for patients at low risk undergoing elective procedures when these operations are performed by a high-volume aortic subspecialist.

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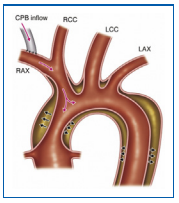
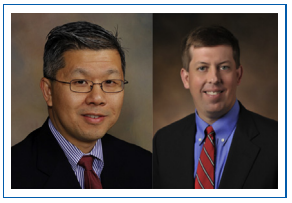
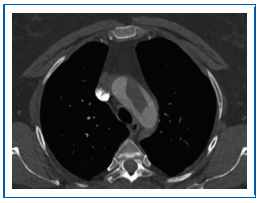
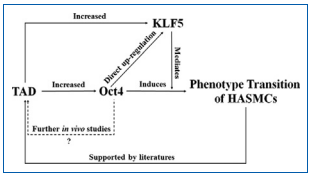
Acquired (ACQ): Aorta









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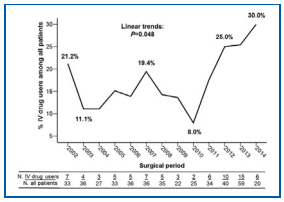
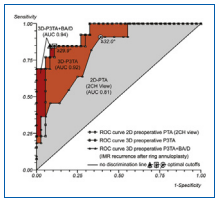


Acquired (ACQ): Mitral Valve



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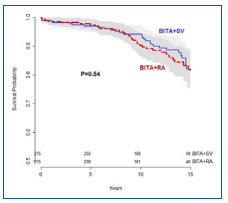
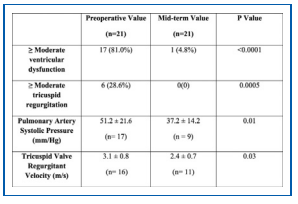
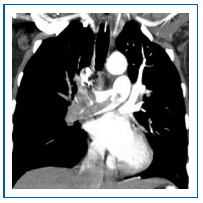
Acquired (ACQ): Coronary



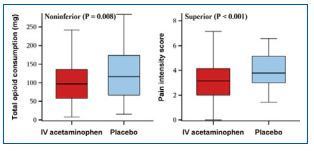
Acquired (ACQ): Pulmonary Embolus

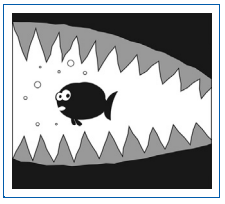


	Preoperative Value (n=21)	Mid-term Value (n=21)	P Value
≥ Moderate ventricular dysfunction	17 (81.0%)	1 (4.8%)	<0.0001
≥ Moderate tricuspid regurgitation	6 (28.6%)	0(0)	0.0005
Pulmonary Artery Systolic Pressure (mm/Hg)	51.2 ± 21.6 (n= 17)	37.2 ± 14.2 (n = 9)	0.01
Tricuspid Valve Regurgitant Velocity (m/s)	3.1 ± 0.8 (n= 16)	2.4 ± 0.7 (n= 11)	0.03



Perioperative Management (PM): Cardiac





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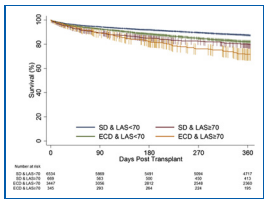
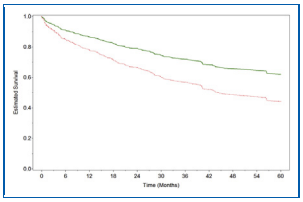
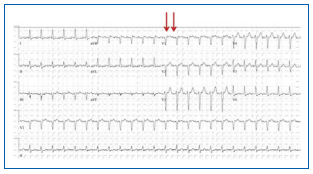
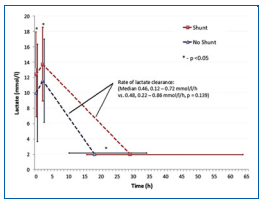
Transplantation (TX): Lung







Mechanical Circulatory Support (MCS): Congenital



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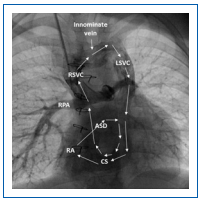
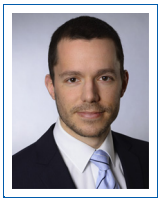
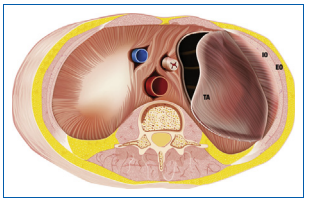
Cardiothoracic Imaging: Congenital

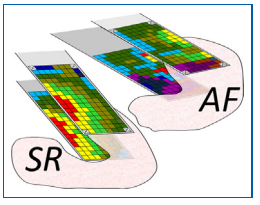




Surgical Technique: Thoracic



Surgical Technique: Acquired



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Case Report: Congenital

Case Reports: Thoracic

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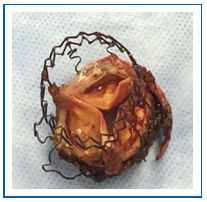
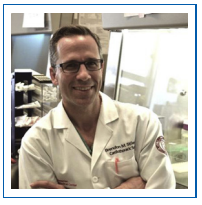
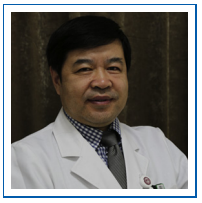
Case Report: Acquired



Letters to the Editor





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Notice of Correction

Announcements

The American Association for Thoracic Surgery

The AATS Graham Foundation

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Supplemental material is available online

Video clip is available online

Full-text online access to *The Journal of Thoracic and Cardiovascular Surgery* is now available for all print subscribers.

See page 668 for details.

The Journal of Thoracic and Cardiovascular Surgery online is sponsored by St. Jude Medical.

Cover Photographs

Left: From Concomitant Replacement of the Ascending Aorta Is Free—For Some. Wheat procedure: Replacement of the aortic valve and supracoronary ascending aorta.

Center: From Intramural Ventricular Septal Defect After Repair of Conotruncal Anomalies: Is There Light at the End of the Tunnel? The defining feature of intramural ventricular septal defect (*VSD*) is a tunnel underneath the trabeculations that persists with often multiple exit points at the free wall of right ventricle (*RV*). *LV*, Left ventricle.

Right: From Operability Assessment in Chronic Thromboembolic Pulmonary Hypertension (CTEPH): Don't Miss the Chance of a Second Opinion! Pulmonary angiography tends to underestimate the amount of disease found at surgery in patients with chronic thromboembolic pulmonary hypertension, particularly at the segmental and subsegmental level. Hence, in our experience, the correlation between the extent of thromboembolic disease and the severity of the pulmonary hypertension has been abandoned from the algorithm to determine surgical candidacy. The key factor associated with good outcome is a correct diagnosis and not necessarily the extent of disease on imaging.