More than six million elderly adults in USA, are newly eligible for statin therapy based on a strict interpretation of the Justification for the Use of Statins in Primary Prevention: An Intervention Trial Evaluating Rosuvastatin (JUPITER) trial (4). The number of individuals eligible for statin therapy increases to more than 10 million adults when extrapolated to individuals with normal LDL-cholesterol levels, as determined by the National Cholesterol Education Program Adult Treatment Panel III (NCEP ATP) cutoff points, and elevated hs-CRP levels. In conclusion, alternate-day dosing may be efficacious and safe alternative to daily dosing for primary prevention in some individuals.

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References

1. Keleş T, Bayram NA, Kayhan T, Canbay A, Sahin D, Durmaz T, et al. The comparison of the effects of standard 20 mg atorvastatin daily and 20 mg atorvastatin every other day on serum LDL-cholesterol and high sensitive C-reactive protein levels. Anadolu Kardiyol Derg 2008; 6: 407-12.
2. Cannon CP, Braunwald E, McCabe CH, Rader DJ, Rouleau JL, Belder R, et al. Intensive versus moderate lipid lowering with statins after acute coronary syndromes. N Engl J Med 2004; 350: 1495-504.
3. LaRosa JC, Grundy SM, Waters DD, Shear C, Barter P, Fruchart JC, et al. Intensive lipid lowering with atorvastatin in patients with stable coronary disease. N Engl J Med 2005; 352: 1425.
4. Michos ED, Blumenthal RS. Prevalence of low low-density lipoprotein cholesterol with elevated high sensitivity C-reactive protein in the US. J Am Coll Cardiol 2009; 53: 931-5.

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Dilemma in the strategy of treatment: revascularization or medical treatment?

Tedavi stratejisinde ikilem: Revaskülarizasyon mu, tıbbi tedavi mi?

Dear Editor,

We have read, with a great interest, the paper titled "Dilemma in the strategy of treatment: revascularization or medical treatment" by Tatlı et al. (1) which gives rise to thought about patients without angina with coronary artery diseases. In their summary of the case, they reported literature search and their own opinions on the case having significant narrowing at the left anterior descending (LAD) and right coroner artery (RCA). Principally, we would like to mention that the one of the most striking point of the case was a 43-year-old female suffering from coronary artery disease. We advocate that the success for all treatment attempts (such as medical, percutaneous coronary intervention (PCI), coronary artery bypass surgery (CABG)) will be low without determination of the etiology of early atherosclerosis.

Besides the study of Hochman et al. (2) cited by the authors in their paper for the proof of revascularization of infarct related artery in the treatment of late stage myocardial infarcts (MI) as being not entirely successful, more well-rounded study of Abbate et al. (3) reported a positive opinion on possibility of the revascularization in late stage cases.

Search of recently published literature revealed that there has been a debate in priority whether to use PCI or CABG in two vascular disease patients (4-6). Kimura et al. (4) compared the PCI and CABG and reported that there was no significant difference between two groups especially in asymptomatic patients with LAD and RCA clogging. However, Daemen et al. (5) also found no differences between groups, the repeated revascularization and major cerebrovascular attacks rates were higher in PCI groups. However this case, as pointed out by Eagle et al. (6) can be considered within the indication of class IIA of asymptomatic coronary artery two-vessel disease.

Our contribution to the authors own views politely stated and open for other ideas is that priority should be directed toward stress tests (myocardial perfusion scintigraphy, stress electrocardiography) before ventricular functions of patients deteriorate and evaluation of live tissue then if feasible PCI and CABG may practiced.

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References

1. Tatlı E, Aktoz M, Aydın G, Yılmaztepe M, Altun A. Dilemma in the strategy of treatment: revascularization or medical treatment? Anadolu Kardiyol Derg 2008; 8: 397-8.
2. Hochman JS, Lamas GA, Buller CE, Dzavik V, Reynolds HR, Abramsky SJ, et al. Occluded Artery Trial Investigators. Coronary intervention for persistent occlusion after myocardial infarction. N Engl J Med 2006; 355: 2395-407.
3. Abbate A, Biondi-Zoccai GG, Appleton DL, Erne P, Schoenenberger AW, Lipinski MJ, et al. Survival and cardiac remodeling benefits in patients undergoing late percutaneous coronary intervention of the infarct-related artery: evidence from a meta-analysis of randomized controlled trials. J Am Coll Cardiol 2008; 51: 956-64.
4. Kimura T, Morimoto T, Furukawa Y, Nakagawa Y, Shizuta S, Ehara N, et al. Long-term outcomes of coronary-artery bypass graft surgery versus percutaneous coronary intervention for multivessel coronary artery disease in the bare-metal stent era. Circulation 2008; 118: 199-209.
5. Daemen J, Boersma E, Flather M, Booth J, Stables R, Rodriguez A, et al. Long-term safety and efficacy of percutaneous coronary intervention with stenting and coronary artery bypass surgery for multivessel coronary artery disease: a meta-analysis with 5-year patient-level data from the ARTS, ERACI-II, MASS-II, and SoS trials. Circulation 2008; 118: 1146-54.
6. Eagle KA, Guyton RA, Davidoff R, Edwards FH, Ewy GA, Gardner TJ, et al. ACC/AHA 2004 guideline update for coronary artery bypass graft surgery: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery). Circulation 2004; 110: 340-437.

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Author reply

Dear Editor,

We appreciate the comments of the authors concerning our manuscript "Dilemma in the strategy of treatment: revascularization or medical treatment?"(1).

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References

1. Tatli E, Aktoz M, Aydin G, Yilmaztepe M, Altun A Dilemma in the strategy of treatment: revascularization or medical treatment? Anadolu Kardiyol Derg 2008; 8: 397-8.

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A normofunctioning caged-ball aortic valve prosthesis for 31 years

Otuz bir yıldır normal fonksiyonları olan bir top kafes aort kapak protezi

Starr-Edwards (S- E) ball cage prosthetic valve was first successfully implanted in mitral position in September 1960 (1). Since then, S-E ball valves have been widely used in all over the world with good results till 2007 when Edwards Lifesciences discontinued production of the S-E valve. Their usage was abandoned because prosthetic valves with better hemodynamics and with less thromboembolic potential were introduced to the market. The S-E ball cage valve was known for its long durability. We report a case with 9 no. S-E aortic caged-ball valve prosthesis, which has been well-functioning for 31 years.

A 50 years old male patient was referred to the echocardiography laboratory after a routine physical examination. He had no complaints. He had undergone aortic valve replacement for rheumatic aortic valve disease with a S-E caged-ball aortic valve (no.9) in 1977. After 15 years of asymptomatic period; his symptoms recurred and he underwent a second surgery and 27 no. Medtronic mechanical monoleaflet mitral valve was implanted in 1995. The prosthetic valve in the aortic position was functioning well at that time. From then, he attended outpatient appointments regularly with no complaints with grade I New York Heart Association (NYHA) functional class. Routine echocardiography and cine-fluoroscopy controls showed normofunctioning aortic and mitral mechanical valves (Fig. 1-2, Video 1. See corresponding video/movie images at www.anakarder.com).

In the past decades; aortic S-E caged-ball valves have been used successfully all over the world. The only Food and Drug Administration (FDA) approved caged-ball valve is the S-E valve. The complications related to S-E caged-ball valves are; thromboembolism, hemolytic anemia, valve failure, cloth wear, endocarditis, and pannus formation (2). Orszulak et al. (3) have reported that survival rate of patients with prosthetic aort valve at 20 years were 31,2 % -including 6,2 % operative mortality- in a series of 1100 S-E caged ball aortic prostheses with a 24.8 years mean follow up time. They found that advanced NYHA class (III or IV), older age (>56 years) and lower ejection fraction (<0.56) were predictive of poor late survival. They did not find any valve failure in 1100 patients and they recommend that especially S-E valves of larger sizes (9A and above) provide an excellent, safe and durable alternative in the aortic position. Gödje et al. (4) have reported 16.6 % survival rate in patients with aortic S-E ball valves after 30 years. For the S-E prosthesis, 40-year survival after mitral valve replacement and 41- year survival after aortic valve replacement have been reported (5).

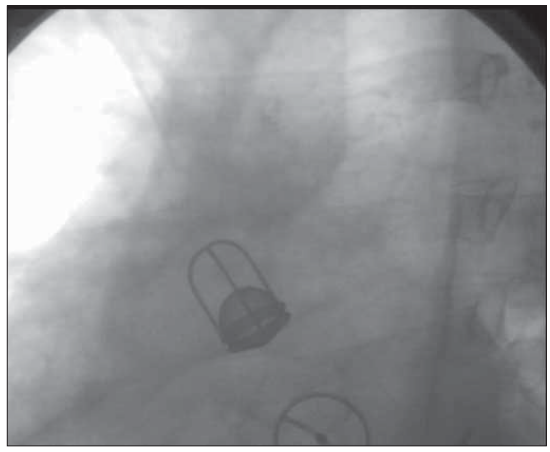

Figure 1. Closing of the caged-ball prosthesis

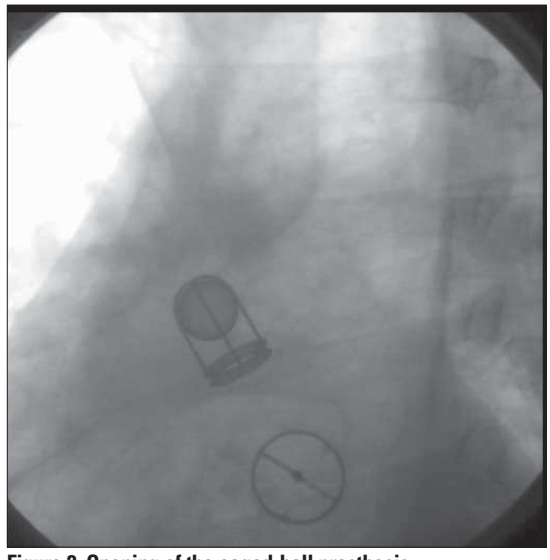

Figure 2. Opening of the caged-ball prosthesis

Although natural heart valves allow blood to flow straight through the center of the valve (central flow), caged ball valves completely block central flow and collisions with the occluder ball cause damage to blood cells, stimulate thrombosis and formation of blood clots. The high pressure gradient, less effective orifice area and the absence of a central blood flow with the patient morbidity rates are the factors that leaded scientists to design new mechanical valves (4).

Our case demonstrates long durability of caged ball valves. The patient has a normofunctioning S-E caged-ball aortic valve implanted 31 years ago. His functional capacity is classified as NYHA class 1.

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