EDITORIAL

Discussion of Clinical Cases: from the Medical Board to the Heart Team

La evolución en la discusión de pacientes: de la junta médica al Heart Team

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"The arrogance of success is to think that what you did yesterday will be sufficient for tomorrow."
W. Pollard 1828

For decades, surgical aortic valve replacement (SAVR) has been the only therapy to reduce mortality in patients with severe aortic stenosis. Short-, mid- and long-term results are indisputable. Among the countless revolutions in modern cardiology, one has been transcatheter aortic valve implantation (TAVI) for severe aortic stenosis. TAVI has been clearly beneficial for patients, with wonderful results in many aspects: clinical, mortality, hospitalization, cost-effectiveness, etc. However, it was also a new form of multidisciplinary treatment for this disease, with cardiac surgeons usually observing in their practice that the transcatheter technique was often selected regardless of the patient's opinion. This commonly resulted in the patient leaving the surgical environment only to remain within the cardiology department.

One of the thoughts implicit in the formidable data analysis performed over the years by Dr. Trivi et al. (1) is evidently the need to evaluate, discuss and agree on the best choice of treatment for each patient. This can be assessed only with an honest analysis, based on clinical practice guidelines, using dialogue, rather than confrontation, and including all stakeholders (i.e., the Heart Team).

Trivi et al. performed a retrospective analysis of the results from their patients over 10 years, with different therapeutic options being discussed by the Heart Team before any potential TAVI was conducted. On the one hand, we can see the results of their therapies are favorable and as expected, suggesting that the appropriate decision was made. On the other hand, while inclusion criteria included only analyzing patients who were initially eligible for TAVI, this procedure was not performed in many cases. The discussion is certainly well outlined, open and honest, although, in the end, the technique (TAVI) suggested at the beginning was performed in some patients but not in others.

However, there is room for further thoughts. Another interesting topic for analysis would be to explain what happened with patients who were initially selected for surgical treatment but who then underwent TAVI following discussion with the Heart Team.

Therefore, a relevant aspect for consideration is to decide which patients need to be evaluated by the Heart Team. TAVI is not a novel procedure and has perfectly fitted into the routine of therapy for aortic stenosis, as has surgery. Perhaps we should focus on patients where the decision is not so clear for reasons such as age, comorbidities, clinical condition, etc. Naturally, a 50-year-old patient with severe bicuspid aortic stenosis needs surgery, and thus, no deep discussion by the Heart Team is required. Likewise, an elderly patient in an experienced facility who is a suitable candidate for TAVI should not raise many questions.

A Heart Team is most beneficial for patients where therapy is not fully certain and where both techniques might be a good choice. Both pros and cons, as well as the results of the site, need to be considered before making the best choice in every case. In the same way as angiotensin-converting enzyme inhibitors are an obvious choice for ventricular dysfunction in heart failure, it is not worth arguing about obvious issues in the Heart Team. We need to focus on genuinely uncertain cases, assessing the best therapeutic option, and not just the technique or specialty. The Heart Team will be truly successful, beyond any right and wrong decisions, when focus is made only on the patient, evaluating their therapeutic options, excluding any futile therapies, and considering that sometimes both techniques are possible, while honestly selecting the

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best choice for that specific patient.

We congratulate Dr. Trivi et al. for their work, which has highlighted the importance of the Heart Team, for maintaining it for 10 years, and for paving the way for countless considerations. The aim of the Heart Team is not to confront fields of specialty or to identify an alpha male in discussions; it is rather a group of specialists (surgeons, cardiologists, anesthesiologists, and very often gerontologists) having an honest discussion on the best choice for every patient based on medical records, complementary tests, the site's experience, and factors affecting each individual, including any unbiased information provided to the patient and personal preferences. After all, this is one of the cornerstones of Medicine.

Conflicts of interest

None declared.

(See authors' conflict of interests forms on the web).

REFERENCES

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