



NEW SERIES

Valvular heart disease update

MUCH HAS CHANGED in the etiology, diagnosis, and treatment of valvular heart disease over the last decade, yet it is still the family doctor, internist, or general cardiologist who most often first detects a valve problem as an asymptomatic murmur. These clinicians are responsible for initiating diagnostic tests and developing a therapeutic strategy, and need to be familiar with current practice guidelines. In this issue of the *Cleveland Clinic Journal of Medicine* is the first installment of a series designed to update internists and cardiologists on valve disease.

Changes in the problems seen

Rheumatic disease has declined in incidence, but we now see more cases of mitral valve prolapse or myxomatous disease of the mitral valve and congenital or degenerative abnormalities of the aortic valve. As many as 2% of people have evidence of mitral valve prolapse on echocardiography, and an estimated 1 in 10 of these persons will eventually require surgery for it. Congenital anomalies of the aortic valve affect 1% to 2% of the general population, and degenerative aortic valve changes affect an increasing number as life expectancy increases.

Management is changing

Medical management is vitally important in preventing recurrent rheumatic disease, endocarditis, and stroke. Furthermore, indications for medical treatment have been changing recently. For instance, vasodilators are now indicated in asymptomatic aortic regurgitation to reduce the leak and to postpone the need for surgery.

Surgical and balloon treatments have changed dramatically over the last decade, with many choices now available. Repair of

defective valves is now possible in many patients who in the past would have received a prosthesis. When valve replacement is necessary, the choice of valve prostheses has widened with the greater durability of newer bioprostheses and the increased expertise in human valve (homograft) insertion.

Long-term follow-up is needed

Long-term follow-up of patients after surgery requires familiarity not only with the procedure performed but also with the likely short-term and long-term complications, with special attention to anticoagulation and compliance.

Scope of the series

Our aim in this series is to focus on the valve lesions most commonly encountered and to provide information to guide clinical decisions. We begin with the role of medical treatment in common heart valve conditions (pages 881-887). Future articles in the series:

- Update on mitral valve prolapse
- Diagnosis and management of common rheumatic disorders resulting in valvular disease
- Indications for surgical or balloon intervention in common valve conditions
- New surgical options and their implications for the physician
- Diagnosis and management of common complications following valve surgery.

We hope you will find the series interesting and useful.

BRIAN P. GRIFFIN, MD

Department of Cardiology, Cleveland Clinic

Diagnosis
and
treatment
have changed
in valvular
disease
in the last
decade