The unfinished saga of invasive procedures for secondary mitral regurgitation

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Secondary mitral regurgitation (MR) is a common valvular heart disease. Its prognostic burden in patients suffering from idiopathic or ischemic cardiomyopathy (ICM) with left ventricular (LV) dysfunction/dilation has been clearly demonstrated. Severe secondary MR is associated with an increased mortality and frequent heart failure hospitalizations. Although guideline-directed medical therapy (GDMT) is the cornerstone of the management of secondary MR, a certain proportion of patients remain symptomatic. For these patients, several surgical techniques have been progressively developed during the last few decades (replacement, repair, sub-valvular apparatus interventions and other ventricular approaches). In the absence of evidence-based medicine, the benefits of these surgical procedures remains controversial, leading to a low level of recommendation in the guidelines. One way to anticipate the future is to look to the past. Recent prospective randomized trials evaluated surgical and percutaneous techniques and led to a better understanding of how best to treat this disease. In this article, we aim to describe the saga of the surgical and percutaneous treatments for secondary MR throughout the previous decades.

Keywords: Secondary mitral regurgitation (secondary MR); mitral valve repair (MVR); mitral valve replacement (MVR); percutaneous procedures; MitraClip


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Introduction

The ancient functional mitral regurgitation (MR), today defined as secondary MR, is a common valvular heart disease resulting from idiopathic or ischemic cardiomyopathy (ICM) with left ventricular (LV) dysfunction/dilation (1). The prognostic implications of secondary MR have been clearly demonstrated showing a strong association between the severity of MR and mortality as well as heart failure hospitalizations (2,3). Although guideline-directed medical therapy (GDMT) is the cornerstone of the management of secondary MR, a high proportion of patients remain quite symptomatic despite a maximal GDMT. The role of mitral valve (MV) surgery is still controversial as a consequence of limited available data, which has resulted in guidelines recommending surgery with low levels of evidence (4,5). Nevertheless, several techniques (replacement, repair, subvalvular apparatus interventions and other ventricular approaches) have been adopted over time, however, no solution has proved superior to another or altered the natural history of the underlying cardiomyopathy (6).

The best way to anticipate the future is to look to the past. In this article, we aim to describe the saga of the surgical and percutaneous treatments for secondary MR throughout the previous decades.

1990s: the “pop-off valve” theory

For many years, it was believed that the MV anatomic-functional complex had a beneficial “pop-off” function
in advanced heart failure, which should be preserved. Surgical correction of MR in end-stage LV dysfunction was considered deleterious and responsible for prohibitive morbidity and mortality (7).

**Early 2000s: “undersized rigid annuloplasty for everybody”**

The “pop-off valve” hypothesis was soon challenged by “the Bolling theory”, which promoted the efficiency of undersized annuloplasty. In 1996, Bolling’s team showed for the first-time reasonable mortality when a surgical undersized annuloplasty was performed for severely symptomatic patients with LV ejection fraction (LVEF) <25%. The technique was deemed to reverse the vicious cycle while restoring valvular competency, alleviating the excessive ventricular workload and improving ventricular function (8). All cohort studies conducted during this decade revealed reasonable operative mortality in this population (1.6% to 8.2% 30-day mortality) (9,10). The technique also should have promoted durable LV reverse remodelling and improved functional class. This theory was reinforced by the results of in vivo studies (ischemic sheep model) showing a decrease in LV radius curvature at the basal, equatorial and apical levels following restrictive annuloplasty. Thus, for the first time, the paramount importance of maintaining the integrity of annular and subvalvular continuity during MV surgery was highlighted and it was assumed that prohibitive morbidity associated with surgical correction could be attributed to the loss of the subvalvular apparatus (rather than the loss of the “pop-off valve”). Therefore, MV repair (MVR) was always recommended over replacement. This benefit was reported (I) in both ischemic and non-ischemic patients and (II) when MV surgery was associated with coronary artery bypass grafting (CABG) surgery (11).

In this specific setting, rigid rings were preferred to fix both inter-trigonal distance and septal-lateral dimension (12). Indeed, in the mid 2000s, the gold standard in functional MR (which, later, was reclassified as secondary MR) was the annulus remodelling by a restrictive annuloplasty (downsized by 2 to 4 sizes) with a nonflexible ring (rather than flexible band) regardless of the cardiomyopathy etiology. This position was supported by both American and European guidelines in 2006 and 2007 despite a total lack of analysis comparing surgery in conjunction with medical treatment versus medical treatment alone (class IC and IIAc, respectively) (13,14).

**Late 2000s: disappointing time for surgical MVr**

As soon as 2005, Bolling’s team raised initial doubts concerning the real benefits for survival conferred by MV annuloplasty (MVA) for significant MR with severe LV dysfunction after 10 years of promoting a proactive approach in patients with secondary MR (15). The promising initial results were discounted by arguments of heterogeneous ring selection, an insufficient annular downsizing and the lack of reported data on the presence of recurrent MR at the follow-up (18).

In the late 2000s, Magne *et al.* compared MV replacement (MVR) versus MVr, both associated with CABG surgery, in ischemic patients (17). Data suggested that MVR was not superior to MVR with regard to operative and overall mortality. Most importantly, this survival equivalence at long-term follow-up (12 years) was found regardless of the MR recurrence rate in the repair group—45% of MVR patients had at least mild MR (*Figure 1*). Since patients with persistent MR despite MVR had the same survival rate as patients with no recurrent MR, the question of the clinical impact of treating secondary MR was raised. Additional doubts were set forth by large retrospective studies analysing CABG alone versus CABG in conjunction with MVA in ischemic patients who were candidates for CABG surgery. Several studies suggested no clear demonstrable survival benefit conferred by MVA as the poor prognosis was related to the underlying cardiomyopathy rather than to the mitral surgery (21,22). A sudden shock wave passed through the cardiovascular surgery field and it became increasingly questionable if modern surgical strategies could really improve patients’ prognosis when compared to medical therapy alone. Finally, most of the publications that shaped recommendations (even the current ones) were monocentric, retrospective studies including small populations with heterogeneous patients (primary and secondary MR, ischemic and non-ischemic secondary MR, broad inclusion criteria regardless of selection on LV dimensions). Moreover, most studies reported the retrospective results of a single treatment (surgery) with no control group. Thus, “evidence based medicine” had not yet reached the surgical world.

**Early 2010s: surgeons want to understand, but...**

In order to provide strong evidence-based recommendations and possibly stimulated by the fast development of percutaneous techniques, considerable efforts were made...
Figure 1 The Achilles’ heel of MVr: the recurrence of MR after MVr increases with time. In this figure, adapted from Magne et al. (17), we have added in red the high recurrence of MR after surgical repair [60% in the CTSN trial (18)] and the lower recurrence after percutaneous repair [17% in MITRA.FR and 5% in COAPT (19,20)]. MVr, mitral valve repair; MR, mitral regurgitation.

Table 1 Ischemic and non-ischemic secondary MR

<table>
<thead>
<tr>
<th></th>
<th>Ischemic</th>
<th>Non-ischemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>LV remodelling and dysfunction; annular dilation/dysfunction; mechanical dyssynchrony</td>
<td>LV remodelling; annular dilation</td>
</tr>
<tr>
<td>Natural history</td>
<td>It remains hard to determine if secondary MR occurs when cardiomyopathies are more severe or if the occurrence of a secondary MR makes the underlying cardiomyopathy more severe</td>
<td>Up to 75% of patients with heart-failure symptoms</td>
</tr>
<tr>
<td>Common features</td>
<td>Up to 50% of cases after AMI</td>
<td>Up to 75% of patients with heart-failure symptoms</td>
</tr>
<tr>
<td></td>
<td>Moderate or severe in only 10–12%</td>
<td>Moderate to severe in only 25%</td>
</tr>
<tr>
<td></td>
<td>Independent of initial LVEF or LV dimensions</td>
<td>More LV dilatation and worse LVEF</td>
</tr>
</tbody>
</table>

MR, mitral regurgitation; LV, left ventricular; AMI, acute myocardial infarction; LVEF, left ventricular ejection fraction.

by surgeons to identify the best candidates for the invasive correction of secondary MR and to choose the best surgical strategies for this population. Table 1 shows the differences between ischemic and non-ischemic secondary MR.

Secondary MR complicating ICM

Most data concerned patients with ICM, especially patients awaiting surgical coronary revascularization, since adding a mitral procedure during CABG surgery had been the standard of care for decades (23). Three subsets of ischemic patients were identified:

(I) Candidates for CABG with severe secondary MR: a randomized study was performed in the US by the Cardiothoracic Surgical Trials Network (CTSN) to compare MVr and MVR over a 12-month follow-up period (18). The authors found no significant difference in LV end-systolic volume index (LVESVI), remodelling or survival between both groups. Two other major takeaways were also identified: (I) the composite major adverse event (rate of death, stroke, subsequent MV surgery, hospitalization for heart failure or an increase in New York Heart Association class of ≥1) occurred in up to 30% of patients at 1-year follow-up, highlighting the large potential for improvement.
in the therapy of ischemic secondary MR; and (II) the investigators found a MR recurrence (≥ grade 2) rate at 2 years of 60% after MVr. Thus, if the persistence of MR had no impact on the survival, the usefulness of treating secondary MR would be challenged. In the subgroup of CABG surgery candidates with severe ischemic MR, no prospective study compared CABG surgery with MR correction versus CABG surgery without MR correction for understandable ethical reasons.

(II) Candidates for CABG with moderate secondary MR [defined as an effective regurgitant orifice (ERO) area of 0.20 to 0.39 cm$^2$] and good LV ejection function (LVEF >30%): in 2012, the Randomized Ischemic Mitral Evaluation (RIME) investigators in Europe proposed to randomize patients referred for CABG surgery with moderate ischemic MR to undergo CABG + MVr or CABG alone (24). The study was stopped early after the 1-year interim data analysis showed a greater improvement in the primary endpoint (peak oxygen consumption) in the CABG + MVr group. In these patients, adding a mitral annuloplasty to CABG was also associated with a greater LV reverse remodelling and a decrease in MR severity. However, no improvement of survival at 1 year could be identified. In the subgroup of patients with mild ischemic MR, there was no evidence that adding a MVr to surgical revascularization improved the long-term survival (25).

(III) Candidates for CABG with poor LV function: in patients with LV dysfunction and moderate to severe MR, adding a MVr to CABG may improve survival compared with CABG alone or medical therapy alone (26).

Secondary MR in non-ICM (N-ICM)

Conversely, secondary MR in non-ischemic patients occurs more often where there is a reduced LVEF. This population is less studied probably because proposing a surgery to frail patients without CABG indication appears to be risky. Preliminary results comparing mitral surgery and medical therapy in “historical patients” with catastrophic LV parameters suggested a benefit of surgical correction of MR in terms of survival and LV remodelling (11). Thus, both patients’ characteristics and modern non-surgical therapy dramatically changed in the last 15 years and this literature should be carefully interpreted. Recent retrospective data showed that postoperative survival was conditioned by the restoration of a LV forward stroke volume (27). Thus, no specific preoperative clinical or echocardiographic prognostic parameters were identified. As of today, surgery is an option with a IIb class of recommendation. This subset of patients probably will be less often referred to surgery and is a possible target for innovative therapies.

Finally, after more than 20 years of fine-tuning, no significant evidence supports a systematic adoption of surgical treatment of secondary MR. Table S1 summarizes the most significant published studies regarding secondary MR.

**Late 2010s: one confirmation (MITRA.FR) and one cat among pigeons (COAPT)**

Based on the encouraging results of the surgical edge-to-edge technique (28-30), percutaneous, transcatheter procedures with the MitraClip (Abbott Vascular, Santa Clara, California) were proposed (31).

In 2011, the EVEREST II trial concluded that MitraClip implantation is safe and feasible and further concluded that MitraClip implication reduced symptoms and improved the clinical status of secondary MR in a series with only 30% of secondary MR patients (32). Due to the design of the study, the efficacy of the MitraClip was judged non-inferior to MVr despite a reoperating rate of 22% in the MitraClip group vs. 2% in the surgical group (33). Thus, by 2012, the potential use of percutaneous edge-to-edge procedures in secondary MR was mentioned in European guidelines (without specific indications) (34).

In August 2018, the results of the MITRA.FR randomized controlled trial were presented, comparing a group receiving GDMT versus a group of MitraClip + GDMT in a population of heart failure patients with secondary MR (19). The study showed an absence of benefit in the primary endpoint (death from any cause or rehospitalisation for heart failure) and in any sub-group analysis. These results were in total accordance with all previous literature and, in particular, when we compared the curve of MITRA.FR with the propensity matched series of Wu et al. (15) (Figure 2).

In November 2018, surprising results were announced in the COAPT study showing for the first time in the history of secondary MR treatment a major benefit of MitraClip implantation on the primary endpoint (cumulative incidence of rehospitalisation for heart failure), on mortality and in
any sub-group analysis (20).

These apparently contradictory results created a “buzz” in the cardiologic community. Hundreds of publications were subsequently published to analyze this discrepancy. Despite similar LVEFs (33.3% vs. 31.3% in MITRA.FR and COAPT, respectively), the severity of regurgitation was higher in the COAPT study (0.31 vs. 0.41 cm$^2$) and LV volumes less dilated (192 vs. 251 mL). This apparent discrepancy led to the rethinking of the definition of secondary MR with the proportionate/disproportionate concept, which had the advantage of reconciling the results of the two studies (35).

After the publication of the COAPT study, in March 2019, the Food and Drug Administration (FDA) approved the MitraClip for the treatment of secondary MR in the U.S. and implantations of MitraClip increased dramatically worldwide. Currently, implantation of MitraClip is the only procedure (surgical or percutaneous) with a proven benefit; in addition to medical treatment, in the treatment of secondary MR. It now is the gold standard against which any new device will be compared. Several new percutaneous repair or replacement techniques (36-43) are the subject of a dedicated keynote lecture and will not be discussed herein but will be discussed in detail in another chapter of this issue.

**What’s next?**

There is no doubt that GDMT, including cardiac resynchronization therapy and myocardial revascularization, should systematically be considered as the first line of treatment in patients with secondary MR complicating heart failure regardless of the LVEF (44). The remaining patients unresponsive to GDMT (60%) as well as those developing secondary MR despite GDMT have the worst prognosis and should be evaluated by a “Valvular Heart Team” and possibly recommended to correct their secondary MR. Every case must be analyzed by integrating both MR quantification and LV analysis (etiology, viability, function, volume). The old definitions of secondary MR, as described in the previous guidelines, should be revisited taking into account the LV geometry (“proportionate/disproportionate theory”) (45). Although very appealing, this classification model is yet to be validated and, even more important, it is necessary to understand how it will help the decision-making for every single patient.

The proper recommendations summarized in Figure 3 should be revisited. New Guidelines are expected in the U.S. in 2020 and in Europe in 2021 and they should take into account the main lessons of the past decades, which are as follows:

(I) Heart failure with secondary MR is a severe disease with a prognosis worsening with the severity of the regurgitation;

(II) All literature strongly suggests that GDMT including cardiac resynchronization therapy and myocardial revascularization should be the first line of treatment for any secondary MR;
(III) The definition of secondary MR should be revisited, integrating the regurgitation in its ventricular environment (size and function);

(IV) In candidates for surgical myocardial revascularization, the indication for treating severe secondary MR with such surgical procedure is still recommended by the guidelines, which seems logical, but one must note that we have no trials supporting this recommendation and we probably will never have such support;

(V) With respect to N-ICM, the benefit of the surgical treatment of secondary MR has never been confirmed by evidence-based medicine, so that such surgery will probably be rare and limited (i) to significant secondary MR associated with other surgical procedures or (ii) when other percutaneous procedures are impossible and when LV function is not too low or (iii) as an alternative to transplantation or long-term mechanical circulatory support;

(VI) In patients contraindicated for surgery, COAPT indicates that the treatment of secondary MR can save lives and improve quality of life in a highly selective group of secondary MR patients. COAPT and MITRA.FR confirm that the MitraClip technique is safe and efficient in reducing the severity of the regurgitation and better than the majority of the surgical series suggesting that the edge-to-edge technique is particularly adapted for the treatment of this disease (Figure 2). MITRA.FR shows the limits of over indication of MitraClip implantation, in particular, when the ventricles are too dilated and the regurgitation too low (the best way to kill a technique is to overuse it);

(VII) The Achilles’ heel of valve repair being the high risk of recurrence of MR, a wider place for MVR (surgical or percutaneous) is expected, in particular, when the tethering is important and the edge-to-edge technique is unsuitable.

**Conclusions**

Looking back through the past decades of the history of secondary MR shows the progress in understanding this complex disease and better defines its phenotype and treatment. The poor prognosis of secondary MR is confirmed and directly linked to the severity of the regurgitation, justifying an aggressive approach starting with a GDMT. The place of surgical treatment has always been a matter of controversy as reflected in recent studies which
have never been able to confirm its efficacy. Conversely, percutaneous treatment has, for the first time, established the concept of a possible virtuous cycle after correction of a severe secondary MR. An opposite randomized controlled trial shows that this benefit is possible only in a very accurately selected population. The challenge for the future will be to define which phenotype of patients and which definition of secondary MR (severity of MR/ventricular remodelling) could actually benefit from a correction. New randomized controlled studies are expected to answer these questions, in particular, at an earlier phase of the disease.

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Footnote

Conflicts of Interest: JFO: Potentially influence received research support from Boehringer, Abbott, Medtronic, Edwards. Received Consulting Fees/Honoraria from Edwards, Medtronic, Servier, Novartis. Received Royalty Income from Landanger, Delacroix-Chevalier. The other authors have no conflict of interest to disclose.

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References


Table S1. Details chart of some of the most significant published studies about secondary MR.

<table>
<thead>
<tr>
<th>Author (ref.)</th>
<th>Study frame</th>
<th>Population</th>
<th>ICM</th>
<th>N-ICM</th>
<th>Comment</th>
<th>Moderate</th>
<th>Severe</th>
<th>LVEF</th>
<th>LV dilatation</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vas et al. (59)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>51 patients underwent CABG and restrictive annuloplasty</td>
<td>X</td>
<td>X</td>
<td>Mean grade 3.4</td>
<td>X</td>
<td>Mean 31%</td>
<td>X</td>
<td>Mean LV ERO &gt;0.2 cm²</td>
</tr>
<tr>
<td>Badhwar et al. (15)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>125 patients manage with restrictive annuloplasty</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>Mean 16%</td>
<td>X</td>
<td>Mean LV ERO 281 ml</td>
<td>Clear benefit to the surgical elimination of MR</td>
</tr>
<tr>
<td>Acker et al. (13)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>193 patients with MR surgery (84% annuloplasty and 15% MVR); Corepa in 50%</td>
<td>X</td>
<td>6.2% are ICM</td>
<td>X</td>
<td>X</td>
<td>Mean 23.9%</td>
<td>X</td>
<td>Mean LV ERO 270.1 ml</td>
</tr>
<tr>
<td>Spoor et al. (23)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>299 patients: BAND vs. RING</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 17% and 21%</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>McGea et al. (18)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>257 consecutive patients undergoing MV repair</td>
<td>X</td>
<td>95% CABG</td>
<td>X</td>
<td>X</td>
<td>Mean 35%</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Milhevic et al. (21)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>CABG alone (100 patients) and CABG + MVA (20 patients)</td>
<td>X</td>
<td>100% CABG</td>
<td>X</td>
<td>X</td>
<td>Mean 35%</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Wu et al. (15)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>128 MVA, 263 no MVA, 293 candidates for MVA but not performed</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 19% to 23%</td>
<td>X</td>
<td>Mean LV ERO 65 mm</td>
<td>No clear demonstration of mortality benefit confirmed by MVA for significant MR with severe LV dysfunction</td>
<td></td>
</tr>
<tr>
<td>Calafiore et al. (17)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>257 patients undergoing MV repair for secondary MR</td>
<td>X</td>
<td>85% CABG</td>
<td>X</td>
<td>X</td>
<td>Mean 35%</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Castellino et al. (23)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>4,988 patients with CAD and MR (561 median treatment, 25% PCI, 34% CABG, 5% CABG + MVR surgery)</td>
<td>X</td>
<td>100% significant CAD</td>
<td>X</td>
<td>X</td>
<td>Mean from 45% to 50%</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sahni et al. (46)</td>
<td>Meta-analysis</td>
<td>Comparative</td>
<td>CABG alone vs. CABG + MVR surgery</td>
<td>X</td>
<td>Only ICM</td>
<td>X</td>
<td>Only moderate</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chan et al. (24)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>CABG alone (39 patients) vs. CABG + MVR (34 patients)</td>
<td>X</td>
<td>Only ICM</td>
<td>X</td>
<td>Mean LVEF 0.18–0.31 cm²</td>
<td>X</td>
<td>Mean 40%</td>
<td>X</td>
</tr>
<tr>
<td>Michler et al. (17)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>CABG alone (151 patients) vs. CABG + MVR (155 patients)</td>
<td>X</td>
<td>Only ICM</td>
<td>X</td>
<td>Mean LVEF 0.2 cm²</td>
<td>X</td>
<td>Mean 40%</td>
<td>X</td>
</tr>
<tr>
<td>Kang et al. (25)</td>
<td>Prospective</td>
<td>Comparative</td>
<td>CABG alone (5 patients) vs. CABG + MVR (50 patients)</td>
<td>X</td>
<td>Only ICM</td>
<td>X</td>
<td>Mean LVEF 2.5 and 2.8</td>
<td>X</td>
<td>Mean 35%</td>
<td>X</td>
</tr>
<tr>
<td>Deja et al. (20)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>CAD amenable to CABG randomized to medical therapy with (831 patients) or without CABG (599 patients)</td>
<td>X</td>
<td>Only ICM</td>
<td>X</td>
<td>Mid in 48% of patients</td>
<td>X</td>
<td>Only LVEF ≤35%</td>
<td>X</td>
</tr>
<tr>
<td>Kamperidou et al. (27)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>130 patients treated with surgical MV</td>
<td>X</td>
<td>78% non-ischemic</td>
<td>X</td>
<td>X</td>
<td>Severe define as ERO &gt;0.2 cm²</td>
<td>X</td>
<td>Mean 31%</td>
</tr>
<tr>
<td>Kamperidou et al. (48)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>76 patients underwent surgical repair (71%) or MVRclip repair (29%)</td>
<td>X</td>
<td>100% non-ischemic</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 0.21 cm²</td>
<td>X</td>
<td>Mean 34%</td>
</tr>
<tr>
<td>Oballa et al. (19)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>Medical therapy alone (155 patients) or associated with MVRclip (152 patients) in patients not considered to be candidates for MV surgery</td>
<td>X</td>
<td>ICM in 60%</td>
<td>X</td>
<td>Mean LVEF 0.31 cm²</td>
<td>X</td>
<td>Mean 33%</td>
<td>X</td>
</tr>
<tr>
<td>Stone et al. (20)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>Medical therapy alone (312 patients) or associated with MVRclip (302 patients) in patients with STS score ≥8%</td>
<td>X</td>
<td>ICM in 60%</td>
<td>X</td>
<td>Mean LVEF 0.4 cm²</td>
<td>X</td>
<td>Mean 31%</td>
<td>X</td>
</tr>
<tr>
<td>Magne et al. (17)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>MVR (184 patients) vs. MV (186 patients)</td>
<td>X</td>
<td>CABG associate in 84% (MVR) and 94% (MV)</td>
<td>X</td>
<td>Severe in 88% (MVR) and 97% (MV)</td>
<td>X</td>
<td>Mean LVEF 43% and 45%</td>
<td>X</td>
</tr>
<tr>
<td>Acker et al. (18)</td>
<td>Randomized</td>
<td>Comparative</td>
<td>MVR (125 patients) vs. MV (126 patients)</td>
<td>X</td>
<td>CABG associate in 75%</td>
<td>X</td>
<td>Mean LVEF 0.4 and 0.39 cm²</td>
<td>X</td>
<td>Mean 42% and 40%</td>
<td>X</td>
</tr>
<tr>
<td>Calafati et al. (49)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>60 repairs and 20 replacements (depending on end-systolic distance between the coaptation point of mitral leaflets and the plane of mitral annulus)</td>
<td>X</td>
<td>CABG associate in 92%</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 0.21 cm²</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lee et al. (50)</td>
<td>Retrospective</td>
<td>Single arm</td>
<td>Risk of MR recurrence in 104 patients who underwent annuloplasty for nonischemic dilated cardiomyopathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 0.28 and 0.24 cm²</td>
<td>X</td>
<td>Mean 28% and 24%</td>
<td>X</td>
</tr>
<tr>
<td>Magne et al. (51)</td>
<td>Retrospective</td>
<td>Comparative</td>
<td>Risk of MR recurrence in 51 consecutive patients undergoing restrictive annuloplasty with or without CABG for ischemic MR</td>
<td>X</td>
<td>CABG associated in &gt;90%</td>
<td>X</td>
<td>X</td>
<td>Mean LVEF 37% and 34%</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

CABG, coronary artery bypass graft; CAD, coronary artery disease; ERO, effective regurgitant orifice; ICM, ischemic cardiomyopathy; LV, left ventricular; LVEDD, left ventricular end-diastolic diameter; LVEDV, left ventricular end-diastolic volume; LVEF, left ventricular ejection fraction; LVEESVi, left ventricular end-systolic volume indexed; MV, mitral valve; MVr, mitral valve replacement; N-ICM, non-ischemic cardiomyopathy; PCI, percutaneous coronary intervention; MVr, mitral valve replacement.