Introduction

Valve-sparing procedures continue to evolve as important components of the cardiac surgeon's armamentarium. In this issue of *Operative Techniques in Thoracic and Cardiovascular Surgery: A Comparative Atlas*, several recognized experts demonstrate the contemporary techniques for atrioventricular valve repair and preservation of the subvalvular apparatus during mitral valve replacement. The issue begins with a unique report on the various operative approaches to atrioventricular valve surgery by Dr A. Thomas Pezzella and colleagues. Because mitral valve repair is the most common of these procedures, I asked both Dr Delos M. Cosgrove of The Cleveland Clinic Foundation, Cleveland, OH, and Dr Lawrence Cohn of the Brigham and Women's Hospital, Boston, MA, to describe their individual techniques. I hope that by juxtaposing their techniques, subtle differences that might otherwise go unnoticed will become more apparent to the reader, an example of why the subtitle of this journal is *A Comparative Atlas*.

Since the inception of mitral valve repair surgery, it has been recognized that one of the most important components of the repair in many patients is the correction of prolapse of the anterior leaflet. Originally, this was accomplished by various chordal-shortening techniques, but on long-term follow-up the recurrence rate of prolapse in patients so treated has been unacceptable. One of the earliest surgeons to recognize this fact was Dr Tirone E. David of Toronto, Canada, who many years ago, began to *replace* chordae rather than *shorten* them. The lack of recurrence in almost 10 years in his series confirms his early suspicions that replacement of chordae was superior to shortening them. In this issue, Dr David shares his experience and expertise with chordal replacement not only during mitral valve repair but also during mitral valve replacement.

Finally, Dr Cosgrove kindly agreed to describe his technique for repairing the tricuspid valve. In my experience, it is becoming more common to repair the tricuspid valve at the time of mitral valve surgery and especially when performing the standard double valve (aortic and mitral) replacement for severe rheumatic valve disease. Although many such patients with mitral valve disease, especially those with pulmonary hypertension, may do well without tricuspid valve repair, I routinely repair the valve if substantial tricuspid insufficiency exists, regardless of the presence or absence of pulmonary hypertension.

I am very aware of the unusual amount of effort required on the part of the contributing authors to perfect the drawings that serve as the centerpieces of each article that appears quarterly in this journal. I am especially indebted to the group of surgeons who contributed to this issue because I am aware that they are among the busiest surgeons in the world. It confirms the addage, "If you want a job done well, give it to the busiest person you know."

James L. Cox, MD