**Title page**

# Title: Letter to the Editor: Early and midterm results of extended septal myectomy: Indian experience

# Article type: Letter to the editor

**Correspondence**: 1. Akhil Raj Anumolu

Contact: +918331860100 Email: [akhilrajanumolu@yahoo.com](mailto:akhilrajanumolu@yahoo.com)

Institution: Andhra Medical College, Visakhapatnam, Andhra Pradesh, India

Address: D.NO:21-153, Main road, Tiruvuru, Andhra Pradesh, India

# Co-authors: 2. Anumolu aakash

Contact:+918985052194 Email: [anumoluaakash@gmail.com](mailto:anumoluaakash@gmail.com)

Institution: Bukovinian state medical university , Chernvtsi, Ukriane

Address: D.NO:21-153, Main road, Tiruvuru, Andhra Pradesh, India

3. Satesh Kumar

Contact: +923325252902 Email: [kewlanisatish@gmail.com](mailto:kewlanisatish@gmail.com)

Institute: Shaheed Mohtarma Benazir Bhutto Medical College Liyari, Karachi

Address: Parsa citi, Garden East, Karachi

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**Letter:**

To the Editor,

With great enthusiasm, we read the article "Early and midterm results of extended septal myectomy: Indian experience" by Narendra Kumar et Al.1 It was auspicious to read this manuscript, and the author's appraisals are to be congratulated. We concede with the endmost conclusion that extended septal myectomy is associated with revocation of ventricular outflow barriers and rectification of ventricular pressures along with hypertrophic cardiomyopathy symptoms. However, we perceive it statutory to theorize accessory points that would supplement the preeminence of this article and add to previous knowledge.

Firstly, retrospective cohort study design is a substantial concern to the study's reliability due to the risk of recall bias and ambiguous documentation, which could be addressed if the authors had incorporated present cases of that moment by conducting a cross-sectional or prospective cohort study. For elucidation, a 2019 study by Alexander Bogachev-Prokophiev et al.2 allocated several patients to go through myectomy and compared it with subaortic interventions, which greatly impacted their findings. Secondly, the limited sample size significantly downsized the power of the study, which was not sufficient enough to report considerable outcomes. For instance, a distinct 2019 research enrolled almost 90th times more participants, which was adequate to establish evidence and its aftereffects. Additionally, more than 2/3rd of patients were males; therefore, gender-specific results cannot be generalized. The authors should have done matching of the study participants and their baseline demographics to validate their results. However, females were equivalent subjects in varied researches.2,3 As established, patients with serious cardiac problems depend on life-saving drugs such as B blockers, anti-arrhythmic, and calcium channel blockers; authors should have commented on their medication history and further resumption or cessation after this surgical procedure, considering it may have affected study's outcomes. Likewise, a 2005 study enumerated various therapeutic measures followed by patients before and after this surgical management.4 Although categorization was based on New York Heart Association classifications, authors could include participants from all classes (I- IV) rather than involving restricted class subjects, which could explain the treatment's safety and efficacy in heterogeneous domains.4 Despite the possibility that several accompanying operative procedures such as aortic valve replacement, coronary bypass graft, and ablative procedures can alter mortality outcomes in patients with cardiovascular problems, authors should have given an idea regarding these coexistent surgical procedures other than mitral valve complications.5 Even though major findings such as the number of deaths due to cardiovascular problems were delineated, rare events were still unaccounted. For clarification, a 2012 study by Attilio Iacovoni et al.5 reported pneumonia and lung cancer as the infrequent cause of non-cardiovascular deaths, explaining other possible causes of increasing mortality.

Finally, new studies with a fair number of participants should be coordinated to find potential influences of this muscle thinning procedure on a patient with left ventricular outflow tract obstruction due to hypertrophic obstructive cardiomyopathy.

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