Reply to Hajj-Chahine

Bartosz Rylski*, Friedhelm Beyersdorf* and Ernst Weigang*

* Department for Cardiac and Vascular Surgery, Heart Centre Freiburg University, Freiburg, Germany
* Department for Vascular Surgery, Vascular Center Berlin-Brandenburg, Academic Hospital of the Charité Berlin, Berlin, Germany

* Corresponding author. Department for Cardiac and Vascular Surgery, Heart Center Freiburg University, Hugstetter Str. 55, 79106 Freiburg, Germany. Tel: +49-761-27028180; fax: +49-761-27028670; e-mail: bartosz.rylski@universitaets-herzzentrum.de (B. Rylski).

Received 11 November 2013; accepted 11 November 2013

Keywords: Acute aortic dissection type A • Iatrogenic aortic dissection • Registry

We would like to thank J. Hajj-Chahine [1] for his insightful comments on our paper, specifically regarding the discrepancy in the outcomes of patients with postsurgical iatrogenic acute aortic dissection type A (iAADA) presented in our study [2] vs results others have reported [3–5].

We reported on 100 patients with iAADA enrolled in the German Registry for Acute Aortic Dissection Type A (GERAADA) between 2006 and 2010. Postsurgical iatrogenic dissection was diagnosed in 43 patients, and their 30-day mortality was 12% (5/43). We agree that this low mortality stands in contrast to previous studies reporting rather dramatic in-hospital mortality of up to 60%. There are several reasons for the discrepancy between our data and other reports. First, in our report, patients underwent surgery between 2006 and 2010. Individual centres usually report results covering the last two or more decades. The investigation of iAADA according to the International Registry of Aortic Dissection was undertaken a decade ago and included patients operated on between 1996 and 2000 [3]. The fact that our study represents contemporary experience may be essential, as we have already observed and reported on significant outcome differences between patients with acute aortic dissection type A treated a few decades ago and those treated very recently [6]. Secondly, patients with postsurgical iAADA underwent a less aggressive surgical approach than those presenting spontaneous dissection. Ascending aortic replacement without aortic root and/or arch repair (performed most likely due to surgeons’ awareness of poor iatrogenic dissection results) might lead to anecdotaly better contemporary early outcomes. However, those patients’ long-term survival and reintervention rates remain unknown. Finally, it is more than conceivable that if an iatrogenic dissection occurs in the operating room and is detected in time, prolonging surgery to permit ascending aortic replacement is feasible with an acceptable outcome. Therefore, an intraoperative iAADA does not necessarily need to increase the perioperative risk dramatically.

Iatrogenic aortic dissection remains a devastating and often lethal complication necessitating emergency corrective surgery. The GERAADA registry’s contemporary results describing outcomes in patients with IAADA are simply more encouraging than those reported previously, and for good reason.

REFERENCES