Re: Proximal aortic repair versus extensive aortic repair in the treatment of acute type A aortic dissection: a meta-analysis

Martin Czerny*

University Heart Center Freiburg-Bad Krozingen, Freiburg, Germany

* Corresponding author: University Heart Center Freiburg-Bad Krozingen, Hugstetterstrasse 55, 79106 Freiburg, Germany. Tel: +49-761-27028180; fax: +49-761-27025500; e-mail: martin.czerny@bluewin.ch (M. Czerny).

Keywords: Acute type A aortic dissection • Proximal aortic repair • Extensive aortic repair • Meta-analysis

The day after you have performed a successful surgery for acute type A aortic dissection, your treatment strategy will never be questioned either by colleagues, the patient’s family or—most important—the patient himself, but it will be questioned if your patient does not survive. This fact shall always form the basis when we are discussing extension of the classical surgical strategy in acute type A aortic dissection which is currently regarded to be ascending and hemiarch replacement.

The authors’ contribution is an important one and supports the awareness training of many within the last decade [1]. However, there is something in between a one-fits-all limited repair and a one-fits-all extensive repair.

There are several obvious advantages favouring extensive repair in acute type A aortic dissection such as the lower incidence of aortic-related complications and consequently, the lesser need for reoperations. However, to appreciate the true value of this, one has to survive extensive surgery.

A more differentiated view when planning surgery in acute type A aortic dissection may close the gap between a one-fits-all limited repair and a one-fits-all extensive repair.

Anything beyond that, regarding the location of the primary entry tear, requires a differentiated approach and extension of the classical surgical strategy by aortic root replacement, aortic arch replacement, frozen elephant trunk implantation or a combination of them as it is well known that the very patients with a remaining patent primary entry tear after initial surgery are the ones at highest risk for early reoperation mostly due to diameter progression [2, 3]. The same is true for patients with malperfusion as many of them do have a primary entry tear located in aortic segments which will not be primarily addressed by ascending and hemiarch replacement [4].

In summary, no surgeon should feel bad when limiting surgery in acute type A aortic dissection to the lowest common denominator still being ascending and hemiarch replacement as any elective reoperation for diameter progression is preferred to an unsuccessful attempt to solve the entire issue during the primary surgery. Nevertheless, as experience with and confidence in advanced surgical techniques progress, prognostic aspects in addition to the life-saving aspects of the primary surgery come to the fore and should be considered when appropriate.

Conflict of interest: none declared.

REFERENCES