Con fistulous complications of aortic dissection may occur in any patient, especially in those with a history of previous cardiac or aortic surgery [2-5]. The incidence of fistulous formation tends to increase with redo surgery. Postoperative adhesions may play an important role in the pathogenetic mechanism of the fistula. In such patients, the dense adhesions probably restrain the free rupture and contribute to the fistulous occurrence.

Undoubtedly, prompt diagnosis and early surgical repair of the dissection and fistula would provide for an excellent outcome. In such complicated situations, we think that one should use all the information and imaging techniques available to provide a timely diagnosis and treatment.

Conflict of interest: none declared.

References


REFERENCES


eComment. Aorto-right atrial fistula in type A aortic dissection

Author: Jamil Hajj-Chahine
Department of Cardio-Thoracic Surgery, University Hospital of Poitiers, Poitiers, France
doi:10.1093/icvts/ivt140
© The Author 2013. Published by Oxford University Press on behalf of the European Association for Cardio-Thoracic Surgery. All rights reserved.

I read with great interest the paper by Pagni et al. concerning the management of a 69-year-old female patient with acute type A aortic dissection complicated by a fistula to the right atrium [1]. This article has two interesting features that could be of use to all of us when faced with a similar case.

The optimal surgical approach to patients who present with acute type A aortic dissection in the setting of previous cardiac surgery is not always apparent. Adhesions from previous cardiac surgery have been proposed to prevent free rupture of the ascending aorta, this lowered risk of rupture and tamponade has led some to suggest delaying the operation with the intention of obtaining cardiac catheterization, especially in the setting of prior coronary artery bypass grafting surgery. Although extensive adhesions might protect against free rupture, there is another risk — fistulization or contained rupture of the aorta into neighbouring cardiac chambers and pulmonary artery. In this case scenario, surgical intervention is emergently required to prevent dismal prognosis secondary to preoperative cardiac dysfunction.

In a recently published study, Kodelll et al. [2] showed that patients with acute type A aortic dissection with a history of cardiac surgery are at increased risk for aortic rupture when compared to aortic dissection without previous cardiac surgery (29 % vs 3.2 %; P = 0.012). However, the rupture is contained in the majority of cases (67%) without tamponade or cardiogenic shock. Only two patients presented with aorto-atrial fistula and cardiogenic shock. These patients died despite aortic repair. Estera et al. [3] operated on two patients with aorto-pulmonary fistulas in the setting of aortic dissection in redo cases. Unfortunately, these two patients also died after the operation.

Reports from the literature are sparse and sporadic [4]. rupture and haemodynamic instability are rare because of postcardiotomy scarring and protective periarterial fibrosis [5]. Aortic fistula to the right heart cavities is a dreaded complication that portends an incremental increased risk of mortality and dismal post-operative outcomes. As outlined in this case report, successful management requires timely recognition along with prompt surgical intervention.

Conflict of interest: none declared.

References