the patient was treated immediately after the endovascular procedure and so there was an obvious direct link between the procedure and the complication. It is also important to point out the different location of the endoluminal stents in relation to the aortic arch vessels take off and, in fact, in our case [1] the stent was covering the origin of the left subclavian artery (Fig. 1), while in Urbanski’s case the proximal edge of the endoluminal prosthesis was much lower and distant from the left subclavian artery as demonstrated by the computed tomography [2].

We decided to manage the operation without trying to displace the stent, the only way to perform an elephant trunk operation, because we considered this manoeuvre as an incremental risk factor not corresponding to the mandatory goal of saving the patient’s life.

In conclusion, we agree that type A retrograde dissection after endovascular treatment of type B is possible either early or late, but the surgical treatment is depending crucially on the anatomical location of the endovascular stent in relation to the descending thoracic aorta and aortic arch. In the near future, it is desirable that further evolution of endovascular prostheses will allow to perform direct anastomoses on those stents cutting off completely the diseased aorta.

References


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Letter to the Editor

Changes in the current approach do not qualify prosthesis–patient mismatch either (reply to Dumesnil et al., EJCTS 2002;21:157–158)

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It was a great privilege for the authors [1] to receive an instant response from Jean Dumesnil and Phillipe Pibarot, whom the authors would like to thank for both their pioneering work and kind comments.

Our group was not the first one to emphasize valve area index (VAI) in the problem of prosthesis–patient mismatch [2]. The actual report presented the ‘phase I’ results assuming that valve prosthesis–patient mismatch might be rather negligible with the use of modern small-sized bileafllet aortic prostheses [3]. In our statistical model, neither geometric (GOA) nor effective orifice area (EOA) played a significant role. This certainly was an interesting finding. Although it was proposed, both GOA and EOA did not improve our results. By contrast, it decreased predictive values as shown in Tables 1 and 2.

In addition, the use of both variables in the very first version of our text [1] was criticized by the statistical reviewer proving the assignation of our patients significant and comprehensible. Nevertheless, we accept that patients’

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Fig. 1. Spiral CT-scan: the proximal stent is covering the origin of the left subclavian artery.

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body surface area (BSA) evolved as a distinct parameter in our model [1]. Definitively, we did not aim to predict the absolute dimensions of left ventricular myocardial mass regression, but to filter patients with a rather 'poor' outcome.

Further, testing of our predictive formula (in press) in 'phase II' for a greater cohort of patients receiving various mechanical prostheses showed excellent results (93%). Yet, even in this case, VAI based on EOA had less influence than GOA.

Although the title of the paper might have been rather provocative, data turned out to be what they were and not what they should have been.

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