The treatment of acute type A aortic dissection: nothing ventured, nothing gained

Marc Schepens*

Department of Cardiothoracic Surgery, AZ St. Jan Hospital, Brugge, Belgium

* Corresponding author. Department of Cardiothoracic Surgery, AZ St. Jan Hospital, Ruddershove 10, 8000 Brugge, Belgium. Tel: +32-50-45-26-90; fax: +32-50-45-26-89; e-mail: marc.schepens@azbrugge.be (M. Schepens).

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It is universally accepted that surgery for acute type A aortic dissection should be aimed towards the exclusion of the ascending aorta associated with aortic valve repair or in exceptional cases valve replacement. The optimal technique to reach this goal in acute situations is by using a short period of deep hypothermic circulatory arrest, if necessary, supplemented by antegrade brain perfusion when an arrest period longer than 30 min is anticipated. As, in general, the actual mortality continues to be high in acute situations is by using a short period of deep hypothermic circulatory arrest, if necessary, supplemented by antegrade brain perfusion when an arrest period longer than 30 min is anticipated. Therefore, it becomes more disputable when we are aiming at the aortic arch in these emergency situations. In specific conditions (arch tears, associated arch aneurysm, complex arch dissection, connective tissue disease, atheromatous arch, etc.), again rather than the general rule, it can be interesting, in view of the future, to replace the arch partially or totally. Few authors have indeed shown that, in their hands, this extensive arch approach is not necessarily related to a higher mortality.

Adding a procedure on top of this with the intention to induce thrombosis of the downstream-false lumen, because a patent-false lumen will promote dilatation and aneurysm formation in the long run, makes things even more delicate. But most aortic surgeons will translate this as a short-sighted viewpoint.

The authors of this paper, published in the European Journal of Cardio-Thoracic Surgery [2], have tackled this difficult and complex problem by using a bare metal stent introduced into the distal aortic arch or proximal descending aorta. Alternatives are actually the use of an elephant trunk, be it frozen or free-floating, although these techniques are more adopted for chronic dissections. For the frozen elephant trunk, it has been shown now that false lumen thrombosis can be promoted, at least in the proximal downstream aorta. Though the patient number is small and the authors realize this, their conclusion is unclouded too: it does not work. Their hospital mortality is similar to what can be expected but their goal to promote thrombosis of the false lumen is not pursued. In 67%, there was similar to what can be expected but their goal to promote thrombosis of the false lumen is not pursued. In 67%, there was...
descending aorta. Despite all actually possible techniques, about 70% of patients after surgery for acute type A preserve a patent-false lumen and in about 50% subsequent aneurysm formation will follow. If we want to improve the long-term results, we will have to aim at complications related to this. Other factors such as blood pressure control, although some authors found this controversial, may also play an important role and can easily be controlled. Although the authors do not succeed in reaching the goal of thrombosis of the false lumen, they are to be congratulated for the fact that they have tried to solve an awfully arduous problem. Nothing ventured, nothing gained. In the mean time, we have to keep our focus on the reduction of hospital mortality.

REFERENCES
