indicated, the intimal injury caused by the tip of the guiding catheter carries a high likelihood of being directed retrograde, and thus the flap can potentially close and seal under antegrade aortic flow pressure. Although the dissection may progress antegrade, a report of iatrogenic AD after cardiac catheterization found that most of the dissections were limited to the right coronary sinus, and there was a favorable outcome with conservative treatment.⁵ In support of their management decision, Timek and colleagues¹ cited an observational series of 10 medically treated patients with AD diagnosed after an interval as long as 12 years (mean 52.6 months) after initial cardiac surgery (half of them for aortic pathologies).² These patients simply represent a surviving selection of an unknown number of affected cases. In the absence of a denominator, this is insufficient evidence to define retrospectively a “paradigm change” in the management of an acute (potentially life-threatening) vascular complication. Late survivors of AD with aortic wall pathology and open false lumen must be distinguished from those with catheter-induced local aortic injury. Those patients with previous CS who are in hemodynamically stable condition may expect an excellent outcome with nonoperative management.^{1,5}

The decision for surgical or nonsurgical therapy remains challenging in patients with other causes of dissection. The 10-year survival with surgical treatment was reported as 68%, which was not significantly different from that for spontaneous AD.⁴ In the absence of sufficient data to estimate the prognosis of medically treated AD in patients with previous CS, the decision will remain difficult, particularly in the case of relatively young patients.

Olaf Stanger, MD, PhD
John Pepper, MD, PhD
Cardiothoracic Surgery

Royal Brompton and Harefield NHS
Trust
London, UK

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Reply to the Editor:

I appreciate the thought-provoking arguments that our case report has generated. Stanger and Pepper present a balanced discussion of the controversial subject of surgical intervention in patients with acute type A aortic dissection (TAAD) with previous cardiac surgery. I agree that patients with previous cardiac surgery and spontaneous TAAD should be treated surgically in the absence of prohibitive comorbidities. These patients do have significantly higher operative mortality, however, as illustrated by a study published since the acceptance of our case report. Klodell and colleagues¹ reported a disparity in hospital mortality of 9.7% versus 38.7% between primary sternotomy and re sternotomy among patients treated for acute TAAD in a propensity score-matched analysis. Interestingly, patients with previous surgery had a significantly higher incidence of aortic rupture, contained in most cases, suggesting that adhesions from previous surgical procedure may not provide “buttressing” after all against this catastrophic complication. Medical therapy

for TAAD has been associated with 58% mortality in a large registry experience,² and as such outcomes of surgical therapy in re sternotomy TAAD appear favorable, although patients chosen for medical therapy usually have a prohibitive risk profile. The patient described in our report was a young woman with stable hemodynamics and a catheter-induced TAAD. We agree that this represents an important distinction, because the mechanism of aortic injury in this setting may be more prone to healing than a spontaneous TAAD and the underlying aortic pathology may be less significant; however, clinical vigilance, close observation, serial imaging and echocardiographic assessment, and a low threshold for operative intervention remain paramount. Because scant data from the literature are available to guide the treatment of TAAD in patients with previous cardiac surgery, clinical judgment and local experience will most likely continue to determine the mode of therapy.

Tomasz Timek, MD
West Michigan Cardiothoracic
Surgeons
Meijer Heart and Vascular Institute
Grand Rapids, Mich

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REMOTE ISCHEMIC PRECONDITIONING IN CHILDREN WITH CYANOTIC HEART DISEASE: LOST IN TRANSLATION?

To the Editor:

I read with great interest a recent report of Pavione and colleagues¹ that