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THE EVIDENCE IS SUSPECT

Reply to the Editor:

I have read the letter to the Editor from Almassi and colleagues with great interest.¹ They have attempted to provide additional clarity to their recently published article² and its accompanying editorial.³ There is no question that the authors of this study “remain educators first and foremost...” However, the shortcomings of this study, which is no reflection on the authors’ commitment to education, are not ameliorated by their comments.

If this study is analyzed according to the Zwisch Model⁴ (supervision is characterized as “show and tell,” “smart help,” “dumb help,” and “no help”), the role of the resident is unclear. The authors state that “attendings generally permitted the resident to perform all of the sutures for each distal placed.” This scenario is certainly not “show and tell,” but it does not discriminate among “smart,” “dumb,” and “no help.” Similarly, the comment that “target vessel sizes were documented to be either similar or larger...” does not demonstrate the resident’s role in choosing the target, assessing its suitability and quality, or even opening the vessel. The most surprising statement comes later: “In surgical education, the successful completion of a case clearly documents that the trainee’s roles and responsibilities were fulfilled and adequately supervised by their attending surgeon.” Certainly, completion of an operation is a mandate, with or without residents present; demonstration of surgical education, by any standard, is not met simply because a resident was in the operating room.

Ultimately, we are all invested in resident education, and the authors deserve credit for their attempt at measuring resident involvement. However, this study highlights the challenges inherent in documenting resident role in an operation; unfortunately, the evidence is not sufficient to support their conclusions.

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FROZEN ELEPHANT TRUNK VERSUS SINGLE-STAGE OPEN REPAIR FOR EXTENSIVE THORACIC AORTIC DISEASE

Reply to the Editor:

We thank Kouchoukos for commenting on our recent article, “The Elephant Trunk Is Freezing: The Hannover Experience.”¹ He pointed out that the alternative to both the conventional and frozen elephant trunk (FET) technique to treat complex aortic arch pathology is an extended open single-stage operation.²⁻⁴ Our group compliments Kouchoukos for his outstanding role in thoracic aortic surgery in general and specifically for his pioneering work with the single-stage approach.

As was pointed out by Kouchoukos, patients with acute aortic dissection have infrequently undergone extended one-stage open repair. A comparison between patients with chronic aortic dissection undergoing extended one-stage repair and those alternatively undergoing a FET procedure was suggested. The complexity of the extended one-stage technique, however, as well as its invasiveness for the patient, seems to discourage the less experienced thoracic aortic surgeon, because only a few groups have actually adopted the concept as yet.

Our group of 51 patients with chronic aortic dissection who had undergone a FET procedure within the study period (August 2001–March 2013) comprised the complete learning curve of this procedure, from the first prefabricated FET grafts⁵ to the novel branched FET grafts first introduced in 2010.⁶ Indications and surgical techniques have changed markedly with increasing experience and the use of branched grafts.⁷ We recently completed a risk analysis of our contemporary techniques (presented at the annual meeting of the European Association for Cardio-Thoracic Surgery in October 2015). It included 18 patients with chronic aortic dissection treated between April 2013 and April 2015 with complete aortic arch repair by means of the FET technique (67% male; mean age, 56 ± 13 years; 22% with Marfan disease;