Authors have nothing to disclose with regard to commercial support.

their research in *The Journal of Thoracic and Cardiovascular Surgery* revealed that the top 5 institutional contributors were Harvard University, followed by the Cleveland Clinic Foundation, Mayo Clinic, University of Toronto, and University of Pennsylvania. Another important aspect to consider is the international visibility of the *Journal*, as most researchers are interested in communicating their findings globally. During this 5-year period, the country that contributed the most was the United States, with 46.8% of the published documents, followed by Japan (7.5%), Italy (7.2%), Germany (7.1%), and Canada (7.1%).

According to the analysts Thomson Reuters, a highly-cited paper is defined as “a paper that belongs to the top 1% of papers in a research field published in a specified year. The 1% is determined by the highly cited threshold calculated for the research field in the specified year.”² Well, the fact that *The Journal of Thoracic and Cardiovascular Surgery* published, on average, 3 highly cited papers annually is probably unknown to most readers.

Because of the length of this letter, we only included a few metrics that are easier to understand and that, in our view, are more valuable to researchers when seeking for an appropriate journal to submit their manuscripts. Perhaps it is time to include some of these metrics on journals' Web sites to assess the potential impact of each journal.

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METRICS MATTER FOR KNOWLEDGE WORKERS LIKE US

Reply to the Editor:

The *Journal* should examine multiple bibliometric end points to compile practical data regarding the importance of its publications.

I read with interest the letter written by Drs Krauskopf and Gamboa.¹ It reflects on the speed and breadth of digital information dissemination today that an editorial published in the *Journal* caught the attention of 2 bibliometricians in Chile. They write in response to Dr Bryan Meyers' timely editorial,² “Do We Need a Bibliometrician to Know Which Way the Wind Is Blowing?” In it, Dr Meyers describes the dramatic growth of measurement tools, but also the challenges inherent with these tools.² He argues that these challenges are particularly apparent for subspecialty journals, which must be concerned with disseminating practical information of daily use to readers that may not necessarily be “impactful” when evaluated by standard metrics. He further suggests that journals such as the *Journal* also have an inherent responsibility to support the early work of young surgeon-scientists, to disseminate experience through case studies, and to highlight our specialty's values, such as surgical education and professionalism. None of these endeavors generate high-impact publications. They may actually depress a journal's impact factor.

Drs Krauskopf and Gamboa write in support of Dr Meyers' contention that “standard metrics are meaningless alone.” They emphasize the high quality of journals that cite articles published in the *Journal*, the quality of institutional contributors, the international visibility, and the remarkable number of “highly cited” articles published by the *Journal*. None of this would be appreciated by simply looking at impact factor alone.

So the question remains: Do we need bibliometricians to know which way the wind is blowing? Of course! Almost everything about our specialty has been built on the idea of metrics. No matter how much pride we take in our manual dexterity, cardiothoracic surgeons are without doubt “knowledge workers,” a term coined in 1957 by Peter Drucker, a well-known management guru. Even then, he anticipated our eventual shift to a data-driven society. Drucker wisely said, “What gets measured gets improved.”³ The key is to figure out what information is needed and to ask the right questions. That should certainly be the mandate of the *Journal*. The *Journal* should critically review its publications and evaluate citations and impact factor, but also consider newer metrics such as downloads, H-index (the number of articles at or above a given citation level equal to the value of a citation threshold),

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second-generation citations, expected citation rates, and C-index (which takes into account differences between specialty fields). We definitely need bibliometricians to gauge those complex winds! Ultimately, careful evaluation of these compiled data by cardiothoracic surgeons will make the *Journal* better and help to focus its future. Rather than be subject to the blowing winds, we should control them. As Drucker cautioned, “If knowledge isn’t challenged to grow, it disappears fast.”⁴

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THE CONSIDERATIONS OF SURGICAL TREATMENT STRATEGIES OF ACUTE TYPE A AORTIC DISSECTION

To the Editor:

Acute type A aortic dissection (ATAAD) is a serious life-threatening disease. Surgery is the optimal strategy to treat this condition; however, there are numerous surgical approaches, none of which has been conclusively demonstrated to be superior. Lawton and colleagues, in their article titled “The Impact of Surgical Strategy on Survival After Repair of Type A Aortic Dissection,”¹ compared patients who had been treated with combined surgical strategies including avoiding cross-clamping of the ascending aorta, deep hypothermic circulatory arrest (DHCA), and immediate restoration of antegrade perfusion (intervention group) with those who had been treated with aortic cross-clamping (control group). Their results showed no significant differences between these 2 groups in terms of 30-day mortality after surgery

or the patency rate of the false lumen; however, long-term survival was significantly higher in intervention group compared with the control group. This single-center retrospective study included 49 patients in the intervention group and 147 patients in the control group. The unequal group sizes might be associated with the differing views regarding surgical strategies for treating ATAAD. The authors indicated that avoiding cross-clamping of the ascending aorta can improve long-term survival; however, in our clinical practice, most patients require ascending aorta replacement plus total aortic arch replacement procedure. We normally use surgical strategies of ascending aorta cross-clamping, DHCA circulatory arrest, and open distal anastomosis. In our experience, cross-clamping of the ascending aorta does not affect long-term survival.

Currently, arterial perfusion through the axillary artery is a widely accepted surgical strategy for ATAAD. This approach can provide selective cerebral blood perfusion during circulatory arrest and also meets the needs of conventional cardiopulmonary bypass, avoiding perfusion of the false lumen or exaggeration of the dissection caused by femoral artery cannulation.²⁻⁴ We believe that the perfusion approach is feasible in practice. Conversely, in some patients, the axillary artery is not suitable for arterial perfusion because it is affected by dissection. In these cases, we can use femoral artery cannulation if the femoral artery is not affected and has a large true lumen for effective perfusion. Combined cannulation is recommended in patients with poor perfusion.

The advantages of open distal anastomosis include direct observation of the dissected aortic arch and proximal descending aorta to facilitate accurate distal anastomosis^{5,6} and selective cerebral blood perfusion during circulatory arrest, which may reduce the risk of neurologic complications, prolong the safety period of surgery, and perhaps improve the survival rate after surgery in patients with ATAAD.^{7,8}

The Stanford classification system is a concise approach to classifying aortic dissections. However, because of the simplicity of classification, it is difficult to use it as instructions to determine a specific treatment. Based on our extensive clinical practice, we propose the Fu Wai classification scheme, which we believe provides a simple way to identify an appropriate instructional strategy and facilitate an effective clinical treatment plan. This classification scheme comprises 4 categories (A, B, C, and D) based on the anatomic site and scope of the dissection. Type A involves the ascending aorta and is restricted to the aorta proximal to the innominate artery. This type of aortic dissection requires ascending aorta replacement by open surgery. If the aortic root is affected by the dissection, it is replaced as well.

Type B is limited to the thoracic descending aorta, which may extend into the abdominal aorta and/or the iliac