Author have nothing to disclose with regard to commercial support.

Adulthood, London, United Kingdom,” and the editorial commentary by Burkhart and colleagues,² “Complex Congenital Aortic Arch Disease: The Need for Mandatory Long-Term Follow-up.”

Belitsis and colleagues¹ solved the problem in an effective but difficult way for the surgeons and the patient. Fortunately, the patient had a good outcome.

We agree with Burkhart and colleagues² on the long-term follow-up of congenital aortic operated cases to avoid the inherent morbidity and mortality they have.

Related to the report by Belitsis and colleagues,¹ we agree with Burkhart and colleagues² on a hybrid approach, that is, after a common carotid artery left subclavian artery bypass is performed. To stent the graft pseudoaneurysm, a short covered stent should be used, and if residual significant gradient exists across the aortic arch, an ascending-descending aortic bypass through a median sternotomy should be performed to avoid a hostile dissection field.³

State of the art imaging techniques, that is, computed angio-tomography and magnetic resonance angiography, allow us to follow up, diagnose, and treat patients in a way that was unthinkable a few years ago. The availability of recent noninvasive techniques and last-generation devices permits us to manage complex problems in different fields (ie, congenital, degenerative, trauma)^{4,5} and others with less risk. The use of hybrid procedures in cardiovascular surgery has to be in the repertoire of any surgeon, and cooperation with other colleagues is the key for success.

This case illustrates how the cardiovascular global community can interact to discuss information that is useful for everyone.

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LONG-TERM FOLLOW-UP IS MANDATORY FOR HYBRID APPROACHES TO COMPLEX CONGENITAL HEART SURGERY

Reply to the Editor:

I want to thank Dr Armenta-Flores et al for their perspective on an interesting and challenging congenital cardiac case. It appears that we are all in agreement with regard to: (1) the need for long-term follow-up in adults with congenital heart disease and (2) the need for surgeons to continue to grow and expand their surgical armamentarium when approaching these interesting patients.

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CARDIOTHORACIC SURGICAL CRITICAL CARE SURGEONS: MANY OF THE FEW

To the Editor:

The editorial commentary by Anderson¹ is a timely and much appreciated communication. This author is in agreement that a truly complete cardiothoracic surgeon² is fully educated, trained, and skilled in all aspects of cardiothoracic surgical practice, including postoperative management and critical care (Figure 1). As such, they are eligible for certification in whichever area of practice (ie, subspecialty) they choose.

Allowing such choice is precisely what the American Board of Thoracic Surgery has done over the years, with the evolution and flexibility of its mechanisms for certification, and the elimination of the requirement of certification