Author has nothing to disclose with regard to commercial support.

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the recommendations proposed by Yu²: aortic root replacement if the root is affected by the dissection, thoracic endovascular aortic repair as first choice for descending dissection, and hybrid total arch replacement or total arch replacement plus modified elephant trunk procedure if Fui Wai type C with arch involvement. Yu and the National Center for Cardiovascular Disease, Fuwai Hospital in Beijing, likely have extensive experience in complex arch replacement and endovascular therapies for aortic pathology with acceptable outcomes in large numbers of patients. However, we continue to advocate for the simple approach of replacement of the ascending aorta for most acute Stanford type A aortic dissections, arch replacement in the few warranted cases, and medical treatment of uncomplicated Stanford type B aortic dissections. With this simple classification and straightforward surgical principles, cardiac surgeons should be successful in the most important goal of this operation—to save the life of the patient from the immediate risks of tamponade, rupture of the aorta, coronary ischemia, or malperfusion.

Jennifer S. Lawton, MD
Division of Cardiothoracic Surgery
Department of Surgery
Washington University School of Medicine
St Louis, Mo

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CARDIOTHORACIC SURGICAL CRITICAL CARE IS CRITICAL TO CARDIOTHORACIC SURGERY

Reply to the Editor:

By the very nature of what is encompassed by the scope of procedures and management of patients undergoing cardiothoracic surgery, patients are inherently critically ill. This critically ill classification has different degrees of duration and complexity. Although there

are a spectrum of cases in cardiothoracic surgery, from esophagectomies and lobectomies to transplant and aortic dissections, it is unlikely that a seasoned cardiothoracic surgeon would say that each surgery and each patient has uniquely critical periods.

Sherif¹ recently commented on Andersen's article regarding certification in cardiothoracic surgical critical care (CTSCC).² In his article, Andersen concludes with a call for a CTSCC subspecialty certificate that would be attainable by all current and future cardiothoracic surgeons.² This specialty certification has been advocated by the Foundation for the Advancement of Cardiothoracic Surgical Care. The acknowledgment of the importance of critical care experience has been discussed nationally,³ by the American Board of Thoracic Surgery (ABTS),⁴ and by Sherif himself in previous articles advocating for core competencies in CTSCC.^{5,6}

Whether all cardiothoracic surgeons have the expertise to deliver superior-quality CTSCC or whether there is a subgroup of cardiothoracic surgeons with a special interest in critical care is the fundamental question for our specialty and the ABTS. Not all cardiothoracic surgeons deliver CTSCC nor are all cardiothoracic surgeons interested in CTSCC. Each practice is different and each health system is different.

Undoubtedly, cardiothoracic surgeons who have an interest in CTSCC and achieve the clinical acumen and training for CTSCC would deliver the best care. As we move toward more integrated training programs, there may be a role for dedicated CTSCC subspecialty fellowships to provide the advanced training. However, we must be mindful of the inherent critical care nature of our specialty. It is imperative for all cardiothoracic surgeons to maintain that skillset.

Whether there is a path for grandfathering with a certifying exam or a need for specialty training with a certifying exam, we can all agree that this is a nuanced decision and I agree with Sherif that the ABTS is to be commended for advancing and role of cardiothoracic surgeons and promoting CTSCC.

Bryan A. Whitson, MD, PhD
Division of Cardiac Surgery
Department of Surgery
Ohio State University Medical Center
Columbus, Ohio

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Notice of Correction

Re: Shrestha M, Kaufeld T, Beckmann E, Fleissner F, Umminger J, Alhadi FA, et al. Total aortic arch replacement with a novel 4-branched frozen elephant trunk prosthesis: single-center results of the first 100 patients. *J Thorac Cardiovasc Surg.* 2016;152:148-59.

In the above-mentioned article, an incorrect version of the disclosure statement was published. The corrected statement is below.

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