Why compromise with an elderly patient?

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Hata and colleagues¹ share their outstanding experience with a fast-track-like solution for surgery using a J-shaped open stent graft. The mean patient age was 81.6 years, with patients ranging in age from 80 to 90 years. From sternotomy, circulatory arrest at 28°C without cerebral perfusion, but aortic crossclamping, was utilized and an open stent graft was inserted without balloon dilation in the descending thoracic aorta. The aortic incision was placed between the left common carotid and left subclavian arteries. This restricted technique was offered to exclude distal aortic arch aneurysm (DAAA), and all 24 patients recovered completely from surgery.

The natural risk of rupture of DAAA and descending aortic aneurysm exceeding 6 cm in diameter is considerable: Approximately 20% of aneurysms have been estimated to rupture in as short as 36 months.² Most DAAA may be dealt with using an endovascular solution such as thoracic endovascular aortic repair.³ Life expectancy among Japanese octogenarians is relatively high, 7.86 years in men and 10.63 years in women.⁴ It is conceivable that the Japanese octogenarian patients studied by Hata and colleagues¹ underwent surgery because the risk of postoperative stroke due to mural thrombi within the aorta could be a major concern during thoracic endovascular aortic repair.⁵ The mental questionnaire the authors employed is commendable; not only the absence of cerebral strokes determines the outcome of surgical success. The authors do a fine job of discussing how rapid rewarming after 28°C may have been beneficial for their patients.

Surgeons need to balance the risks associated with prophylactic surgery and those of not operating. Preoperative information, including at least the diameter of the DAAA, is warranted before making the decision for surgery. What would an elderly patient gain from tolerating even a compromised restricted technique if there is no guarantee of completely excluding the possibility of DAAA? Follow-up computed tomography scanning to evaluate plausible remodeling of the aorta after surgery may be considered. After the pilot experience described by Hata and colleagues,¹ we need thorough, complete, and critical evaluation of the technique.

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Central Message

The strategy of prophylactic treatment of distal aortic arch aneurysm includes assessing the risks of surgical intervention.

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Quality of life may be immensely associated with a patient's physical activity of the moment, and worrisome speculation of a future endangered by a possible aneurysm rupture may be less of a matter in elderly persons. The key question remains: Does a physically deconditioned elderly patient desire surgical intervention that could include follow-up and adjunct treatment such as a possible second-stage operation? In an elective case, there is plenty of time to discuss treatment strategy with a patient. It is up to the medical community to listen when an elderly patient is willing to manage his or her condition with prophylactic treatment. Appeasing surgical ambition should not be the aim of any treatment, and a limited surgical option, such as that presented by Hata and colleagues,¹ may be the right individual solution for some patients—regardless of age—or it may not.

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