Author has nothing to disclose with regard to commercial support.

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THERE'S MORE THAN ONE WAY TO SKIN THIS CAT

Reply to the Editor:

We reported a case of a frail 78-year-old woman who presented with an aorto-esophageal fistula after thoracic endovascular aortic repair.¹ The endograft had migrated distally and the scaffold material kinked, leading to pressure ulceration of the adjacent esophageal wall. The distal migration also resulted in a type IA endoleak causing pressurization of the aneurysmal sac, which ultimately decompressed into the esophageal lumen through the perforation causing hematemesis. Because of the frailty of our patient, our goal was to provide the least invasive treatment option that could achieve control of bleeding and eliminate the infection source. We performed a right-to-left carotid-carotid bypass concomitant with proximal extension of the thoracic endograft that resulted in expected coverage of the left common carotid artery. We offered staged esophagectomy after initial stabilization, but the patient and her caregivers declined further operative interventions and elected to pursue medical management alone. We agree with the editorial commentary of Dr Ikonomidis² that this patient remained at a high risk for a catastrophic event, especially considering that the source of infection, namely, esophageal perforation, could not be addressed.³

Aorto-esophageal fistula is a rare but devastating complication after thoracic endovascular aortic repair. Similar to our case, the management is frequently complicated by the comorbidity and poor baseline status of the patient, as well as accompanying sepsis and hemodynamic instability. A few options have been reported in the literature that describe strategies directed at control of aortic bleeding and removal of the infection source, with or without extraction of the thoracic endografts.³ Because this complication is rare and published literature sparse, the standard of care is not yet established. Aortic segmental replacement with endograft extraction is generally preferred. In their Letter to the Editor, Dr Lick and colleagues⁴ present an appealing strategy for off-pump extra-anatomic aortic bypass and resection of the diseased aortic segment combined with stent graft extraction. However, in moribund or highly frail patients, the approach proposed in our case may be

considered because leaving the endograft may not necessarily predict poor outcomes when other treatment goals are met.^{3,5} Prolonged antibiotics are strongly advocated if the latter strategy is used. As such, this is a complex problem in a sick patient population. Thus, we believe that the management should be tailored to the individual case taking into account the overall status of the patient because there's more than one way to skin this cat.

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STERNOTOMY EXTRA-ANATOMIC BYPASS FOR STENT-GRAFT EXTENSION

Reply to the Editor:

I read with interest the letter to the Editor submitted by Lick and colleagues¹ in response to the manuscript entitled "Aorto-esophageal fistula resulting from aortic endograft migration" by Fernandez and colleagues² and its accompanying editorial.³ Contained within the letter is an elegant description of the use of ascending aorta to supraceliac aorta extra-anatomic bypass performed via median sternotomy before posterolateral thoracotomy and resection of the graft, infected aorta, and involved surrounding tissue.

I find this treatment to be an excellent option for dealing with this difficult clinical problem. As stated by the authors, the use of 2 separate surgical fields allows for sterility of the extra-anatomic bypass, there is no need for cardiopulmonary bypass or hypothermic arrest, and "since the descending aorta is excluded proximally and distally, the stent-graft removal is simplified, and the surgeon can concentrate on field debridement, including en-bloc resection of lung or esophagus as needed."¹