Commentary: Open surgery for descending thoracic aortic disease: “Pride and prejudice”

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Although diagnosis of descending thoracic aortic disease (DTAD) is relentlessly increasing, there are still relevant gaps in evidence in many aspects of its management.¹ Thoracic endovascular aortic repair (TEVAR) and open surgery (OS) have been usually assessed as competitive therapies, although the ways in which these 2 strategies might complement each other should have prompted more sound investigations. As industry has boosted tremendous innovations in endovascular repair, clinical practice has followed technical developments without robust evidence from randomized trials. Although the quality of evidence is low, data from available meta-analyses have underscored that patients who undergo TEVAR, for both aneurysm and chronic dissection, experience a reduced risk of mortality and major complications within 30 days of intervention compared with patients who undergo OS.^{2,3} This positive prognostic impact of TEVAR seems to fade over the long term as an increased need for secondary aortic procedures because of the inability to promote aortic remodeling on treated aortic segments or the progression of the disease elsewhere becomes evident. A paradigm shift has occurred favoring endovascular treatment, and fewer hospitals and training programs adequately train surgeons to perform OS. Paradoxically, surgeons will be increasingly challenged by the hurdles of secondary aortic procedures.⁴

In this issue of the *Journal*, Fujikawa and colleagues⁵ reported on their striking experience with OS. The article is kind of an old-school surgical report: straightforward, with an ample description of operative techniques, a minimalist statistical approach, and a focus on a few clear, hard outcomes. In an era of political correctness, it is frankly developed on the 2 pillars of “only the brave” (“we have no turn-down policy”) and “I did it my way” (a proud, pragmatic, adherence to institutional dogma). Over 2 years, this team performed 168 procedures via left thoracotomy for a variety of DTAD, although the article does not disclose if surgery was always the only possible

Luca Salvatore De Santo, MD, and the staff at Casa di Cura Montevegine.

Central Message

Clinical practice has followed technical developments favoring endovascular treatment for DTAD. In centers of excellence, surgical treatment may achieve superior outcomes.

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option. The overall in-hospital mortality rate was 0.6%, with a 4.7% incidence of spinal cord injury but no case of paraplegia. Rates of pulmonary and renal complications were also satisfactory. High volume, a dedicated multidisciplinary approach, training, and strict adherence to a standardized operative strategy synergistically account for such impressive outcomes. Sadly, estimates of postoperative survival and freedom from reoperation were limited to a 24-month follow-up frame, thus preventing any inference on long-term outcomes. The inherent clinical bottom line does not need much of an editorial comment. It is so obvious to sound too bleeding heart. Referral to aortic centers of excellence is the only guarantee to meet the demands of the substantial human and structural resources required for these procedures. Accurate reports on baseline characteristics and inherent long-term outcomes are crucial to define the subset of patients who might benefit most from OS.

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