Author has nothing to disclose with regard to commercial support.

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although bringing access to isolated regions, may not fare as well because of limited resources.

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LUCK FAVORS THOSE WHO ARE PREPARED IN AORTIC DISSECTION

Reply to the Editor:

We thank Poon and Field for their interesting letter and provocative question regarding a reasonable benchmark for mortality in the repair of type A aortic dissection. They are correct in stating that the dataset used by McClure and colleagues¹ lacks the granularity to address details such as the reason for surgical turnaround in type A aortic dissections, highlighting an intrinsic limitation of using large clinical administrative databases (eg, large sample size but lack of data granularity). Although not conducted, the CorHealth Ontario Registry coupled with hospitalization data from the Canadian Institute for Health Information Discharge Abstract Database generates report cards for various cardiac procedures, including coronary artery bypass grafting and valvular surgery.² Certainly, this concept can be applied to aortic dissection to further determine the temporal trends in operative mortality amongst institutions to confirm the authors' suggested operative mortality benchmark of 10% to 15%. Potential limitations of this approach are the exclusion of institutions that perform very low volumes of any particular procedure to prevent unintended identification of any individual patient per privacy laws that govern the use of personal

health data, and that risk adjustment has not yet been validated in this cohort.

Type A aortic dissection continues to be a challenging disease to diagnose and manage promptly. In the best of circumstances, patients can expect a reasonable probability of a good outcome. Yet, with aortic dissection, there remains an element of chance that influences early diagnosis and management; for example, a patient's place of residence, the astuteness of the diagnosing physician, and the availability of expert care to treat the disease. Various models of care for type A aortic dissection have been implemented. In Ontario, a centralized system is used to refer these critically ill patients to the nearest cardiac surgical center—this leaves the decision to operate to an individual surgeon. In greater Toronto, a metropolitan area of more than 5.5 million people, dedicated thoracic aortic surgery teams take turns in accepting referrals for aortic pathology disease. Whether the triage system has improved patient outcomes is uncertain, although the transfer of patients more efficiently should directly lead to better patient outcomes in a disease where delay in surgical treatment is deadly. It highlights the difficulty in assessing complex interventions for uncommon diseases, with widely heterogeneous patients, and where outcomes are dependent on careful patient selection, surgeon skill, and circumstance.³ We wholeheartedly agree that for complex problems there is no 1-size-fits-all solution and depends on the context and geography of the locale. Although care should not be standardized, we should strive to achieve uniform outcomes for this disease, whatever that target should be. We need to reduce the role of chance and luck in the treatment of this devastating disease.

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