Commentary: More magic from Cleveland

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Not for mere mortals?

Central Message

The reported results for treatment of cardio-aortic disease are outstanding, whether or not the aorta is addressed in the operation.

See Article page 1669.

What should be done with a dilated ascending aorta, when the reason to operate is some other cardiac pathology? In this issue of the *Journal*, Idrees and colleagues¹ attempt to answer this important question on the basis of a large experience at the Cleveland Clinic. Unfortunately, because all procedural decision making was left to the discretion of the many individual surgeons involved, we are immediately led down the rabbit hole of a complex propensity analysis that gave me migraine. I offer relief to those similarly afflicted: you need only know that in the 2 propensity-matched cohorts, early mortality was less than 1%, with or without addressing the aorta. Stroke was well less than 2%. Credit for these stunningly, astonishingly good results is appropriately given to “expert imaging, careful patient selection, refinement in surgical techniques, rescue from adverse events, and the recognized benefits that come with delivery of care by a dedicated multidisciplinary cardioaortic team.”¹ At the Cleveland Clinic, it appears that removal of a dilated aorta can be added to another kind of cardiac operation without penalty.

Is there a metamessage? Perhaps He-Who-Must-Not-Be Named looms in the background. “TAVoldemoRt” is rapidly invading all varieties of aortic valve disease on the basis of outstanding results in randomized trials of transcatheter aortic valve replacement (TAVR). Yet the results reported here are at least as good—might it be that clever patients who wand their way to the banks of the Cuyahoga are equally safe with surgery? Even (perish the thought!) the banks of the Hudson, the Charles, the Schuylkill? But centers of excellence cannot possibly treat everyone, and they cannot throw an invisibility cloak over the simplicity of transcatheter procedures.

It is important to note that Idrees and colleagues¹ use *prophylactic* in their title, and they emphasize a “more proactive approach” in the text. Common adjectival synonyms for *prophylactic* include *preventive* and

precautionary. *Prophylactic* certainly applies to patients with aortas larger than 4.5 cm, because that size boundary in guidelines is based on evidence that removing aortas in that size range is an appropriate preventive precaution. *Proactive* is less a synonym than an embellishment of *prophylactic*, carrying as it does implications of boldness, dynamism, vision, and anticipatory action. I assume that Idrees and colleagues¹ have adopted those nuances of *proactive* to support operating on aortas smaller than 4.5 cm, outside current guidelines.

It may not be a coincidence that operating on patients with aortas smaller than indicated by current guidelines expands the definition of aortopathy, and aortopathy is currently a contraindication for TAVR. Note that the average aortic diameter in this series is 4.7 to 4.8 cm (see Table E1 in the article of Idrees and colleagues¹). There is nothing prophylactic, proactive, or vaguely controversial about the decision making applied in that clear majority of patients in this series who had an aorta larger than 4.5 cm. No data are presented separately, however, on patients with aortas falling below the 4.5-cm threshold. The decision making of Idrees and colleagues¹ outside current guidelines has thus been justified *entirely* by presenting overall outstanding results. Is that enough? Although it indirectly implies that risk is low, the benefit side of the equation can only be addressed by comparing long-term outcomes in the subgroup of patients with aortas smaller than 4.5 cm with those of similar patients who were left untreated. Opening new cardioaortic markets against TAVR may not work without evidence of

benefit. To do so is not different from the proactive use of TAVR in asymptomatic mild aortic stenosis, which may be right around the corner.

Reference

1. Idrees JJ, Roselli EE, Blackstone EH, Lowry AM, Soltesz EG, Johnston DR, et al. Risk of adding prophylactic aorta replacement to a cardiac operation. *J Thorac Cardiovasc Surg*. 2020;159:1669-78.e10.