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REPLY: YOU CAN'T ALWAYS GET WHAT YOU WANT

Reply to the Editor:

For patients with aortic dilatation who are free of symptoms, establishing the timing of aortic repair is the most crucial health decision they will likely face in their lifetimes.¹ For their clinicians, the timing of repair is almost universally based on the aortic diameter. For most symptom-free patients with an aortic aneurysm, the threshold of repair is set at 5.5 cm or larger by contemporary practice guidelines.^{2,3} Depending on patient circumstances, the hinge point of repair may be lowered to between 4.0 cm and 5.0 cm. For patients with symptoms, surgery is warranted regardless of aortic diameter.

In the study in this issue of the *Journal* by Saeyeldin and colleagues⁴ (including the senior author, Dr Elefteriades), 781 patients with ascending aortic aneurysms were reviewed. In this study, they evaluated the impact of lowering the 5.5 cm diameter-based threshold for surgery to 5.0 cm or larger, in addition to further lowering that threshold to 4.0 cm in the presence of unexplained chest pain, strong family history, severe connective tissue disorder, or disease of a bicuspid aortic valve. Saeyeldin and colleagues⁴ found that when their algorithm was followed, the risk of 30-day death after ascending aortic replacement was an outstanding 1%. They

found, however, that when their algorithm could not be followed (if comorbidities ruled out surgery or if the patient refused surgery), the risk of late aortic death or an aortic event was 12% or 13%, respectively. In addition, Saeyeldin and colleagues⁴ noted that in patients with aortic diameters between 4.0 cm and 4.9 cm who were without the specified risk factors, the likelihood of a late aortic risk factor dropped to 1% to 2%.

The recent letter by Bugan and colleagues⁵ touches on the continuing controversy of how far to lower diameter-based thresholds of repair. The primary concern of Bugan and colleagues⁵ is how to treat the group of patients within the space between the existing (5.5 cm) and suggested (5.0 cm) hinge points. Further, Bugan and colleagues⁵ argue that the study conducted by Saeyeldin and colleagues⁴ could have evaluated their existing data better by using a different grouping strategy for patients in the study; Rather than analyze their triage algorithm, Saeyeldin and colleagues⁴ should have narrowed the study's focus, the better to examine the hinge point.

Should existing guidelines drop the threshold of repair from 5.5 to 5.0 cm in symptom-free patients who are without additional risk factors? Bugan and coauthors⁵ state that Saeyeldin and colleagues⁴ have missed an opportunity to evaluate their data in terms of a practical, evidence-based recommendation to support lowering the threshold of repair to 5.0 cm. It is very likely that when aortic practice guidelines are updated, the guidelines authors will reconsider the hinge point for repair. The quest for a definitive diameter continues.

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REPLY: KEEN QUESTIONS APPRECIATED

Reply to the Editor:

We thank Bugan and colleagues for their kind comments regarding our recently published article examining the clinical effectiveness in the real world of a simple algorithm for ascending aortic aneurysm decision making.¹ Our algorithm triaged to surgery those patients with (1) ascending aortic size greater than 5.0 cm or (2) smaller aneurysms accompanied by chest pain, a strong family

history, severe connective tissue disease, or associated bicuspid valvular disease requiring treatment (Figure 1). Other patients were triaged to medical treatment.

Regarding the points on which Bugan and colleagues request clarification, we have the following specific comments:

1. They note a difference in aortic size between the medical and surgery noncompliant and overwhelming comorbidities groups. Yes, the medically triaged patients had smaller aortas. Size is indeed the core criterion for medical versus surgical treatment. That is the fundamental cornerstone criterion of the evaluated algorithm.
2. They wonder about the regression equation inclusion groups. Regression looked at triage only of the patients included in the study—those triaged to medical management and those triaged to surgery who did not actually undergo surgery (surgery noncompliant and overwhelming comorbidities group).
3. They ask, was there better medical therapy in one group? Bugan and colleagues point out the importance of decreasing blood pressure and shear stress in the medical treatment of aneurysm disease. They wonder whether the quality of medical treatment of the surgery noncompliant and overwhelming comorbidities group potentially biased the results. We wish that medical treatment could decrease adverse events in the dilated ascending aorta. We have reviewed the literature multiple times, and we find that there is simply no conclusive evidence that medical treatment is effective in decreasing aortic events.²⁻⁵ Furthermore, Bugan and colleagues point out that one group had more

Time for a Left-ward Shift in Ascending Aortic Guidelines?

FIGURE 1. Is it time for a leftward shift in intervention criteria for ascending aortic aneurysm? Reprinted with permission from: Ziganshin BA, Zafar MA, Eleftheriades JA. Descending threshold for ascending aortic aneurysmectomy: is it time for a “left-shift” in guidelines? *J Thorac Cardiovasc Surg*. 2019; 157:37-42.