Similar to the outcomes reported by others,^{5,7} Wang and colleagues⁶ emphasize primary entry tear exclusion or excision as the likely key to short- and long-term success when treating non-A non-B dissections. Some advocate for open total arch repair with frozen elephant trunk deployment to treat the entry tear and stabilize the distal aorta. Concerns for high operative mortality and spinal cord injury are justified. Others rely primarily on an endovascular strategy to treat non-A non-B dissection. Although this strategy is less invasive and potentially accompanied by lower operative mortality in the emergency setting, approximately 1 of 3 of those surviving the initial procedure require additional interventions. Retrograde type A dissections are particularly troubling with the zone 0 and 1 thoracic endovascular aortic repair needed to address a majority of arch tears. SCI can also complicate these innovative solutions. Irrespective of the preferred treatment algorithm, non-A non-B aortic dissection appears to be a surgical disease. Greater awareness, more experience, and perhaps a

different name should contribute to improve outcomes for this rare form of aortic dissection.

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Commentary: What's in a name?

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"What's in a name? That which we call a rose by any other name would smell as sweet."

Spoken by Juliet in Act 2, Scene 2, of *Romeo and Juliet*, by William Shakespeare.

Over the past to 50 years, the classification schema for acute aortic dissection originally developed by DeBakey and the Stanford group have served the medical community well.^{1,2} The Stanford classification (A and B), which was

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CENTRAL MESSAGE

Although the authors provide a novel approach to open treatment of acute non-A non-B aortic dissection, it remains controversial. The recent STS/SVS nomenclature may provide better characterization.

simple, provided practical guidance for both treatment and prognosis. Because of this simplicity, the Stanford classification has been widely adopted by those inside and outside of the cardiovascular surgical community. The DeBakey classification (I, II, IIIa, and IIIb) has also been very

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valuable. This system allowed for more definition regarding anatomy.

As treatment in cardiovascular surgery has advanced, the endovascular revolution has led to realizations that the Stanford and DeBakey classification systems has limitations. These systems do not clearly define the specific extent of the dissection flap or the location of the tear. Moreover, the transverse arch involvement created ambiguity for treatment. As a result, much was left to interpretation by cardiovascular surgeons.

The limitation of the current classification schemes for aortic dissection is no better represented than by the non-A non-B dissection. First, this is a double negative grammatically. If it is neither, then what is it? Second, this arises from uncertainty about where the tear originates. The original schemes did not differentiate between the tear or flap. It is the tear that the surgeon wants to either resect or seal. But this may be difficult to determine unless adequate imaging is provided. Moreover, at the initial presentation, optimal imaging may not be available to make these determinations. Third, the transverse arch becomes the hinge point of whether the acute dissection will be treated by a proximal (ascending arch) or a distal (endovascular) procedure. These factors underscore the fact that aortic arch dissection can be very complicated and the name is not enough.

Wang and colleagues³ expand their simplified approach to the frozen elephant trunk procedure for acute proximal (type A or I or II) dissection by adopting it specifically for non-A non-B acute dissections. Their overall experience was extensive, allowing them to collect 28 patients with confirmed non-A non-B dissection. The technique involved a standardized frozen elephant trunk procedure with sternotomy, cardiopulmonary bypass, and circulatory arrest, but the frozen elephant trunk graft is modified by incising the Dacron (DuPont, Newark, Del) graft portion to allow for an island for the great arteries. The dissection tear is repaired directly, and then the stent graft portion is deployed in the descending thoracic aorta. The island opening of the Dacron portion is sutured to the ostium of the great arteries as a single island in a running fashion. This suture line is carried along the lesser curvature as well, securing the Dacron portion in the distal ascending aorta. The longitudinal aortotomy in the ascending aorta is then closed in a running fashion. The authors reported expeditious operative times with mean aortic crossclamp, circulatory arrest, and

cardiopulmonary bypass times of 29, 26, and 78 minutes, respectively. Early outcomes were commendable, with no mortality and morbidity. Midterm follow-up observed no retrograde dissections.

The authors performed thoracic endovascular aortic repair for acute aortic dissection, but now have secured the proximal landing zone by suturing the Dacron graft to the transverse arch. This has the advantage of reduction in operative times and overall simplicity. An important factor to consider is the following: the potentially diseased ascending aorta remains. This will require continued surveillance because there remains a risk of proximal dissection.⁴ From a pragmatist's point of view, if one is going to perform a sternotomy, initiate cardiopulmonary bypass, and subject a patient to circulatory arrest, why not just replace the ascending aorta as well?

The authors are still to be commended for introducing their simplified approach and clearly defining non-A non-B acute aortic dissection. In the end, this report underscores our limited nomenclature when it involves dissections in the transverse arch. The Society for Vascular Surgery and Society of Thoracic Surgeons have developed a classification scheme that accounts for this, providing more clarity to arch dissections.⁵ However, it is more complicated and will take time to adopt. With further validation, these systems will better characterize the non-A non-B aortic dissection, allowing better prognosis and, ultimately, better treatment.

"What's in a name?" That which we call a *transverse arch dissection* by any other name would still be as *disastrous*.

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