prosthetic or homograft and primary repair of the esophagus and conclude that this approach is both feasible and promising.¹ Clearly, as the authors point out, the decision to primarily repair the esophagus must be made on an individualized basis, given the clinical circumstances.

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Commentary: Aorto-esophageal fistulas for 500: What is Monday morning quarterbacking?

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Aorto-esophageal fistula is an infrequent medical conundrum and surgical catastrophe. Despite advances in care and technologies, they remain an efficient assassin. Nonsurgical intervention or sole medical therapy are uniformly fatal.^{1,2} Surgical therapies retain a high morbidity as well as considerable early and delayed mortality. These patients often present with severe comorbidities, sepsis, and hemodynamic compromise. Jeon and colleagues³ present their institution's retrospective review of 10 cases of aorto-esophageal fistula of various etiologies spanning a little over a decade managed with their favored approach of interposition aortic homograft replacement and primary esophageal repair. Etiologies, as usual, vary between primary aortic ruptures and aneurysms, esophageal rupture, and

TEVAR fistula with muscle buttressed esophageal repair and substernal aortic bypass.

CENTRAL MESSAGE

Aorto-esophageal fistula is lethal despite advancements. Medical optimization, radical versus staged repairs, in situ versus extra-anatomic vasculocentric repair, and conduit choice influence outcomes.

secondary to open aortic graft replacements or endovascular thoracic aortic stenting. Interposition graft replacement was completed in 9 instances, but the preferred homograft used only in 5, albeit without mortality in the reported timeframes. Primary esophageal repair by layers, irrigation, and wide mediastinal drainage was the treatment of choice for the foregut injury with follow-up endoluminal vacuum assistance when required. Three patients underwent forms of esophagectomy. There were 2 deaths in the series corresponding to prosthetic graft replacement instances in settings of sepsis.

Frequently with uncommon disorders, case groupings to evaluate common factors positively influencing outcomes is

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Disclosures: The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication July 9, 2020; revisions received July 9, 2020; accepted for publication July 10, 2020; available ahead of print July 15, 2020.

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J Thorac Cardiovasc Surg 2022;163:2010-1

0022-5223/\$36.00

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<https://doi.org/10.1016/j.jtcvs.2020.07.031>

difficult, and this aortoesophageal fistula series is no different. It presents both as the initial sign of complicated primary aortic or esophageal pathology or as the secondary end result of previous interventions in these organs. The authors seek resection of the diseased vessel segment while introducing a graft and 2 vascular anastomoses in a contaminated field, recognizing the high rates of recurrence and failure for definitive endovascular stenting.⁴ The cryopreserved homograft choice is believed to offer improved tolerance to the contaminated medium, but is not without issues.⁵ They may not be readily available as in this series, prove short or small, and be prone to aneurysmal degeneration.

To paraphrase a wise man, there is only 1 chance to cause a first impression in the esophagus. Aortoesophageal fistulas have usually stolen that chance away. The role of in situ primary repair of a serosa-lacking esophagus should be evaluated on a case-by-case manner, as the authors express. Despite supportive literature for delayed primary esophageal repairs, aortoesophageal fistulas have been in the making considerably longer than the 72 hours usually considered in these reports.⁶ Wide drainage of the intraluminal and extraluminal spaces are adjuncts to aid in healing, but do not sterilize the aortic graft field. There is no mention of buttress techniques with interposed vascularized tissue flaps as omentum, anterior mediastinal thymic fat, or intercostal muscle. Despite endoscopic and contrast esophagram inspection, interval computed tomographic imaging should be considered for undrained collection surveillance. Continuous insidious subclinical soilage is a staple of delayed bowel repairs and cause of significant recurrence and morbidity in aortoenteric fistulas.

To consolidate a solid Monday morning quarterbacking session, attention is aimed at the myriad nontechnical elements in the management of these patients. Despite support for radical surgical approach in the treatment of this problem,⁷ the role of the multispecialty approach

in our era of specialized care cannot be understated.⁸ Initial presentations in hemodynamic shock, uncontrolled sepsis, malnutrition, metabolic disorders, morbid obesity, pulmonary pathology, and cardiovascular disease must be managed with same aplomb as the fistula itself because they compound the morbidity and mortality of this process and carry implications for the surgical choices for care. Medical management with long periods of antibiotic therapy are paramount in care. Jeon and colleagues³ are to be commended for performing an objective, critical look at the devastating outcomes of aortoesophageal fistula and seeking to establish a reproducible institutional approach to affect outcomes while maintaining an individualized evaluation for management of the condition.

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