Until more light is shed on the reason for the high dropout rate after stage 1 operation, the experience of Coselli's group¹ asserts the role of the staged reverse RET as an essential tool in the aortic surgeon's armamentarium and sets an important goalpost that future therapies can be compared with.

See Article page 1252.

Commentary: Criticism is easy, art is difficult (French proverb)

Jean Bachet, MD, FEBCTS

In their article in this issue of the *Journal*, Coselli and colleagues¹ report an original and rather rare experience of staged replacement of the thoracic or thoracoabdominal aorta, followed by replacement of the proximal aorta. The descriptions of the techniques used in the 2 stages as well as some necessary secondary repairs are clear and readily understandable.

This report raises some questions, however. The first concerns the rarity of such procedures. It is indeed intriguing that only 94 cases have been treated in 23 years (a mean of 4 cases a year) in a world-renowned center that has one of the largest recruitments and experience with extended aortic replacement worldwide. This rarity might explain why many patients suffering from such extended or evolving lesions may not be referred to centers able to manage them adequately.

More importantly, one may be intrigued by the fact that 36 patients died after stage 1 and that 19 patients did not return to undergo the second procedure, for various reasons. Thus, only 27 patients out of the 85 (32%) who survived the initial RET procedure could experience the second stage.

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1. Coselli JS, Krause H, Green SY, Zhang Q, Amarasekara HS, Price MD, et al. A 23-year experience with the reversed elephant trunk techniques for staged repair of extensive thoracic aortic aneurysm. *J Thorac Cardiovasc Surg*. 2022;163:1252-64.

Jean Bachet, MD, FEBCTS

CENTRAL MESSAGE

Could a systematic strategy of one-stage extended aortic replacement result in more favorable outcomes?

As the authors state, “these findings suggest that patients with extensive aortic aneurysm need a more rigorous approach to ensuring compliance with a surveillance protocol, in part through an aggressive continuing education component.” However, they also may suggest that a more aggressive and straightforward strategy might be applied to those patients, and that a systematic “one-stage only” may be developed and carried out.

Indeed, the authors note that “for many of the patients who died of unknown causes during the between-stages interval, the diameter of the aortic arch met diameter-based criteria for repair (≥ 5.0 -5.5 cm) at the time of stage-1 repair.” Thus, one may wonder why all patients did not undergo the entire necessary aortic replacement in a single stage, considering “that this technique was carried out as ‘prophylactic’ repair in patients without current indications for proximal aortic repair but at risk for future arch dilation because of patient-specific factors such as HTAD, chronic

DeBakey type I aortic dissection, and prior graft replacement of the ascending aorta.”

Could the late results be better? Of course, nobody can tell. But if we look at the surgical results of stage 1, we may suppose, without great risk of being wrong, that they would be rather improved. In this matter, it would have been interesting had the authors informed their readership about their possible (and probable) changes in indications and management of those lesions and had moved on to a

more systematic “single stage” of systematic extended strategy in the recent years of this long and impressive experience.

Reference

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