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Commentary: Cardiac surgeons adhere to societal guidelines for aortic surgery... sometimes

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"If all of your friends jumped off a bridge, would you jump too?" is a question that many will remember from their childhood, but the relevance of its meaning applies throughout life. In medicine and surgery, the fact that many people treat patients a certain way does not mean that it is the correct or best way. Although there is an inherent tendency to treat patients based on how our mentors did it, what our colleagues say, and what we are accustomed to, the ultimate goal is to treat patients based on scientific evidence. In this issue of the *Journal*, Guo and colleagues¹ present the results of a survey regarding the practice patterns and indications for aortic aneurysm repair among Canadian surgeons. Although we should not deduce any information on how to treat patients from this survey, it does demonstrate the lack of equipoise among cardiac surgeons regarding criteria for aortic interventions. How much of this is due to a lack of knowledge about aortic guidelines rather than a true disagreement over which aortic

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CENTRAL MESSAGE

The practice pattern and criteria for aortic interventions vary among cardiac surgeons, and equipoise regarding when to intervene is lacking.

measurement or index is the most accurate predictor of adverse aortic events is impossible to know.

A survey such as this has many limitations. In an effort to obtain as many responses as possible from all Canadian cardiac surgeons, the content of the survey is limited to lessen the burden of completing it. The authors included body surface area in the base case information, and they seem to have a predilection for using aortic size index. However, they do not include the necessary information for other aortic parameters that surgeons may use, such as aortic height index, aortic length, or cross-sectional area.² The individual response rate is missing nearly one-half of the surgeons, and some of those who responded performed no aortic aneurysm repairs. Whether the opinions of surgeons who do not actually treat the disease matters is debatable. Identifying information is optional to preserve privacy, so we may not know the volume or experience level of the surgeon. Finally, the authors compare high-volume and

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low-volume surgeons, but how they determined this arbitrary cutoff is not clear. Clearly, volume–outcome relationships exist among many different types of aortic surgery, but the definition of “high volume” is debatable and varies by procedure.³⁻⁶

With aortic aneurysms, knowing what our friends are doing should not necessarily inform us as to what we should be doing. Our decisions need to be based on more rigorous scientific data. Unfortunately, the level of evidence offered by a survey may be considered level D in the GRADE system: consensus (or lack thereof) among individuals who may or may not be experts in the field. The authors are correct that much debate exists in the literature regarding aortic size criteria; however, guidelines are created by experts who analyze all available data and make recommendations based on the best available evidence while minimizing the effects of individual biases. Although it is not the author’s intent that this survey data should be used as evidence, the only applicable point we can take away is that more

rigorous studies, such as randomized trials, would be helpful.

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