about bias in patient selection. Given that patients on dialysis are covered by Medicare, access would not seem to be an issue. Mortality risk is in fact lower in older African-American ESRD patients compared with whites.³

Finally, the authors' perspective statement offers a somewhat confused and mixed message. They urge a need for "careful patient selection" for aortic aneurysm repair, while encouraging emergent surgery for type A dissection. If the point of elective aortic aneurysm surgery is to prevent

complications such as dissection, then it seems discordant to hold back on the former while encouraging the latter.

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Commentary: A word of caution (and a note of optimism)

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End-stage renal disease and chronic dialysis are conventionally known to increase the general operative risk in cardiac surgery and to be a marker of both complicated postoperative course and decreased late survival. With the power only national databases can provide, the current analysis by Ogami and colleagues,¹ based on the United States Renal Data System, obtained clinical and follow-up data of 726 thoracic aortic surgery recipients for either non-ruptured aneurysm or acute type A dissection while on chronic dialysis. The current analysis is significant, as it addresses a question that was previously approached only through limited series and clinical common sense based on personal/local experience: the legitimacy of offering major thoracic aortic surgery to patients whose prognosis is burdened by chronic dialysis. The paper could not but conclude that the long-term survival of these patients is

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CENTRAL MESSAGE

The late benefits of thoracic aortic surgery are mitigated in patients with end-stage renal disease, but those of renal transplantation are not (necessarily) abolished after careful selection.

severely affected by their chronic disease(s) and that caution needs to be exerted in offering elective thoracic aortic surgery.

Unfortunately, the price paid for the power of the study is the lack of "granular" information about questions that are well present in the mind of an aortic surgeon, for example, whether the use of hypothermic circulatory arrest or a greater extension of the aortic replacement truly impacts early mortality/morbidity and whether the benefits of valve-sparing aortic root replacement over valve replacement are maintained in this population, questions that only this series might have the power to but cannot explore, regrettably. More importantly, the causes of death at follow-

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up (namely if aorta-related) are unknown. Due to unavailable information, we cannot assess the relative weight of aortic versus kidney disease in determining the prognosis, and this restricts the lessons we can learn from this important work. As such, the directions the reader can draw with respect to decision-making (both before and during surgery) remain quite “qualitative” (except for the identification of some risk factors for overall mortality), and we will continue to rely much on clinical sensibility. At least, we can suggest that the horizon for “durability” of aortic surgery must be importantly scaled back compared with the general population; this might plead against liberal total arch replacement in acute dissection if not anatomically obliged, or aggressive root replacement in borderline situations, or liberal employment of circulatory arrest for aortic resection beyond the ascending aorta for chronic aneurysm, and so on.

In contrast, one significant message for clinicians resides in the outcome after renal transplantation in this specific patient population (Figure E3). In the aneurysm and dissection subgroups, 8.3% and 5.9% of cases, respectively, received transplantation. Undoubtedly, a

selection bias has existed in the access to renal transplant favoring younger patients and those with fewer comorbidities. Not surprisingly, kidney transplant rates in the study timeline are far below the rates reported for the general population of patients on the waiting list.² The current data do not support indiscriminate access to renal transplantation for these patients but underline that a significant survival advantage still exists: transplantation remains effective in cases considered to be potential candidates, despite major aortic disease. Careful clinical appreciation is nonetheless essential and should be declined according to the type of disease and its potential anatomical consequences (ie, extent of residual aortic dissection after repair of the thoracic segment).

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