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Commentary: Propelling best-practice medicine into the 21st century

Matthew Pichert, MD, and Arnar Geirsson, MD

Tenorio and colleagues¹ provide an excellent analysis demonstrating promising results for the treatment of a complication that infrequently appears in any given single aortic practice. In this edition of the *Journal*, they present a retrospective analysis of a prospective multinational database consisting of 8 specialized aortic centers that characterizes the results of 29 patients undergoing fenestrated branched endovascular aortic repair of either visceral or intercostal artery aneurysms who have undergone past open abdominal aortic aneurysm repair. Despite a wide array of center-specific grafts/technologies used, their outcomes were excellent, where 30-day mortality was zero; however, freedom from reintervention at 2 years was 61%. With patients having undergone abdominal aortic aneurysm repair living 15 to 20 years after initial treatment in trials such as EVAR 1 (Endovascular Aneurysm Repair 1), debate over best practice moves from initial intervention to reintervention.² An Achilles heel of evidence-based medicine has been the establishment of best practices for rare complications, with studies on reintervention delegated to high-volume single centers using data spanning decades.³ This leads to uncertainty as to generalizability to other specialized centers as well leaves the data vulnerable to comparing changing technologies and techniques over the study period.

Tenorio and colleagues navigated these challenges by using the Trans-Atlantic Aortic Research Consortium network of investigators, who are listed as collaborators. Through the combined efforts of all involved, Tenorio and colleagues managed to gather enough cases of patch

Matthew Pichert, MD (left), and Arnar Geirsson, MD (right)

CENTRAL MESSAGE

Multicenter collaboration allows rare complications and resulting interventions to be studied like never before.

aneurysm repairs within a 10-year period to assume normality for statistical analysis. Of note, this analysis does not address generalizability to low-volume institutions, and the authors acknowledge treatment techniques evolved even within the 10-year period studied.

Nonetheless, the collaboration represents the future of data-driven best practices for rare complications, rare populations, and further patient stratification for common interventions. A rising issue in academic medicine from multicenter collaborations becomes data access, management, and authorship. With academic promotions based on first authorship, senior authorship, and so forth—a paper detailing best practices for a rare complication could leave a few primarily recognized for the work of many. While all authors here are appropriately thanked and recognized, academic medicine may need to adjust the current system to encourage and not discourage interinstitutional collaboration.

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