Commentary: Dissection in the elderly—do the right thing, fix them!

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As quality measures permeate the cardiac surgical landscape, risk aversion continues to creep into everything that cardiac surgeons approach, from coronary bypass to aortic valves. This risk aversion is now creeping into emergent aortic surgery. The threshold of risk defining futile care continues to drop based on both improvements of routine care and the avoidance of greater-risk cohorts of patients. Elderly patients have long been discussed as such a group in acute aortic dissection repair, but the literature, including the article by Bojko and colleagues, continues to demonstrate that elderly patients with acute type A dissection do better with operations than without intervention.

The article by Bojko and colleagues compares the midterm outcomes of septuagenarians with octogenarians following type A repair, including mortality over time and quality-of-life inquiries. Short-term mortalities were clearly worse than those of younger patients with hospital and 30-day mortality of 21% and 29% for the 2 cohorts, whereas 5-year survival was 50% and 34%. These number are sobering but clearly better than the 90% mortality at a month for medically treated dissection.

Although surgeons need to be paying attention to outcomes, the greater-risk operations cannot stand in the way of doing the right thing for patients. Type A repair is not a low-risk operation for anyone, no matter what their age. The best published results demonstrate a mortality in the 10% range. Even in the International Registry of Acute Aortic Dissections, the acute type A repair carries approximately 20% mortality. This commentary is not a plea for futile care. The 2-surgeon consensus approach mentioned by the authors is a useful adjunct to avoiding operations on those who would not benefit. However, as these data demonstrate, age alone should not preclude acute type A repair. No matter the age, if the procedure is not futile, do the right thing and repair it.

Reference