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.

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.

References
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. 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).

References