Commentary: The evolving management of type B aortic dissection

Abe DeAnda, Jr, MD, and Evan Lipsitz, MD, MBA

As our understanding of aortic disease progresses, so does the need to provide a set of up-to-date, evidence-driven, consensus guidelines. Such guidelines are not meant to be static but rather a living document that can (and will) change as newer data are added. Previous guidelines have been published at moderate intervals with the compendium and summary of pertinent data inclusive of all aortic disease. Recently, the American Association for Thoracic Surgery provided a more focused guideline for the management of acute type A aortic dissection (TAAD), this has been followed by the American Association for Thoracic Surgery/Society of Thoracic Surgeons guideline for the management of type B aortic dissection (TBAD) in this issue of the Journal of Thoracic and Cardiovascular Surgery.

TBADs vis-à-vis TAADs at present have a wider range of therapeutic approaches and surgical options. This is not because of more clinical trials that have compared outcomes but more likely reflects the evolution of innovative methods for dealing with a complicated problem. Several factors account for this inexactitude in TBAD therapy. One is that the early mortality of untreated TAAD is prohibitive, whereas in TBAD it is not. Second is the lack of clarity around the long-term benefits of medical therapy in patients with TBAD and the ability to ameliorate future complications such as aneurysmal degeneration. Third is the lack of widely available endovascular solutions for TAAD. To date there has not been a large, prospective clinical trial that has compared open surgical with endovascular approaches with TBAD, and likely there will never will. The 2 more well known and frequently referenced trials, Acute Dissection: Stent graft OR Best medical therapy (ADSORB) and Investigation of Stent Grafts in Patients with Type B Aortic Dissection (INSTEAD), both compared thoracic endovascular aortic repair (TEVAR) with optimal medical management and both were small studies—ADSORB had 61 patients (31 optimal medical therapy and 30 TEVAR) and INSTEAD had 140 patients (68 optimal medical therapy and 72 TEVAR). Despite the small group sizes important clinical information was obtained (eg, the importance of eliminating or minimizing flow in the false lumen).

MacGillivray and colleagues have taken the best current and available data to provide us with a series of recommendations for the management of TBAD. As is the custom, the process is divided by 2 major variables, chronicity and patient-specific factors, summarized in a clinical guideline that will change over time.
by the experience of the providers, and it does not include patients with connective tissue disorders, etc. Nonetheless, what is apparent and what is acknowledged by the authors is the empty space in the lower right corner and one area that is ripe for future studies and examination. Specifically, what do we need to do for the chronic, noncomplicated TBAD? How often should TBAD be imaged as part of a surveillance strategy? As evidence and experience grow, these recommendations will be refined, with the work of MacGillivary and colleagues laying the foundation.

**References**


