



THORACAL AORTIC DISSECTION

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INTRODUCTION

Aortic dissection; It is defined as the displacement of the intima layer by pushing along the course of blood flow by separating the intima and media layers as a result of tearing in the media layer of the aorta (1). Despite innovations in diagnosis and treatment and advances in technology, the mortality-morbidity rate is still one of the cardiac emergencies. It can have negative consequences that affect many organs and systems. Malperfusion, which results in malnutrition of tissues and organs, causes significant problems and is seen in 16-33 % (2-4).

History

About 250 years ago, the cause of death of George the second king of England was stated as dissection by Maunoir, and the existence of this pathology was accepted by making a clear definition (5,6). Laennec used the term “dissecting aneurysm” by stating that dissection was seen early in the formation of aneurysm in the first quarter of the 19th century (7). The definition of cystic medial necrosis was described by Erdheim in 1930 (8). Davy and Gates made the first radiological definition (9). The first successful operations in this area were also made in the 20th century (10-12).

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fore in patients with aortic dissection who have significant comorbidities and are not suitable for open surgical treatment (58). The endovascular treatment strategy is described in detail in the relevant section.

Deeb et al. reported that the risk of surgical death was approximately 90% in patients with acute type A dissection who developed circulatory disorders. And they stated that cardiopulmonary bypass, hypothermic circulatory arrest and excessive blood transfusion were the reason for this high rate (2). In acute dissection, the presence or absence of intraluminal thrombus is not an obstacle for emergency surgical treatment. Patients with subacute and chronic aortic dissection should also be treated electively within the framework of their current risk factors, clinical conditions, and regulated medical treatments (33). While continuing the debate on the place of surgical treatment for patients with acute distal aortic dissection, the current practice is to follow up closely in the intensive care unit under medical treatment (61-67). In acute type B dissection, since the vessel wall is thin and easily torn, it may not be transferred to the graft to be interposed. It is preferred that the diameter of the graft to be used is slightly smaller than the diameter of the aorta in order to prevent distal aneurysm formation (33).

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