

- **Type II** → confined to the ascending aorta
 - *Classically seen in elderly patients with atherosclerotic disease and hypertension.*
- **Type III** → originates distal to the subclavian artery in the descending aorta
 - IIIa → extends distally to the diaphragm
 - IIIb → extends beyond the diaphragm into the abdominal aorta.

Risk factors → hypertension, atherosclerosis, male, connective tissue disorder, bicuspid aortic valve, Turner's syndrome, Noonan's syndrome, metabolic disorders, syphilitic aortitis, pregnancy, trauma, iatrogenic, cocaine use.

Investigation

The definitive way of diagnosing this is by imaging, but baseline bloods will also be done anyway, with at least **4 units** of crossmatched packed red blood cells. It will also be highly likely an ECG will have been done to exclude other chest pain causes.

Bloods

- FBC (may show leucocytosis), U&E, LFT, clotting
- D-dimer (may be elevated)
- Troponin (may be elevated)
- ABG/VBG
- Group and save, crossmatch.

CT Angiogram

- Recommended 1st line imaging
- Allows for classification, diagnosis and anatomy of the pathology
- Can assist surgical planning.

CXR

- May show widened mediastinum and left-sided pleural effusion
- May appear normal and not definitive

Transoesophageal Echo

- Provide useful information especially in proximal or retrograde cases when concerned about valve involvement
- Operator dependent.

