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Aortic dissection is defined as disruption of the aortic wall, forming intimal flap and separating a true from a false lumen ***(Svensson et al., 1990).*** It is characterized by the presence of a hematoma in the media of the aortic wall which separates the intima from the adventitia and ultimately creates a false lumen ***(O'Gara & Desanctis, 1995), (Eichelberger, 1994).***

Improved understanding of the condition came with comprehesive treatise of ***Shennan (1934).*** Surgery for aortic dissection began 50 years ago with attempts to fenestrate the internal layer and create a re-entry passage in the abdominal aorta.

Direct attempts were made to revascularize branch vessels occluded by the dissection or to wrap the aorta in a vein attempt to avoid rupture.

As in most types of thoracic aneurysms the pioneering work came from ***DeBakey*** and ***Cooley*** in Houston.

DeBakey (1954) directly attacked an aneurysmal descending aortic dissection, closed the false lumen and performed end to end anastomosis.

He then described the ***DeBakey*** classification of aortic dissection type I, II and III.

Spencer (1962) described the first successful repair of a chronic ascending aortic dissection with aortic regurgitation. The native valve was preserved by resuspension.

Morris and ***Colleagues*** at ***Baylo (1963)*** were the first to repair an acute ascending aortic dissection. This patient was followed with moderate aortic regurgitation untill 1977 when elective aortic valve replacement was performed.

Remarkably, the false lumen remained patent without aneurysm formation and the patient was well in ***1990.***

Wheat (1965) made a major contribution by defining the aims and methods of medical management pending surgery. Careful blood pressure control was emphasized and became the standerd treatment for uncomplicated descending aortic dissection ***(Westaby, 1998)***.