reconstruction and were not affected by infrapopliteal distal bypass occlusion. These findings were also observed by us when we analysed the results of failed popliteal, tibial and peroneal reconstructions. Although there were no controls in our series, that is, analysis of the rate of knee salvage for below amputations without an antecedent femoral distal bypass, we concluded that our rates of knee salvage for tibial (71%) and peroneal (54%) vascular bypass failure were not dissimilar from what would be anticipated had the reconstruction never been performed. On the other hand, we did demonstrate a significant loss of the knee when it came to a failed femoral popliteal bypass. The anticipated knee salvage rate was approximately 83%, and in our series we showed that knee salvage decreased to 48% following a failed femoral popliteal bypass. This point, not addressed by Dr. Panayiotopolous, is important. Vascular surgeons should not conclude that all failed bypasses will not lead to loss of the knee joint. In our experience, a failed popliteal bypass can impact negatively on knee salvage. We do advocate an aggressive approach for limb salvage and certainly for tibial/peroneal reconstructions in that failure of these procedures does not appear to affect the rate of knee joint loss.

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References

Authors' Reply
We thank Dr Dardik for his interest in our paper. He will notice from the title that our grafts were to single crural or pedal vessels and therefore grafts to the popliteal artery were excluded.

We alluded to the failed femoro-popliteal graft in the discussion section and cited the problem of propagated thrombus affecting impatent geniculate branches which could result in loss of the knee. Dr Dardik's comments are therefore important when considering all infrainguinal grafts which include grafts to the popliteal. We welcome his confirmation of our results on the effect of knee salvage following occlusion of infrapopliteal grafts.

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