as coil embolization and stent placement for type V aneurysms, which was performed in two of their patients. We would like to elaborate on the coil embolization of dissecting aneurysms.

There are many articles reporting the endovascular treatment of SIDSMA in recent years; many patients with dissecting aneurysms were treated by placement of self-expandable and open stents without coil embolization, and all of them were discharged uneventfully.[2-4] We believe that the dissecting aneurysm would thrombose and that the aneurysm size would be reduced after placement of a stent, with gradual resolution of the false lumen and improved remodeling with patency of the true lumen. There likely exists a risk of rupture of the dissecting aneurysm with placement of coils, and the true lumen may also be compressed if coils are used. Although the authors have a good result after coil embolization of the dissecting aneurysm in two patients, we think it may not be necessary to perform such embolization.

Zhongzhi Jia, MD
Jinwei Zhao, MD
Guomin Jiang, MD

Department of Interventional Radiography
The Second Hospital of Changzhou Affiliated
to Nanjing Medical University
Chang Zhou, Jiangsu Province, China

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Regarding "One-year outcomes from an international study of the Ovation abdominal stent graft system for endovascular aneurysm repair"

It was a great pleasure to read the article by Mehta et al,[1] who reported for the first time in the literature the 1-year outcomes of the Ovation trimodular stent graft system. The authors reported a technical success of 100%, with no stent graft migration or type I, III, or IV endoleaks.

Interestingly, according to the demonstrated patient characteristics, the maximum diameters of the treated aneurysms were 54 ± 9 mm, whereas the juxtarenal neck angulation was mild or moderate: 19 ± 14°. Therefore, it could be noted that these characteristics describe an aneurysm study group of limited difficulty, in which the anticipated technical challenges in deployment and iliac gate catheterization of the endograft are easily managed. However, our personal experience with the Ovation device dictates that when managing larger aneurysms with/or greater neck angulation, certain procedural difficulties can be encountered because of its structural differences compared with other devices.[2]

The Ovation device is a trimodular prosthesis comprising a nitinol-unsupported polytetrafluoroethylene main body and two limb gates with inflatable rings that are simultaneously released freely in the aortic lumen.[1] Because the ipsilateral limb is neither fixed nor contained within the iliac tract by the time of the main body unsheathing, we have frequently observed an anteroposterior accommodation of the limb gates rather than the more common side-by-side limb configuration of other bimodular stent grafts, thus rendering the cannulation of the contralateral limb challenging and often leading to the cross-limb configuration (as Fig 3, B suggests), that is, a technique prolonging the procedural time.[3]

On the basis of the aforementioned information, it would be interesting to note if the cross-limb technique was performed or whether any additional maneuvers were used to facilitate the contralateral limb catheterization.[4] Furthermore, because the authors report successful management of aneurysms with challenging anatomy (63 patients, among whom 13 had an aortic neck length of ≤10 mm and 11 more had a neck length of <10 mm and iliac diameter of <6 mm), it would be interesting to have their feedback on the procedural duration, fluoroscopy time, and amount of contrast, comparing the aneurysms of challenging anatomy with the those of typical anatomy (98 patients).

Efstratios Georgakarakos, MD

Department of Vascular Surgery
"Democritus" University of Thrace
University Hospital of Alexandroupolis
Alexandroupolis, Greece

George Trellopoulos, MD
Dimitrios Pelekas, MD

First Surgical Clinic
General Hospital "G. Papanikolaou" Exohi
Thessaloniki, Greece

Chris V. Ioannou, MD
Nikolaos Kontopodis, MD

Vascular Surgery Department
University of Crete Medical School
Heraklion, Crete, Greece

Dimitrios Tsetis, MD

Unit of Interventional Radiology
University of Crete Medical School
Heraklion, Crete, Greece

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Reply

On behalf of the Ovation pivotal trial investigators, I much appreciate the opportunity to respond to the insightful letter from Prof Georgakarakos and colleagues.