



ELSEVIER



CORRESPONDENCE

Letter to Editor

Dear Sir,

Your timely survey¹ emphasised the use of oral antiplatelet agents in the perioperative period of carotid endarterectomy (CEA). There is a growing realization of the important role of transcranial Doppler and intravenous antiplatelet therapy in the control of platelet microemboli and associated perioperative strokes.² Pre-operatively, recurrent and frequent symptoms may be due to superimposed platelet thrombus in unstable carotid plaque, analogous to the acute coronary syndrome.² Indeed, IV Dextran have been used to reduce the microembolic load, control symptoms and to allow timely progress to CEA on the next elective list.³

Although your survey questioned respondents on the use of IV dextran perioperatively, we note that its use is only mentioned in the intraoperative results section. In fact, most of the literature on IV Dextran's use has been in the pre- and post-operative period.^{3,4} Dextran, however have been associated with significant side-effects.⁴ More recently Tirofiban, a cardiac glycoprotein IIb/IIIa inhibitor, has been assessed in carotid patients with TCD detected microemboli.⁵ Both pre- and post-operative microemboli were rapidly and safely controlled.

Yours sincerely,

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Comment On: "A 15-Year Experience with Combined Vascular Reconstruction and Free Flap Transfer for Limb-Salvage", C. Randon, B. Jacobs, F. De Ryck, K. Van Landuyt, F. Vermassen Eur. J Vasc Endovasc Surg 2009;38(3):338–345

Dear Editor,

Randon et al. recently published the long-term Belgian experience in combining bypass grafting and microvascular free tissue transfer to revascularise severely ischaemic feet with large tissue defects with poor healing potential.¹ We share the joy from their results, but not necessarily from the way our results were used as comparison. Our patients did not have less diabetes, smaller lesions nor poorer results.² Most of the patients had diabetes in both series, 70.5% in their, and 73% in our series, not 25%, which was the proportion of the type I diabetic patients.

Table 1 Corrected comparison of the two largest European series on combined vascular reconstruction and FFT for limb-salvage.

Author year	N	Diabetes %	Patient survival at 5 yrs	Limb salvage at 5 yrs
Tukiainen et al. 2006 ²	81	73%	63%	66%
Randon et al. 2009 ¹	78	70.5%	51%	70%

Only large defects may need coverage, especially if deep and in vulnerable location. We found that increased risk for amputation was associated with location of the ulcer in the heel area, and diameter exceeding 10 cm (corresponding roughly surface area of 50–75 cm²), in our material 54% of the tissue defects exceeded this measure. We did not cover minor defects smaller than 10 cm² though the article at issue so stated.¹

We are pleased to present the results in a redressed form (Table 1) but including only these two series, largest available in Europe so far. The results are quite identical and give us an excellent means to further emphasize the feasibility of combined microvascular free flap and vascular reconstruction in selected group of patients.

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