CORRESPONDENCE

Comments regarding "Predictors of Stroke and Paraplegia in Thoracic Aortic Endovascular Intervention"

Dear Editor,

I would like to thank the authors of the recent article "Predictors of Stroke and Paraplegia in Thoracic Aortic Endovascular Intervention" for their contribution to the literature.1 One major current issue in the management of thoracic aortic pathologies relates to the management of the left subclavian artery (LSCA). More historical data suggested that the revascularisation of the LSCA was unnecessary prior to endografting the thoracic aorta or aortic arch. However, more recently, a considerable body of evidence, based around large single centre series, have suggested that revascularisation of the LSCA is mandated in cases where coverage is required to achieve a suitable proximal aortic landing zone.2 This has been shown to reduce death, stroke and paraplegia rates.

It was surprising therefore that, given the extremely strong evidence in favour of LSCA revascularisation, only 9% of patients in the reported series actually had the LSCA revascularised. This comprised eighty-seven patients from their series that had the LSCA covered (29.7% of all cases), but revascularisation in just 9.2% (8/87). Even for those patients with a zone 1 landing zone only 21.9% (7/32) had LSCA revascularisation. A failure to demonstrate an effect on paraplegia requires further dissection of the case-mix as this runs against previous evidence.

More positively, the authors reached the same conclusion, that LSCA revascularisation is associated with the better surgical outcomes compared to covering the LSCA without revascularisation. It is hoped that this message reaches other surgeons performing these high-risk procedures.

References


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Response to comments regarding "Predictors of Stroke and Paraplegia in Thoracic Aortic Endovascular Intervention"

Dear Editor,

We thank the authors for their interest in our paper.1 The issue of revascularising the left subclavian artery (LSCA) when the origin is deliberately covered during thoracic endovascular aortic repair (TEVAR) remains controversial. In common with their own experience we changed our indications for revascularising the LSCA during the course of our experience, having a lower threshold for performing this later in the series. We agree that this is beneficial for reducing stroke.

The claim that the evidence for revascularisation of the LSCA is “extremely strong” is not borne out by the literature. The recommendation by the Society for Vascular Surgery to revascularise the left subclavian during TEVAR when the origin is deliberately covered by the device is categorised as C as it is based on level III evidence. There are no randomised controlled trials on this subject and to perform one may be considered unethical. The assertion that revascularisation of the left subclavian is now “mandated” would suggest that it is obligatory.

Carotid subclavian bypass is not without risk. Complications include damage to the brachial plexus, the phrenic

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