INVITED COMMENTARY

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Katz et al provide results from a prospective cohort analysis of patients undergoing primary stenting of the superficial femoral and popliteal arteries. It is important to recognize that to achieve the degree of success reported in this series, the authors excluded 52 patients, or nearly a quarter of the greater cohort, because of orificial superficial femoral artery (SFA) occlusions or combined SFA, popliteal and/or tibial artery occlusions. These patterns of disease represent red flags to most seasoned endovascular specialists, who view them as contraindications to intervening on the femoral and popliteal segments. It is likely that the clinical judgment shown in avoiding interventions on patients with these patterns of disease allowed the authors to achieve such safe, effective, and durable outcomes.

By defining loss of primary patency as "development of restenosis of 50% or greater" in addition to stent occlusion, the article sets a high standard in terms of duplex-based surveillance and definition of stent failure. Today, it is too common to have studies define loss of primary patency as occurring only with stent occlusion or in some instances only if the extremity requires reintervention (ie, "target lesion reintervention").

This less stringent definition of primary patency means that as long as the extremity has not required a subsequent procedure, the intervention being studied is categorized in the primary patency group. In this context, the current article presents a welcome and realistic assessment of SFA intervention that may actually underestimate patency. Such rigorous methodology is more in line with that historically applied to the study of open bypass procedures and should be promoted as a standard within the endovascular community, including endovascular trainees.

The primary limitation of the report is the absence of control group treated without primary stenting. This limitation is common among studies of peripheral interventions and is predictable in this particular group of patients, where routine or primary nitinol stenting is already such an accepted method of treatment. The absence of a control group limits the reader's ability to draw conclusions about whether primary stenting extends the anatomic limits of lower extremity intervention compared with balloon angioplasty alone. As such, the study's greatest value is reporting success rates and outcomes, which it does effectively.

The strengths of the study, including its prospective nature, length of duplex-based follow-up, and rigorous definition of primary patency, combine to provide a useful report on infrainguinal endovascular intervention. The authors are to be congratulated on the effort taken to complete this important work.