Dr. Azuma and his colleagues’ paper categorized the revascularization of an angiosome as direct or indirect. This fails to recognize the 3 dimensional anatomy of angiosomes that includes arterial—arterial connections in the foot and ankle between the arteries feeding the angiosomes. By failing to recognize the critical role those connections play in revascularization, the paper cannot accurately judge the quality of revascularization of a given angiosome.

In counter-distinction, Varela’s paper\(^3\) recognizes that fact by describing 3 types of revascularization of a given angiosome: direct, indirect through arterial—arterial connections and indirect. They found no significant difference in healing and limb salvage rates between the directly revascularized group and the indirectly revascularized via arterial—arterial connection(s) group. On the other hand, there was a significant difference between both groups when compared to the indirectly revascularized group without arterial—arterial connections.

I recommend adopting the Varela’s categorization of revascularization whenever using the angiosome concept to more accurately evaluate the quality of revascularization, limb salvage rates and wound healing outcomes. The first would be the direct revascularization (DR) of the artery feeding a given angiosome. The second would be the indirect revascularization (IRc) of the artery feeding a given angiosome via arterial—arterial connections. The third would be indirect revascularization (IR) where the artery feeding the angiosome remains occluded. In this instance, healing will depend on whether the “choke” vessels\(^5\) between angiosomes eventually open up or not.

**REFERENCES**


**Response to Letter to the Editor: ‘Factors Influencing Wound Healing of Critical Ischaemic Foot after Bypass Surgery: Is the Angiosome Important in Selecting Bypass Target Artery?’**

Dear Editor,

As the author of the letter mentioned, the arterial connection between angiosomes is crucial to determine the efficacy of angiosome-indirect revascularisation. However, it was not easy to classify IRc (indirect revascularisation with arterial—arterial connection) and IR (indirect revascularisation without arterial—arterial connection) because of the following reasons. (1) Preoperative arterial images such as DSA from the femoral artery, sometimes failed to show a detailed arteriogram in a severely ischaemic foot because a sufficient amount of contrast agent could not reach the foot. (2) Angiography after the establishment of a bypass could reveal the precise image of the foot. However, differentiating between IRc and IR was still difficult, because connecting arteries were also involved in arterial disease to various degrees or the connection was composed of very fine arterioles, and it was difficult to determine whether the network could contribute blood supply to the neighbouring angiosome. (3) Because the angiosome concept had not been popularised at the time of our retrospective study, the detailed three-dimensional completion angiographies were not available in many cases. (4) Angiography itself has certain limitations and cannot demonstrate the functional or haemodynamic role of the connecting circulation between angiosomes. As we mentioned in our manuscript, indocyanine green dye is utilised to intraoperatively stain the “living angiosome” in some cases to ensure that the angiosome-indirect flow through the bypass graft can contribute to feeding neighbour angiosomes.