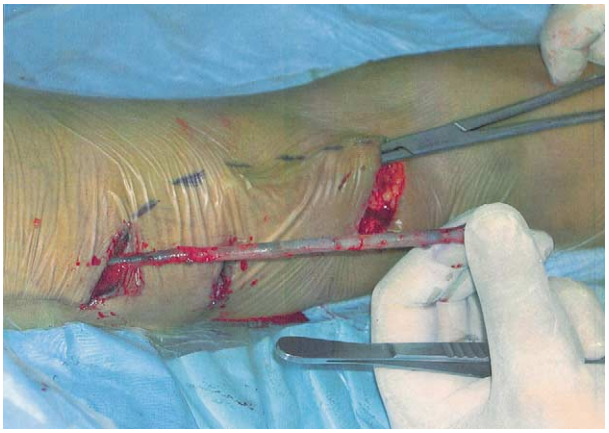

Dissection of the vein through the horizontal incisions and creation of a subcutaneous tunnel.

Regarding response to "Vein transposition in the forearm for autogenous hemodialysis access" and "Basilic vein transposition : An underused autologous alternative to prosthetic dialysis angioaccess"

We read with interest the comments of M. Cikirikcioglu and E Duran (J Vasc Surg 2002;36:202) proposing a new technique of basilic vein harvesting, with 5 interrupted small incisions and endoscopic dissection. They have used this technique successfully in 16 patients undergoing basilic vein transposition in the past 2 years.

Their and our concerns were to decrease the rate of skin necrosis, lymphatic and serous leakage, which is frequent when long single incisions are performed.[1,2] In order to reduce the number of small incisions and to avoid the use of an endoscope, which is not always available and could increase significantly the length of surgery, we have used 3 small horizontal incisions (instead of 5) without endoscopic dissection to perform 20 basilic vein transpositions in 20 patients between September 2002 and July 2003 (Fig).

The average duration of surgery was 50 minutes, and because we have been able to perform this operation under axillary block (installed by ourselves) for the last 10 patients, they were considered day cases. We did not have any skin infections, necrosis, or disruptions in these patients. We observed 3 hematomas of small importance in between the small incisions, certainly due to the skin retraction during the procedure. None of these necessitated any surgical revision. Hence we recommend the use of a small drain for 24 hours. The assisted primary patency rate with this technique was 85% at 6 months.

We offer this new technique for your consideration.

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doi:10.1016/j.jvs.2003.08.025

Regarding "Cryopreserved saphenous vein allografts in infrainguinal revascularization: Analysis of 240 grafts"

Farber et al (J Vasc Surg 2003;38:15-31) have defined a specific role for the use of cryopreserved saphenous vein in infrainguinal revascularization. However, their reference to the umbilical vein is based on an article published in the *Journal of Vascular Surgery* in 1988. The authors should have referred to a subsequent publication,[1] which clearly showed no aneurysmal degeneration in the series followed during the decade 1990 to 2000. Their comments and conclusions with regard to the current status of the use of umbilical vein grafts would have been different and more accurate in describing the current status of this material.

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doi:10.1016/j.jvs.2003.08.025

Regarding "External iliac artery endofibrosis: A new possible predisposing factor"

When no fewer than seven authors contribute to a case report, one may reasonably expect that a thorough literature search has been performed. However, Scavèe et al failed to do so in their article on external iliac artery endofibrosis, published in the July issue of the Journal (J Vasc Surg 2003;38:180-2). Firstly, contrary to their statement, the disease was described before 1986.[1] Secondly, their "additional possible explanation" of the disease by psoas muscle hypertrophy was published by Pils et al[2] as early as in 1990. Finally, other possibly contributing factors such as increased cardiac output and adaptive systolic hypertension during strenuous efforts,[3] are not mentioned in their discussion.

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doi:10.1016/j.jvs.2003.08.029

Reply

We appreciate the interest of Dr Mosimann in our article and are grateful to him for bringing to our attention the results of his and his colleagues' observation regarding the external ilac artery endofibrosis. We were somewhat surprised, however, to note that recent and current publications on this topic did not mention this letter reference.

The concept of endofibrosis goes back to at least 1966,[1] and the first description of the external iliac artery endofibrosis was published in 1985 by Walder and colleagues.[2]

Finally, we fully agree that the precise pathophysiologic mechanism of EIAE still remains unclear. Several causes and predisposing factors were found to be of significance in the genesis of EIAE. Studies should add further information regarding the pathophysiologic mechanism of EIAE.

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