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### Regarding the Commentary for “Novel sutureless telescoping anastomosis revascularization technique of supra-aortic vessels to simplify combined open endovascular procedures in the treatment of aortic arch pathologies”

We thank Dr Ballard for his comments. Although skepticism can be a good thing, we might remind him that such skepticism greeted innovative disruptive technologies like balloon angioplasty and endovascular aneurysm repair. While our technique may not be as important as these procedures, we believe it does provide a simpler, safer way of performing aortic branch anastomoses, particularly in adverse circumstances. As such it should be helpful to vascular surgeons and at least deserves their attention and evaluation.

Our method offers major advantages in terms of substantially reducing the need for vessel dissection and end organ ischemia. Even if some cannot reproduce our short anastomotic times exactly, they were accurate for our group and could be duplicated by a number of our trainees and visiting vascular surgeons who learned them easily.

We do believe these techniques will be helpful to vascular surgeons and their patients, and represent a better way of performing anastomoses, especially in challenging conditions. We hope many others will be interested in using our technique, and we look forward to reports from them that they have found it useful.

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### Regarding “Aneurysmal iliac arteries do not portend future iliac aneurysmal enlargement after endovascular aneurysm repair for abdominal aortic aneurysm”

We would agree with the authors<sup>1</sup> that aneurysmal degeneration of the iliac arteries does not occur in either normal or ectatic

arteries at the time of endovascular aneurysm repair (EVAR), but only up to 5 years postendovascular repair.

We have previously shown<sup>2-4</sup> that up to 5 years after EVAR, aneurysmal dilatation does not take place. However, between 5 and 12 years, there is a low (<3%) but definite incidence of aneurysmal dilatation. We too reported that aneurysmal dilatation occurred in arteries of <20-mm diameter. We also reported that the aneurysm formation occurred in arteries, which were the landing site of EVAR, as well as in iliacs that were contralateral to the uni-iliac landing site in that type of reconstruction.

We note that the above study ran to only 5 years after EVAR. We would expect a similar incidence of aneurysmal degeneration in the iliacs in this study after 5 years in survivors with intact endografts.

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### Reply

We appreciate the letter by Dr Mohan Adiseshiah. It addresses a limitation of our study in that our follow-up is limited to those data which are collected on the Zenith clinical trial. It certainly would be interesting to see if we had similar results out to 12 years or if the iliac arteries remained stable. Unfortunately, those data are not available.

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