impact on this number and reduce the mortality and morbidity associated with aneurysmal disease.

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Regarding “Deep vein harvest: Predicting need for fasciotomy”

We read with interest the article presented by Modrall et al (J Vasc Surg 2004;39:387-94). The authors present a large experience, but we were surprised by the high incidence of fasciotomy. As a whole, 17.8% of the limbs required a fasciotomy after deep vein harvest. The incidence after operation for infected aortic prosthesis was 19.3%. This does certainly not reflect our own experience!

We have been using the technique of in situ reconstruction with the deep veins for prosthetic infection for more than 10 years and some of our results have been published previously.1,2 Our overall experience with in situ reconstruction, using the deep veins, in infection after aortic prosthetic covers now 90 patients (aorto-enteric fistula, n = 25; “primary” infection, n = 65). Five patients required a partial graft excision (ie, iliofemoral venous interposition), but the majority (94.5%) underwent complete graft excision and in situ replacement by venous aortofemoral (n = 75) or aortoiliac (n = 10) graft. With regard to our technique, we would like to emphasize that, with just one exception, we never harvested the deep veins in combination with the ipsilateral greater saphenous vein. After harvesting the veins, the wounds are closed immediately and the limbs are packed by an elastic bandage before continuing the operation. Intermittent pneumatic compression is used routinely for 5 days.

Overall, in this series of 90 patients, the deep veins were harvested in 172 limbs and deep vein harvest was complete—according to the definition of Modrall et al—in 165 limbs (96%). Preoperative ankle-brachial indexes (ABIs) were known in 160 limbs (93%). The mean ABI was 0.74 ± 0.28 and an ABI ≤0.5 was noted in 40 cases (25%) (Figure). As in the series of Modrall et al, the need for fasciotomy was left to the clinical judgment of the surgeon, with 4 patients (4.5%) requiring a fasciotomy within 30 days of the operation. This means a limb-related incidence of only 2.3%. One fasciotomy was performed during the initial operation on a patient who was operated on emergently because of acute ischemia. The other 3 patients developed an acute ischemia after unilateral thrombosis of the venous graft in the immediate postoperative period. Repair consisted of thrombectomy, and concomitant fasciotomy was felt necessary. The preoperative ABIs in these 4 limbs were 0.2, 0.4, 0.6, and 1.1, respectively.

Because 3 of the 4 fasciotomies were the result of technical failures, we cannot confirm the data presented by Modrall et al. Knowing that 87% of the fasciotomies in their series were performed during the initial operation, we also wonder which parameters they have to justify this position and whether the authors have any data that a fasciotomy was in fact really necessary.

From our series, we instead conclude that acute venous morbidity with compartment syndrome after deep venous harvest represents an exceptional event. This is also in agreement with some other (smaller) series, in which acute venous hypertension and compartment syndrome were not mentioned as a problem after harvesting the deep veins.3-6

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Reply

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