Regarding “Endovenous laser treatment of the short saphenous vein: Efficacy and complications”

I enjoyed the excellent article of Gibson et al., and have a question about the details of endovenous laser treatment (EVLT) with respect to the Giacomini vein termination. The recurrence rate of the small saphenous vein (SSV) is generally more than 30%. The point where the Giacomini vein connects to the SSV differs among individual patients, ranging from immediately subfascial (Fig. B) to deep near the saphenopopliteal junction (Fig. A). By using EVLT beginning distal to the termination of the Giacomini vein, in order to preserve flow from the Giacomini vein to the SSV in type B patients, a long SSV stump is left, which might cause treatment failure and recurrence. Do the authors always start EVLT from distal to the termination of the Giacomini vein when treating type B patients? How do they perform EVLT in patients with reflux in both the SSV trunk and Giacomini vein?

We prefer to start EVLT from 1 cm to 1.5 cm distal to the SSV to avoid leaving a long residual SSV stump. Therefore, for almost all patients, we conduct EVLT proximal to the site where the Giacomini vein is drained. Contrary to the variability of the Giacomini vein termination, in case of the gastrocnemius vein terminating into the SSV near the saphenopopliteal junction, we sometimes perform EVLT 1 to 1.5 cm distal to the site where the gastrocnemius vein entered into the SSV to maintain the normal venous flow of the gastrocnemius vein.

Our clinical experience with more than 4600 limbs (including 1086 SSVs) treated with EVLT spans 5 years, with all patients undergoing post-EVLT duplex scans at multiple time periods. Our routine follow-up duplex scan schedule is 2 days, 1 week, 1 month, 3 months, 6 months, thereafter annually. Surprisingly, we have never seen a deep vein thrombosis in any of our patients.


Regarding “Duplex surveillance following carotid surgery: effect of management policy”

I refer to the study by Ballotta and colleagues, which described the outcome of 599 patients following carotid endarterectomy. The authors report excellent perioperative results and also examine the outcome of follow-up duplex surveillance. The authors conclude that their findings strongly support the value of duplex surveillance every 6 months after carotid surgery. The interpretation of this study needs to take into account controversies regarding managing asymptomatic carotid artery disease. An imaging finding is primarily of value if it alters the clinical management of the patient. The potential findings from surveillance after carotid surgery include ipsilateral restenosis or contralateral progression of stenosis. While this and other studies indicate that both these problems can be easily and commonly identified by duplex surveillance, the management of them remains controversial. Ipsilateral restenosis particularly, if developing within the first year following surgery, is believed to have a benign natural history and, therefore, many clinicians treat such lesions medically. Similarly, the management of asymptomatic carotid stenosis also remains controversial with meta-analyses suggesting significant but small reduction in stroke incidence based on interventional treatment of all patients with asymptomatic carotid stenosis. Only two of the patients in the present study suffered a stroke associated with progression of