

related mortality both among men with and without known COPD or cardiovascular diseases: mortality ratio: 0.22 (95% C.I.: 0.08–0.65), $P=0.006$, and 0.24 (95% C.I.: 0.09–0.63, $P=0.004$, respectively).

Conclusion: High-risk population screening would prevent less than half of AAA-related deaths. Therefore, restricting screening to such high-risk groups does not seem justified, but cost effectiveness analyses are needed to reach a firm conclusion.

Endovascular Repair of Symptomatic Penetrating Atherosclerotic Ulcer of the Thoracic Aorta

Pauls S., Orend K.-H., Sunder-Plassmann L., Kick J., Schelzig H. Eur J Vasc Endovasc Surg 2007;34:66-73.

Background: In this study we evaluate published and personal experience of Endovascular Repair (EVAR) of penetrating atherosclerotic ulcers (PAU).

Patients and method: In 12 patients (mean 74 years, 58–87 years) PAU was diagnosed with computer tomography (CT). Symptomatic ulcers were treated by vascular surgeons using stentgrafts via a femoral access route. Patients were followed up clinically and with CT for an average of 849 days (186–1968 days).

Results: 11 patients had severe acute thoracic pain, one patient presented with hemoptysis. CT showed well outlined ulcer, intramural hematoma, and contrast enhancement of the aortic wall ($n=12$), pseudoaneurysm ($n=11$), intimal calcification adjoining the ulcer ($n=10$), pleural ($n=9$) and mediastinal fluid ($n=4$). Mean duration of surgery was 68 min (32–120 min). Primary technical success was achieved in all patients. There was no perioperative complications except one acute hemorrhage from an intercostal artery and one iliac dissection. 3 months after stentgraft application owing to a severe stenosis of the right common femoral artery, an iliofemoral bypass was performed in one patient. All patients were free of symptoms after the procedure. There was incomplete sealing of PAU in 2 of 12 patients, but no re-intervention was needed. All patients were alive during follow-up.

Conclusion: Symptomatic PAU is a potentially fatal lesion. Considering the low morbidity and mortality of EVAR, this option might be first choice.

Stenting of Common Iliac Vein Obstructions Combined with Regional Thrombolysis and Thrombectomy in Acute Deep Vein Thrombosis

Husmann M.J., Heller G., Kalka C., Savolainen H., Do D.D., Schmidli J., Baumgartner I. Eur J Vasc Endovasc Surg 2007;34:87-91.

Objectives: To evaluate the efficacy of stent placement after infrainguinal loco-regional thrombolysis and iliac thrombectomy (surgical TT) of acute deep vein thrombosis (DVT) in patients with May-Thurner-Syndrome.

Material and methods: We retrospectively analysed a group of 11 patients (9 women) (mean age 34 years, range 16–64 years) with surgical TT and additional intra-operative stenting due to compression of the common iliac vein. Patients underwent venography to demonstrate outflow patency after surgical TT, and to identify any obstruction at the level of the left-sided common iliac vein ("Beckenvenen-Sporn"). Obstruction at the level of arterial crossing was treated using Wallstents placed via an introducer sheath from the inguinal access site. Stents were fully deployed using balloons adjusted to the size of vein. Patients were treated with oral anticoagulants for 6 months, and followed using duplex ultrasonography.

Results: Technical success defined as complete vein patency and normal valve function was documented in all 11 patients. One patient needed early stent extension due to residual stenosis. At 6 months follow-up one patient (9%) had an asymptomatic occlusion of the stented common iliac vein. In all 11/11 (100%) patients the femoral segment was found to be patent, and in 1/11 (9%) there was mild reflux with few clinical symptoms of post-thrombotic syndrome. The calculated cumulative primary patency rate for venous iliac stents was 82%, and assisted patency rate was 91%, which remained unchanged over a mean follow-up of 22 months.

Conclusion: Combining surgical TT and stenting of common iliac vein obstructions in DVT is safe, effective, and results in a acceptable venous patency.

Results and Significance of Colour Duplex Assessment of the Deep Venous System in Recurrent Varicose Veins

Ali S.M., Callam M.J. Eur J Vasc Endovasc Surg 2007;34:97-101.

Objectives: To establish the status of the deep veins in patients presenting with recurrent varicose veins and the effect on treatment decisions.

Design: Retrospective clinical series.

Materials and methods: Duplex examination of 570 consecutive patients (843 limbs) presenting with recurrent varicose veins (CEAP C2-4).

Results: Approximately one third of these patients (34.8%:294 limbs) had no deep venous abnormality; 173 limbs with superficial vein abnormalities only had great and/or small saphenous junction incompetence, the remaining 121 legs had abnormal perforating or communicating veins. Deep venous abnormalities were found in 549 limbs with evidence of persisting deep venous obstruction in only 20. Deep venous incompetence was found in 529 limbs (62.7% of all legs). However three segment incompetence (common femoral, femoral and popliteal veins) was found in only 181 legs (21.4%), two segment incompetence in 137 (16.2%) and one segment incompetence in 211 (25%).

Conclusions: Deep vein incompetence is common in patients with recurrent varicose veins. Deep venous obstruction is an infrequent finding but total deep venous reflux (three segment incompetence) affects just under one quarter of all limbs with recurrent varicose veins. Ablation or surgery of varicose veins in this group may be less effective. Patients should be advised of the implications of this finding.