LETTERS TO THE EDITOR

Regarding “Salvage of a difficult situation: Method for conversion of a failed endograft”

We have read with great interest the technical note by Milner, Verhagen, and Blankensteijn (J Vasc Surg 2003;38:397–400) about the conversion of failed endografts incorporating the proximal attachment system of the endograft in the new proximal anastomosis. According to our own experience, this can also safely be accomplished with the distal part of an aortouniiliac graft, leaving the femorofemoral crossover graft intact.

We report briefly the midterm results of a case where a modification of the technique described by Milner et al. was used. An 83-year-old woman with a symptomatic 7.5-cm infrarenal aneurysm was treated in 1999 with a aortouniiliac stent graft, femorofemoral crossover graft, and contralateral occlusion. The endovascular procedure was chosen because of her old age and numerous comorbidities (Talent, Medtronic, USA).

At the 18-months follow-up examination, migration of the prosthesis and enlargement of the diameter of the aneurysm were found. The patient refused any further examination or treatment at this time. A few weeks later she was admitted with the clinical symptoms of a ruptured aneurysm. Intraoperatively we found a ruptured aneurysm with a retroperitoneal hematoma and a graft that had migrated into the sac of the aneurysm. The iliac part of the endograft was well incorporated.

The endograft was transected proximal to the aortic bifurcation and removed. The left limb of a 16 × 8-mm clotted Dacron prosthesis was trimmed and closed with a 3/0 Prolene suture. The proximal anastomosis was performed in the usual fashion with the infrarenal neck of the aorta. The distal anastomosis was performed end-to-end between the right Dacron limb and the iliac extension of the endograft with a running 3/0 Prolene suture. The metal skeleton was incorporated into the anastomosis. The patient had an uneventful recovery. Follow-up angiography computed tomography scan with three-dimensional reconstruction 36 months after surgery showed a patent hybrid Dacron endoprosthesis and a patent femorofemoral crossover graft (Fig).

Our case supports the opinion of Milner et al that the well-incorporated parts of a failed endograft can be left intact. They can be used for the anastomosis with a conventional graft that facilitates the whole procedure.

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Regarding “Performance characteristics of the venous clinical severity score” and “Validation of the new venous severity scoring system in varicose vein surgery”

Twice your journal has published articles purporting to demonstrate the validity of the new Venous Severity Score or its components and advancing it as an improved method for venous disease severity measurement.1,2 On both occasions the high linear correlation between the Venous Clinical Severity Score (VCSS) and the CEAP classification has been reported and used as an indication of its validity. This high correlation is not just expected, as the authors concede, but is a certainty since the VCSS is specifically derived from the CEAP clinical score, itself derived from the CEAP classification system. It is only because just seven of ten items in the CEAP clinical classification are also in the VCSS, rather than ten of ten items, that there is any variation at all.
For the VCSS to be uniformly adopted, it must prove itself at least as good at severity measurement as other existing validated instruments, rather than being compared with that from which it is derived, and a better statistical tool than correlation must be used.

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REFERENCES


Reply
We thank the Editors for giving us the opportunity to respond to Mr Beresford’s letter concerning our recently published article. Mr Beresford focuses on the high linear correlation between the Venous Clinical Severity Score (VCSS) and the CEAP classification (CEAP clinical class and score). However, the stated purpose of the study was to validate the ability of these scores in quantifying the outcome of varicose vein surgery and to determine whether one was more sensitive than the other.

We agree that the high correlation between the 2 scores is expected; however, because the VCSS uses a 0 to 3 grading scheme (0 = absent, 1 = mild, 2 = moderate, and 3 = severe, applied to all 10 clinical descriptors), it was supposedly better than the CEAP clinical class. Although correlation is the appropriate statistical test for direct comparison of two different scaled variables, we failed to demonstrate any superiority of the VCSS in comparison with the CEAP clinical score already in use in terms of postoperative reduction of clinical severity indicators. In addition, we used “better” statistical tools than correlation; receiver operating characteristic curves and measurements of the area under the curve were employed to test the ability of both scores to differentiate mild and moderate from severe venous disease. The latter method has obvious utility in assessing the overall discriminatory validity of an individual scoring instrument. As we think that there is no ideal method of assessing venous outcome, we are currently using additional scoring tools, like the Aberdeen varicose vein symptom severity score.1

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Regarding “Fate of excluded popliteal artery aneurysms” and “Graft patency is not the only clinical predictor of success after exclusion and bypass of popliteal artery aneurysms”

We were stimulated by two recent articles in the Journal of Vascular Surgery that demonstrated continued expansion of popliteal artery aneurysms following ligation, due to persistent collateral perfusion.1,2 In a recent case of ours, a 77-year-old man with a history of idiopathic thrombocytopenia (platelet count 42) presented to his general practitioner complaining of posterior knee pain. He was found to have a lump behind the knee and was referred for a duplex ultrasound scan. This showed a popliteal aneurysm with a maximum diameter of 2.6 cm. The aneurysm contained thrombus. Following platelet transfusion, he underwent ligation of the popliteal artery aneurysm. Once the distal popliteal artery had been ligated, the proximal popliteal artery was controlled and opened. Thrombogenic foam (Spongostan; Johnson and Johnson, Skipton, United Kingdom) was rolled up and packed into the popliteal aneurysm in order to ensure thrombosis of the aneurysm sac. The proximal popliteal artery was then ligated and a reversed vein bypass was performed. The postoperative period was uncomplicated. The patient returned three weeks after the procedure and a repeat duplex ultrasound scan was performed. The ligated aneurysm sac was noted to have no persistent flow, indicating complete exclusion of the aneurysm.

This case indicates that packing of the aneurysm sac with thrombogenic foam appears to be an effective technique for improving the exclusion of popliteal aneurysms in the early stage. Similar material has been effective in the occlusion of side branch endoleaks after endovascular repair of abdominal aortic aneurysms.3

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REFERENCES