Dear Editor,

Dubois et al., reported their 18-year experience regarding the treatment of mycotic aneurysms with involvement of the abdominal aorta. In their study, the term 'mycotic aneurysm' remains misleading and this problem is common in most studies regarding vascular infections. 1

Strictly speaking, the term 'mycotic aneurysm' has been reserved since 1885 for infected aneurysms resulting from bacterial endocarditis complicated by septic arterial emboli or an infected aneurysm in the sinus Valsalva resulting from contiguous spread from an infected aortic valve. 2, 3 These aneurysms were common in the pre-antibiotic era, however, nowadays are extremely rare. 4

Wilson et al., classified the infected aneurysms according to their clinical characteristics: mycotic aneurysms (endocarditis-related), microbial arteritis (bacteremia-related), infection of existing aneurysm (bacteremia-related) and post-traumatic infected false-aneurysm (trauma-related). 5 The incidence of infected aneurysms increased in response to the increasing prevalence of immunosuppressed hosts, invasive hemodynamic monitoring, angiography, and drug addiction. 3 This change in pathogenesis led to the fourth type of infected aneurysm as a relevant clinical entity.

This classification should be followed in future reports regarding vascular infections and the term 'mycotic aneurysms' should be limited only to the respective cases. Therewith same clinical entities can be compared and the results will be representative and more valuable.

References


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Response to Comments of Dr. Bisdas and Dr. Teebken on the Terminology of Mycotic or Infected Aneurysm

Dear Editor,

We agree with Dr. Bisdas and Dr. Teebken that terminology on 'infectious aortic disease' and especially the term 'mycotic' has always been a source of discussion and confusion. Standardization of this terminology could be of help.

However, nowadays the majority of vascular surgeons keep to the commonly used definition of mycotic aneurysm to include all kind of infected aneurysms. This is also the way we used the term 'mycotic aneurysm' i.e. microbial arteritis and infection of existing aneurysm according to Wilson et al. 5

A more precise classification as presented by Wilson et al. 1 with more respect for the different pathogenetic pathways of infected aneurysms could lead to a more comparable reporting of all these entities. However, one could question whether the differentiation in mycotic aneurysm, microbial arteritis and infection of existing aneurysm has any

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therapeutical impact. In all cases both the source of infection and the ‘infected aneurysm’ itself have to be addressed.

Reference


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Comments regarding “A Retrospective Study of Intravascular Ultrasound use in Patients Undergoing Endovascular Aneurysm Repair: Its Usefulness and a Description of the Procedure”

The use of Contrast Enhanced Ultrasound for Intraprocedural EVAR deployment completely eliminates the need for nephrotoxic iodinated intra-arterial contrast.

Dear Editor,

I was delighted to read your retrospective study using Intravascular Ultrasound (IVUS) during EVAR stent-graft deployment and commend you for describing a technique to significantly reduce the intra-arterial contrast used. The availability of EVAR and the number of patients deemed suitable for these procedures is growing immensely. As techniques evolve and become more complex, such as fenestrated and branched grafts, the corresponding procedure times and thus exposure to greater volumes of nephrotoxic iodinated contrast and radiation also increases.

I agree that your IVUS technique will help with these matters but will not eliminate them completely. In 2008 Dr Dirk Clevert first described the use of real-time intra-operative microbubble contrast-enhanced ultrasound for EVAR stent deployment and for post-procedural endoleak detection (both immediate and late as part of a surveillance programme). I have visited Munich and witnessed this procedure that requires no intra-arterial contrast but does require the use of much reduced doses of intra-procedural angiographic fluoroscopy. More recently the German group has published their longer experience and refinement of the technique with a series of 17 patients and compared this group with 20 treated using “conventional EVAR” consisting of iodine contrast media with intra-operative fluoroscopy.

The use of intra-operative microbubble contrast ultrasound for stent deployment completely eliminates the need for any completion angiography or the use of any intra-arterial contrast and significantly reducing the radiation exposure, which IVUS does not appear to match. I look forward to your further work that you allude to regarding the combined use of IVUS and ultrasound contrast, but suggest that this should not be limited to those with a contraindication to iodinated media but can be applied more widely.

References


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Response to comments regarding “A Retrospective Study Of Intravascular Ultrasound Use In Patients Undergoing Endovascular Aneurysm Repair: Its Usefulness And A Description Of The Procedure.”

Dear Editor,

We thank Dr. Dindyal for his comments regarding our paper; we have provided a response regarding the issue that he had raised, mainly regarding the usefulness of contrast-enhanced ultrasonography (CEUS).

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