CORRESPONDENCE

Comment on "What is the Place of Surgery for Intermittent Claudication?"

Dear Editor,

In their editorial What is the place of surgery for intermittent claudication?, Campbell and Birchley argue that surgery can offer benefits in terms of health-related quality of life (HRQL). However, whether surgery is in fact a worthwhile endeavour remains unclear. The Swedish Board of Technology Assessment in Health Care (SBU) concluded in 2007 that there is only limited evidence for improved HRQL by revascularisation in IC patients.

The authors suggest that decisions about interventions for IC are unlikely to be better informed by controlled studies due to poor patient recruitment, referring to the MIMIC trial. We are convinced that Campbell and Birchley would agree that conclusions regarding the effectiveness of technologies are best based on controlled trials. Recruitment into trials can be improved by less selective inclusion criteria allowing open surgical and/or endovascular revascularisation and also allowing invasive treatment for the occasional non-invasive group patient that deteriorates significantly. In a randomised study of surgical/endovascular versus non-invasive treatment, we included approximately 60% of referred claudicants ≥85 years. Presently, we include 61% in a new study with similar inclusion criteria but updated interventions.

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None.

References


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Response to comment on "What Is The Place Of Surgery For Intermittent Claudication?"

Dear Editor,

We thank Jivegård et al for their interest in our editorial. We do not argue that surgical revascularisation is anything more than an option to be considered where anatomical patterns of disease and patient choice support it. "Limited evidence" is not the same as "No evidence" and in a field as difficult to study scientifically as revascularisation in claudication this distinction becomes the more important. In the absence of large and definitive randomised controlled trials we are left to make judgements about individual patients with the available evidence.

In terms of expanding the scope of future trials, the double-edged sword is that more lax criteria for trial entry and types of intervention will arguably lead to reduced certainty about the place of particular types of treatment. We certainly do support the value of adequately powered