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of cardiovascular diseases, following in the footsteps of Dr. Borioni we would once again like to stress the importance of extending this pre-operative procedure to all CEA candidates without a history of CAD. Hopefully, other centers will achieve results similar to Dr. Borioni's and ours, thereby contributing to the widespread use of what we presently consider the most reliable tool for diagnosing and simultaneously treating CAD at the time of hospitalization for CEA and other peripheral arterial surgery. Coronary angiography would consequently be dissociated from preconceived ideas pertaining to its mistakenly presupposed danger and invasiveness.

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Re: 'Preferred Strategy for Hemodialysis Access Creation in Elderly Patients'

We praise Tordoir et al. for their comprehensive review of the available evidence for vascular access in the elderly.[1] The recommendation of an early cannulation arteriovenous graft (AVG) as a first access contradicts all published vascular access guidelines and challenges the "one-size-fits-all" approach to vascular access.

Most published outcomes of arteriovenous fistulae (AVFs) are poor, with high primary failure and moderate patency rates.[2] Therefore, the concept of an autologous AVF being the best form of vascular access is only valid if we assume all AVFs work well.

A nonmaturing AVF results in extended catheter use, with its added morbidity and mortality burden. As the dialysis population ages the dogmatic approach recommended by the guidelines must be challenged and emphasis placed on a tailored approach to vascular access.[3] Exhausting vascular access through loss of venous capital is unlikely in elderly patients, and the main priority is to achieve a functional vascular access promptly.

However, age alone should not be a contraindication to AVF creation. Many patients aged >65 years are fully active and may have a lower "physiological age". Transplantation listing is based more on this concept than prescriptive age, with positive results. The details of the vignette are lacking and while in these patients an AVG may be the best option, the selective use of autologous AVFs may give superior longer term outcomes with less intervention required.

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Response to Letter to the Editor 'Re: Preferred Strategy for Hemodialysis Access Creation in Elderly Patients'

We agree with the comments that most guidelines advise a "fistula first" policy in the incident and prevalent hemodialysis population. However, in concordance with their remarks, autologous arteriovenous fistulae (AVFs) are only valid if all AVFs perform properly and are functional for daily practice. That is precisely the bottleneck of creating vascular