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?, 1 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. 2 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, 3 we included approximately 60% of referred claudicants ≤ 85 years. Presently, we include 61% in a new study with similar inclusion criteria but updated interventions.

Conflict of Interest/Funding

None.

References

2 The MIMIC Trial Participants. The adjuvant benefit of angioplasty in patients with mild to moderate intermittent claudication (MIMIC) managed by supervised exercise, smoking cessation advice and best medical therapy: results from two randomized trials for stenotic femoropopliteal and aortoiliac arterial disease. Eur J Vasc Endovasc Surg 2008;36:680–8.

L. Jivegård* J. Gelin J. Nordanstig K. Österberg
Department of Vascular Surgery, Sahlgrenska University Hospital and Institute of Medicine, Sahlgrenska Academy, Gothenburg University, Gothenburg, Sweden
*Corresponding author. Tel.: +46 313 427486.
E-mail address: lennart.jivegard@vgregion.se (L. Jivegård)

C. Taft
Health and Care Sciences, Sahlgrenska Academy, Gothenburg University, Gothenburg, Sweden

Available online 3 December 2010

© 2010 European Society for Vascular Surgery. Published by Elsevier Ltd. All rights reserved.
doi:10.1016/j.ejvs.2010.10.012

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
prospective randomised controlled trials. We wish Jivegård and colleagues well with their current study and look forward to seeing the results.

D. Birchley*
B. Campbell
Royal Devon and Exeter Hospital, Vascular Surgery, Barrack Road, Exeter, United Kingdom
*Corresponding author.
E-mail address: dbirchley@hotmail.com (D. Birchley)

Available online 24 November 2010

© 2010 Published by Elsevier Ltd on behalf of European Society for Vascular Surgery.

Percutaneous Access for Endovascular Aortic Aneurysm Repair. Potential Predictors of Success must be Reappraised

Dear Editor,

Thank you for the excellent systematic review on percutaneous access for endovascular aneurysm repair (pe-EVAR).1 Data abstraction reveals that, relevant studies published online several months before Malkawi et al. submission, were omitted.1 Evidence of significantly lower primary success rates with increasing sheath size was mentioned.1 This fact remains a logical scenario but conflicting results appeared after the largest available study by Eisenack et al. (adding another 500 patients or 904 femoral groins) with negligible effect of sheath size on success rate.2 Instead, the significant issue of operator experience, had the pivotal role in predicting pe-EVAR outcomes.2 Considering all 4 missing studies, and a recent study by Krajcer et al.,3 adding totally 714 more patients (1219 femoral groins), thus ~40% expansion of the previous review population, and when splitting all pe-EVAR literature in two equal quantititative periods, (1st: 1999–2008 and 2nd: 2008–2010, initial 1450 and latest 1509 femoral access sites respectively) we found that (Table 1) the earlier period had worse primary success rate (88.7% vs 95.4%) and increased combined device-related and patient-related open conversion rates (8.6% vs 3.4%).

Considering that mean sheath size is almost the same, and assuming that learning curves are rather similar among institutions, this discrepancy might be explained by operator expertise. Interestingly, increasing experience eliminates other potential predictors of pe-EVAR success rates like sheath size or anatomically related factors, like obesity.2

A meta-analysis is warranted to further clarify the contribution of all possible predictor of success in pe-EVAR era.

References


G.S. Georgiadis*
G.A. Antoniou
M.K. Lazarides
Department of Vascular Surgery, "Demokritos" University of Thrace, University General Hospital of Alexandroupolis, Greece
*Corresponding author. Alexandrou Papanastasiou 7 str., Alexandroupolis 68100, Greece.
Tel./fax: +30 2551037171.
E-mail addresses: docvasc@otenet.gr, ggeorgia@med.duth.gr (G.S. Georgiadis)

Available online 20 November 2010

Table 1 Early and late pe-EVAR results.

<table>
<thead>
<tr>
<th>Period</th>
<th>Patients</th>
<th>Femoral access sites</th>
<th>Mean sheath size used (Fr)</th>
<th>Overall pe-EVAR success rate</th>
<th>DR-/PR-OC’s(s)%</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st period</td>
<td>917</td>
<td>1450</td>
<td>17.7</td>
<td>88.7</td>
<td>104 (7.1)/22 (1.5)</td>
<td></td>
</tr>
<tr>
<td>(1999–2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001/ &lt;0.001</td>
</tr>
<tr>
<td>2nd period</td>
<td>884</td>
<td>1509</td>
<td>18.8</td>
<td>95.4</td>
<td>50 (3.3)/2 (0.13)</td>
<td></td>
</tr>
<tr>
<td>(2008–2010)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1801</td>
<td>2959</td>
<td>92.4 (weighted mean)</td>
<td>154 (5.2%)/24 (0.8%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Reported on pre-close technique femoral access entry site basis.

© 2010 European Society for Vascular Surgery. Published by Elsevier Ltd. All rights reserved.
doi:10.1016/j.ejvs.2010.10.013

DOI of original article: 10.1016/j.ejvs.2010.02.001.