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REFERENCES

1. Nevelsteen A, Lacroix H, Suy R. Autogenous reconstruction with the lower extremity deep veins: an alternative treatment of prosthetic infection after reconstructive surgery for aortoiliac disease. J Vasc Surg 1995;22:129-34.
2. Farret A, da Ros CT, Fischer CAC, Mandelli JP, Farret LC Jr. Suprarenal aorta reconstruction using a saphenous spiral graft: case report. J Trauma 1994;37:114-8.
3. Kieffer E, Bahnini A, Koskas F, Ruotolo C, Le Blevec D, Plissonnier D. In situ allograft replacement of infected infrarenal aortic prosthetic grafts: results in 43 patients. J Vasc Surg 1993;17:349-56.
4. Donaldson MC, Wirthlin LS, Donaldson GA. Thirty-year experience with surgical interruption of the inferior vena cava for prevention of pulmonary embolism. Ann Surg 1980; 191:367-72.

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Regarding "Early history of aortic surgery"

To the Editors:

I recently read this fine report and was especially interested to read on page 748 that the first successful repair of a ruptured aneurysm by our own group was performed on October 21, 1954 at Baylor Hospital, which is in Baylor University Medical Center, Dallas, Texas. This operation, on a 65-year-old man who lived nine more years, was performed by me with the assistance of Dr Dale Austin and consisted of the emergency resection and bifurcation homologous graft replacement of a ruptured abdominal aortic aneurysm. This has been reported in the literature by me (Kleinsasser LJ. Homologous graft replacement of major vessels, the aorta and its branches. Texas State J Med 1955;51:498-502 [case 3]).

Since this is one of the earliest reports of a successful resection of a ruptured abdominal aortic aneurysm and homologous graft replacement and was mentioned in this article, it would seem appropriate for the *Journal of Vascular Surgery* to publish this information because of its historical interest and in the interest of accuracy. Unfortunately, this information was not included in the bibliography and was not included in Table II, in which "Early cases of ruptured abdominal aortic aneurysm successfully treated by resection with homograft replacement" are listed. Actually mine preceded that of Javid et al.

LeRoy J. Kleinsasser, MD

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Reply

On page 478 of my article,[1] I mentioned the case to which Dr Kleinsasser referred in his letter. Unfortunately, because of an inadvertent oversight, the reference was not appended. I am sorry for this omission. The patient was operated on October 21, 1954, at Baylor Hospital in Dallas, Tex. Dr Kleinsasser was the surgeon, and the late Dr Dale J. Austin (my partner) was the assistant surgeon. The patient survived, and the case was reported in 1955.[2] It is one of the early cases of successful repair of a ruptured abdominal aortic aneurysm.

Perhaps some additional comments are in order in my reply to Dr Kleinsasser's letter. As I stated in my letter, the omission of the reference was inadvertent, an error on my part and certainly not deliberate. I have apologized to Dr Kleinsasser privately and now publicly for the error of omission. "Our own group" was a poor choice of words and was intended to include all those working in vascular surgery in Baylor Hospital in Dallas—surgeons, anesthetists, nurses—and was not meant to include or exclude any appropriate individuals. In my enthusiasm to demonstrate the vascular work being done at Baylor Hospital in Dallas, I inadvertently omitted the reference to Dr Kleinsasser's case, for which I am very sorry. Dr Kleinsasser and I have been friends and colleagues for 45 years and have never had a dispute or disagreement over a case. Dr Kleinsasser is to be congratulated on the outcome. Many thanks.

Jesse E. Thompson, MD

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REFERENCES

1. Thompson JE. Early history of aortic surgery. J Vasc Surg 1998;28:746-52.
2. Kleinsasser LJ. Homologous graft replacement of major vessels, the aorta and its branches. Tex State J Med 1955;51:498-502.

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Regarding: "Anastomotic tissue response associated with expanded polytetrafluoroethylene access grafts constructed by using nonpenetrating clips"

To the Editors:

We have pondered with special concern the thorough study by Dal Pont et al (J Vasc Surg 1999;30:325-33), which dealt with arterial and venous anastomoses performed with nonpenetrating clips and conventional sutures.

Recently we systematically studied, on an experimental basis, the differences between the new nonpenetrating accurate-legged titanium clips (vessel closure system) and conventional sutures in arteries and veins of pigs.[1,2] Twenty end-to-end clipped and twenty sutured vessel reconstructions, using 7.0 polypropylene sutures, were carried out in the carotids, jugular, renal veins, and venae cavae, following transversal angiotomies. Harvesting of the repaired vessels was performed following angiographic evaluation of their patency 8 weeks later. The specimens were studied macroscopically and microscopically. The anastomoses remained patent in both methods with a sta-