

not increase the seal zone length and did not prevent a type I endoleak in two of the patients treated in their series.¹

Although the durability of endovascular repair for PAAA is unknown, the early benefits are clear in this high-risk group of patients. Customized fenestrated and branched stent grafts that will preserve flow to essential visceral arteries now allow proximal seal and fixation to be achieved at and above the renal level. This endovascular treatment option was not discussed by Sachdev et al but can, and should now be considered for the treatment of juxta-renal PAAA.²⁻⁵

We accept that in symptomatic patients there may not be the time to refer, plan, and manufacture these advanced stent grafts. In addition, the need for precise alignment/deployment can be technically more difficult when working within the reduced space of a previous surgical graft.^{3,5}

James R. H. Scurr, MRCS
Robert K. Fisher, MD, FRCS

Regional Vascular Unit, Royal Liverpool University Hospital
Liverpool, United Kingdom

Richard G. McWilliams, FCRS FRCS

Department of Radiology, Royal Liverpool University Hospital
Liverpool, United Kingdom

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Reply

Branched grafts may be particularly useful in the treatment of para-anastomotic aneurysms of the infrarenal aorta, which are characterized by short necks.¹ However, as is mentioned in the letter, the time required to refer the patients to centers that are currently per-

forming these procedures, as well as to manufacture the appropriate, custom-made devices, may prohibit expeditious repairs in patients who are symptomatic or ill. Furthermore, side branch technology, which is required for true pararenal and thoracoabdominal lesions, remains in the early stages of development.

The marked variability of the visceral artery takeoff from the aorta, combined with the frequently present occlusive disease in the visceral artery origins and throughout the artery, makes deployment as well as maintenance of patency challenging. None of the patients treated in this series had aneurysmal disease involving the origin of the renal arteries.

Although transrenal fixation does not necessarily increase the seal zone of endovascular stent grafts, it does allow for anchorage of the device in a segment of aorta that is usually spared from significant dilation.^{2,3} Our study demonstrates that devices that offer transrenal fixation may be adequate for treating aneurysms involving the proximal anastomosis of an infrarenal aortic graft.⁴

The letter writers correctly point out that proximal type I endoleaks developed in two of our patients after they were treated with devices offering transrenal fixation for proximal para-anastomotic aneurysms of the infrarenal aorta. However, 15 other patients treated with transrenal fixation for para-anastomotic aneurysms in the same location did not develop proximal type I endoleaks during a mean follow-up period of 20.7 months (range, 0.8-76.6 months).⁴ Although the use of branched and fenestrated grafts in patients with para-anastomotic aneurysms may be extremely useful in select patients, commercially available devices may exclude many of these aneurysms with satisfactory results, allowing for earlier time to repair in a greater number of centers.

Ulka Sachdev, MD
Michael Marin, MD

Department of Surgery
Mount Sinai Medical Center
New York, NY

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