with CLI requires evaluation by specialists. This evaluation should also consider the major decrease in quality of life after major amputation, the decreased productivity associated with major amputation, newly required nursing care costs, and economic and time burdens on the patient's family. However, we believe that cilostazol has been sufficiently evaluated and should be used in patients in whom the drug is expected to be particularly effective for major event reduction (age ≤75 years old, ambulatory, not receiving dialysis, Rutherford class V), as suggested in Fig 6 of our original article.[1]

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Regarding "Basilic vein transposition versus biosynthetic prosthesis as vascular access for hemodialysis"

Morosetti et al present a study concluding that, when possible, brachiobasilic arteriovenous fistula (BBAVF) should be created in preference to the insertion of an arteriovenous graft (AVG).[1] This conclusion concurs with those of other studies.[2]

The AVG group in the current study combines forearm loop AVGs (FLAVG) and brachioaxillary AVGs (BAAVG). This grouping should be considered to be inappropriate, as FLAVG and BAAVG are not directly comparable. The majority of AVG failures are due to stenosis at the venous anastomosis. These stenoses do not lead to draining vein occlusion, or adversely affect the arterial inflow.[3] The placement of a FLAVG should not therefore prevent the future creation of a BBAVF. The formation of a BBAVF, however, does preclude the formation of a FLAVG as, following occlusion of the basilic vein, only BAAVG can be considered. It is perhaps more appropriate to consider the FLAVG as a halfway house between a primary access (radiocephalic or brachiocephalic AVF), and a secondary access (BBAVF or BAAVG), and as such FLAVGs should be considered separately to BAAVGs.

A large multicenter randomized study directly comparing BBAVF and FLAVG showed that although primary patency rates are lower and complication rates higher in grafts, secondary patency rates were equivalent between the two groups.[4]

Although primary and secondary patency data in isolation are important for assessing the efficacy of a vascular access intervention, just as important is the effect that the intervention has on subsequent access attempts and longevity. Thus, as described above, as FLAVG does not preclude BBAVF formation and does not reduce venous capital, it may therefore increase the longevity of total vascular access attempts in that arm. Conversely, creation of BBAVF precludes FLAVG, reduces venous capital, and thus reduces the overall longevity of vascular access in that limb.

Finally, it is noteworthy that FLAVG with modern self-sealing grafts can allow almost immediate vascular access for emergency dialysis and act as a medium-term bridge to more definitive dialysis access.

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Reply

The comparison between the present study[1] and those reported in the other references[2,3] is not correct. In fact, they are retrospective studies, while our study is a randomized one (so the statistical power of our results is stronger despite the minor sample size).

Our data are not so far different from those reported in the current literature on this topic. In fact, most of the authors conclude that native vascular accesses show a better primary patency when compared with the prosthetic ones. Moreover, most of the authors consider prosthetic vascular accesses (VA) as a whole as one single group for follow-up, regardless of the different configurations and insertion sites. This is the reason why we gathered prosthetic VA in one batch as well.

Basilic vein stenosis and consequent thrombosis, which could develop after a forearm loop arterovenous graft implantation, in most cases makes basilic vein itself fully unusable for transposition, and in any case, it reduces the vessel length (which is itself a limit to transposition because often the vascular segment available for needle puncturing is not so long).

The randomized study by Keuter et al[4] compares "autogenous brachial-basilic fistula in the upper arm (BBAVF) or a prosthetic brachial-antecubital forearm loop (PTFE loop)," which are exactly the same VA kinds we considered. This puts in evidence the fact that forearm arterovenous grafts (AVGs) and basilic vein transposition represent two concurring chances for the surgeon in compromised patients. This study concludes that primary patency (PP) is lower for AVGs. In our study, we found that PP was higher for BBAVF; that is exactly the same conclusion. Similarly, results regarding secondary patency are superimposable between the two studies.

As regards the impact of a specific kind of VA set-up on subsequent attempts and longevity, keeping in mind the need to spare patient's vessels, we could state that a loop AVG could be implanted anyway after BBAVF thrombosis, using a brachial artery comitans vein.

Finally, we fully agree on the possibility of using AVGs as an immediate vascular access in selected patients. In fact, in our conclusions, we state that "given the shorter time to use, in subjects showing compromised clinical conditions and in who a temporary VA is not reliable, AVG could be the first choice."

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