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**AUTHOR CONTRIBUTIONS**

Conception and design: RS

Analysis and interpretation: RS, ML

Data collection: ML, JL

Writing the article: RS, ML

Critical revision of the article: RS, ML, JL, DS, DN

Final approval of the article: RS

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**REFERENCES**


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**DISCUSSION**

Dr Randolph L. Geary (Winston-Salem, NC). Dr Samson and colleagues are to be congratulated for a provocative presentation and excellent clinical results in a challenging group of patients. This topic is controversial and the literature fairly evenly split with half of the largest case series arguing left renal vein ligation is safe and the other half concluding the vein should be kept in continuity to avoid renal insufficiency, hematuria, or pelvic venous congestion. Our bias at Wake Forest is that mobilizing the vein and exposure of the juxtarenal aorta is required. We have a very low threshold to perform LRVDAL whenever improved exposure of the juxtarenal aorta is required.

The authors know whether transient renal dysfunction contributed to the length of stay or perhaps an increased number of cardiopulmonary complications? Again, I congratulate the authors on their excellent clinical results and thank them for bringing this controversial topic to our attention.

Dr Samson. Thank you for your questions, I am going to answer the last one first. I do not have the data to show whether their transient increase influenced the length of stay and it is something that we will look at and perhaps include in the manuscript. As far as whether we ligate the renal vein only when it is technically necessary or whether we have a low threshold – originally, in the study, obviously we ligated it only when we felt it was necessary. Now we say, if you don’t mind me being somewhat sarcastic, “hey look there is the renal vein, let’s go ligate it”, because we really do believe that it gets in the way and prevents operating on a more normal aorta. In our opinion, ligation of the renal vein is the key to safe aortic surgery and all theproblems that occur with aortic surgery occur when you try to operate to a diseased aorta. So we now ligate the left renal vein with impunity. The other problem with trying to preserve the renal vein and simply ligating its tributaries is that if you don’t get a good view of the aorta, you are then with your back against the wall because you can no longer ligate the vein. So we would much prefer to just ligate the vein at that time. Finally, all 8 patients with baseline renal failure were captured in the long-term follow-up.


