
DISCUSSION

Dr Ahmed M. Abou-Zamzam, Jr (*Loma Linda, Calif*). I would like to congratulate the authors on a nice presentation and a well-written manuscript. This single-center, retrospective study seeks to analyze the effect of tibial runoff on outcomes following primary stenting of superficial femoral (SFA) and popliteal artery disease. In a retrospective study of nearly 300 cases performed over 7 years, the authors have found that tibial runoff does not appear to influence overall outcomes. Primary patency and limb salvage were equivalent in patients with zero or one patent tibial arteries compared to patients with two or three patent tibial arteries. Not surprisingly, the Trans-Atlantic InterSociety (TASC) II classification did predict outcome. These results agree to some degree with numerous reports in the literature and add to the growing, and confusing, data regarding percutaneous treatment of infrainguinal disease. The one take-home message I can agree with is that TASC II classification trumps outflow. I have four questions:

First, the authors have chosen to use the simplified tibial runoff scoring system. This is pretty much a yes/no score for each runoff vessel. At this meeting 4 years ago, the Tucson group reported, using the more complex Society for Vascular Surgery (SVS) scoring system, that runoff did influence outcome following SFA stenting. Why the discrepancy in this report? Did you analyze your data with the more complete scoring system?

Second, you have adopted a policy of primary stenting. This study spans 7 years and undoubtedly numerous stent types. Everyone by now has their favorite stents for the SFA. What stent did you use, and why? Did you look at outcomes by stent types? Also, this study included no covered stents. Do you use them?

Third, your study includes a predominance of patients with claudication. We might understand caution in treating tibial disease in patients with claudication. However, when treating limb threat, isn't it tempting to intervene? Groups have suggested that if tibial outflow is compromised, perhaps results of SFA/popliteal interventions would be improved with tibial interventions. When should tibial interventions be performed?

Fourth, finally, did you do an analysis of primary assisted and secondary patency? How are these affected by runoff?

I enjoyed the presentation and manuscript and look forward to your responses. Thank you

Dr Jenny J. Lee. Dr Abou-Zamzam, thank you for your insightful comments and thoughtful questions. I will attempt to answer them in order. Our data were recently reanalyzed utilizing a modified SVS scoring system and we found that runoff did not affect primary patency rates using either scoring method. We currently employ a number of different nitinol stents and have found them all, with the exception of the Luminexx stent, to perform in a similar fashion. At present, we currently use covered stents infrequently, most often as a treatment for repetitive intrastent stenosis. Tibial intervention was performed concurrently in about 6% of our patients, all of whom had tissue loss or gangrene. Runoff was graded based upon completion arteriography. In answer to your final question, the focus of our paper was on primary patency rates, and primary assisted and secondary patency rates were not calculated. I would like to thank the society for allowing me to present our work and for the privilege of the floor. Thank you.