related to the amount of free cell area between scaffolding components. We have few comments.

From our animal laboratory experience we do agree that observed velocity alterations seem to be stent type specific. Far more than just free cell area, however, overall stent design and procedure related properties such as length, sizing, and self-expandability all influence post-procedural hemodynamic perturbations and velocities, even in the absence of residual stenosis.

Secondly, concerning the two predominantly used stents, the Wallstent is an example of a Braided Elgiloy Self-Expanding Stent (BESSE) constructed of independent wires. Acculink has a Surface-Spanning Micro Stent (SSMS) architecture with interconnected wires, and this, more than free cell area, influences wall apposition and subsequent alterations in carotid wall mechanics.

Thirdly, stent placement causes a compliance (Cp) mismatch between the stented part of the artery and its native upstream and downstream segments. In diseased arteries, the arterial wall contributes to the overall stiffness of the stented site, and this varies according to the amount of atherosclerosis and calcium load within the wall. Therefore, final Cp alters to various degrees, which might explain why DUS velocities are significantly elevated in a percentage of patients but not in all.

Fourth, current stents are self-expanding, and their diameters steadily increase with time (possible arterial remodelling), potentially achieving better expansion of the lumen. Serial measurements of stent diameter confirmed continued expansion after Wallstent deployment, with most marked expansion occurring during the first three months. Pierce et al aimed to analyze DUS before and immediately after stenting. However, post-intervention DUS was obtained in no less than a median five days (range: 1-25 days). This is a serious study limitation, and timing of postoperative DUS should have been standardized preferentially within 24 hours and at three months following the procedure. In the meantime, vascular laboratories should realize that carotid stent placement itself leads to elevated velocities, which might well be stent type specific.

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Reply
We appreciate the astute and thoughtful comments regarding our study. As outlined, it is certainly clear that many factors contribute to the elastic modulus and compliance of the carotid artery after stenting, which result in changes in flow hemodynamics. Our data highlights the importance of stent design and its salient role in demonstrating elevated duplex velocities in the absence of angiographically demonstrable stenosis after carotid stenting.

We do agree that the optimal timing of postoperative duplex ultrasound (DUS) after carotid stenting has not been established, but we doubt this is a real study limitation. Although initially we obtained duplex scans within 24 hours after stenting, the timing of the postoperative DUS was later postponed, primarily as a factor of study design. Many of the patients in our series were enrolled in post-marketing registries and clinical trials (eg, SAPIPHIRE, CREST, EMPIRE), all of which require post-intervention DUS at one month. Because most randomized clinical trials assessing carotid stenting required postoperative DUS at one and six months and yearly thereafter, such protocols have been widely adopted in most centers. We believe that DUS at one month should serve as a baseline study and that changes in blood flow velocities related to stent design are validated at this time period. Obtaining DUS at one and 90 days, as suggested, may be unnecessary, cost-ineffective, and clinically impractical. Obviously, long-term changes in blood flow velocities related to stent design and incidence of in-stent restenosis need to be further investigated. In this regard, we are currently conducting studies to quantify to what extent stent design differences in carotid velocities may influence DUS criteria for precisely defining restenosis after carotid artery stenting.

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Regarding “A randomized trial of cryo stripping versus conventional stripping of the great saphenous vein”

It was with great interest that we read the article by Klem et al, describing a trial comparing two methods of stripping of the great saphenous vein (GSV). They are to be complimented on having presented a clearly honest and large prospective series on cryo stripping. However, some comments have to be made.

The first comment is on the primary outcome, residual GSV at 6 months. Although it seems likely that residual GSV will influence the outcome at long-term, little is known about this phenomenon. We do know that residual veins after endovascular treatment do not correlate well with clinically recurrent disease. It is a pity, therefore, that authors did not mention clinical recurrent disease at follow-up; this should have given us at least an impression, especially since both techniques performed the same in the quality of life scores.

Second, I would like to comment on the technique used. Most surgeons that use the cryo device freeze much shorter than 10 seconds: 3 to 5 seconds suffice to adhere the vein to the probe, and in such manner, a much smaller part of the adjacent tissue will freeze together with the vein. Generally thereafter, the vein may be extracted after invagination, causing less tissue damage, and enabling a second or third passage of the probe in case the vein ruptures during extraction. Invagination is generally not possible when the cryo probe is used in the “classic” manner, with a large block of frozen tissue at the tip. The less subtle stripping, and the necessity of a cosmetically unwanted and time consuming distal inclusion in conventional stripping are the main reasons for using the cryo probe.

Third, I would like to emphasize the fact that significantly more of the patients lost for follow-up were in the conventional