CORRESPONDENCE


The systematic review and meta-analysis by Kakkos et al.1 highlights the non-inferior outcomes and safety of new oral anticoagulants (NOAs) used in venous thromboembolism (VTE) compared with conventional treatment with vitamin K antagonists (VKAs). However, there are few areas that remain unsettled and further analysis of the existing trials may be needed.

The results could possibly be different if cost-effectiveness and quality of life were analyzed. Although the authors mentioned the presence of cost-effectiveness studies of NOAs used to treat VTE,2,3 such analysis has not been provided in this meta-analysis to assess the cost–benefit ratio. One could reasonably argue that this issue could have an important impact, similar to that of the cost-effectiveness of NOAs versus VKAs, on the treatment of atrial fibrillation.4

Quality of life assessments of oral anticoagulants have been attracting interest since as early as in 1991.5 As such, a specific instrument has been developed and validated.6 Therefore, the inclusion of lifetime quality adjusted life years and cost of NOAs compared with VKAs as additional outcomes should be assessed in previous and future clinical trials.

REFERENCES


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We would like to thank the authors of this letter for giving us the opportunity to discuss further the value of the new oral anticoagulants (NOAs) in the management of venous thromboembolism (VTE), which was the subject of a meta-analysis recently published in the European Journal of Vascular and Endovascular Surgery.

Several areas remain unsettled, and further analysis of the existing trials may provide additional information on the efficacy and safety in predefined subgroups of the trials, although this process will limit the power of the analysis. Assessment of cost-effectiveness requires specific methodology, and was not the purpose of the investigation. This is usually a stand-alone study based on the results of the original studies. However, it is agreed that cost-effectiveness studies should be performed, particularly in the secondary prevention of VTE, where an improved patient survival with the NOAs compared with placebo was evident from this meta-analysis. Likewise, the reduced bleeding rate with the NOAs compared with warfarin in VTE treatment is expected to tip the balance in favour of the former. Ideally, cost-effectiveness studies also should be carried out for each NOA separately, because of the different properties of these agents. Secondary prevention studies comparing the NOAs with warfarin head-to-head in patients with unprovoked VTE are scarce (RE-SONATE trial), and could be performed to
Re: ‘Aneurysmal Degeneration of the Inflow Artery after Arteriovenous Access for Hemodialysis’

We read with interest the recent article by Mestres et al. and would like to congratulate our colleagues on such a high number of cases. In our recent review we found only 23 cases reported between 1951 to 2014. The authors conclude that bypass remains a safe and effective option. Given the fact that donor artery aneurysm formation is the result of long-term (10–15 years from the time of construction) pathophysiological processes, bypass might be a safe but not necessarily the best long-term solution. Firstly, recognition of a “non-affected arterial section” by chronic aneurysmal degeneration for the proximal and distal landing zone of the bypass remains difficult. Secondly, the majority of these patients present with pain as a consequence of compression of nerves, veins, and/or local tissue, thus a complete resection and end to end grafting might be more effective in alleviating symptoms and restoring flow. Thirdly, aneurysmectomy followed by interposition grafting (vein, PTFE, and composite) tends to maintain more of the natural anatomy thus reducing the susceptibility of the new bypass to trauma, kinking and/or compression. Finally, only one case (n = 1) in the series (n = 12) was treated by aneurysmectomy and therefore the authors have not provided adequate numbers for comparison of long-term outcomes among the two surgical modalities of exclusion and bypass versus aneurysm resection and interposition grafting.

Overall, we acknowledge that such cases pose a significant challenge both in detection and surgical correction. With the longer duration of AVF in combination with prolonged life, it is perhaps no surprise that we are witnessing more of these “inflow aneurysmal degenerations” that were once rare in clinical practice.

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None.

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**REFERENCES**