repair. The latter perhaps may be due to patient preference, clinical deterioration, or severe comorbid conditions that preclude survival even with attempted repair.

We believe that the transfer process for rAAA can be improved to ensure optimal outcomes with efficient utilization of resources. Potential strategies include improvements in the transfer process, as outlined by Dr Altreuther, as well as improved guidelines to identify patients whose survival is unlikely and for whom care measures other than transfer may be considered.

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Regarding "Prospective, randomized study of cutting balloon angioplasty versus conventional balloon angioplasty for the treatment of hemodialysis access stenoses"

In their recently reported randomized trial, Saleh et al found that cutting balloon angioplasty improved treatment area primary patency of graft-vein anastomotic lesions at 6 and 12 months compared with conventional balloon angioplasty.[1] However, for lesions at other locations treated with cutting balloons, there was no benefit over conventional angioplasty. We believe the study has several important limitations that require further discussion.

The study included both native arteriovenous fistulas (AVFs) and prosthetic grafts, but it is well established that prosthetic grafts require more interventions to maintain patency than AVFs do.[2] These two scenarios have vastly differing pathologic processes and outcomes and cannot be grouped as if similar. Reporting the proportion of native AVFs and grafts in the study and subgroup analysis separating both types of access would provide additional important information.

Saleh et al classify lesion location into four categories: venous, graft-to-vein anastomotic, intragraft, and arterial anastomotic. In native AVFs, only two of these categories apply. In such cases, venous refers to all lesions from the arteriovenous anastomosis to the cephalic arch. The terminal portion of the cephalic vein is particularly prone to restenosis after conventional angioplasty and is, in and of itself, an area of research interest. Observational studies also suggest that lesion length and angioplasty in newer AVFs may also be associated with higher rates of restenosis.[3] Information on access age, lesion characteristics, and comparison of patency at other specific venous locations might generate additional hypotheses on the indications for cutting balloon use.

Cumulative or secondary patency (ie, the time from initial angioplasty until the access is abandoned) is the most important outcome for patients as it represents the functional life of the access. However, the authors do not report this outcome; instead, the main patency definition used is treatment area primary patency. Reporting access circuit primary patency (ie, the time from initial angioplasty to repeated endovascular intervention for any lesion in the access circuit) is mandatory and ultimately more important than isolated lesion primary patency. Thrombosis leading to access loss is important because of the potential for exposure of the patient to mortality risk associated with central venous catheters. Freedom from access interventions is another important measure of quality of life for hemodialysis patients. None of these clinically meaningful end points are measured or reported in the trial.

This study is timely, given the increasingly strong evidence supporting the use of stent grafts in many of these scenarios, such as the original FLAIR trial and presented results of REVISE and RENOVA, all randomized trials demonstrating graft preservation superior to angioplasty to 2 years.[4] One other recent study, by Aftab et al, suggested the utility of cutting balloon compared with angioplasty in AVFs,[5] although Vesely and Siegel's larger trial in prosthetic grafts did not.[6] Given these mixed messages and limits of presented data within the current study, we believe that the study by Saleh et al does not support the widespread use of cutting balloon angioplasty for dialysis access stenosis.

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Regarding "Management of acute limb ischemia in the pediatric population"

Peripheral vascular injuries of the lower extremity in the pediatric population are rare but can result in significant morbidity. These injuries are usually iatrogenic after catheterization or invasive monitoring. Pediatric peripheral vascular trauma is far less frequent, and there is scarcity of reported experience with

management of such injuries. In the trauma setting, the management has traditionally been based on adult experience; but vascular injuries of pediatric patients may differ from those of adults in that significant injuries are underdiagnosed because they are more commonly asymptomatic, are more associated with vasospasm, or occur with more severe life-threatening injuries that take priority in the resuscitation process.[1]

Kayssi et al[2] recently described their large series of 151 pediatric vascular injuries secondary to multiple causes, mostly iatrogenic injuries. They demonstrated successful outcomes by using nonoperative management with anticoagulation in most patients. Although all of their trauma patients underwent operative intervention, there is no consensus yet regarding the necessity of immediate surgical treatment of all such injuries, especially in neonates and infants. We recently reported our experience with 32 pediatric lower extremity traumatic vascular injuries that underwent definitive operative repair.[3] The greatest concerns with vascular injuries in pediatric patients are restoration of sufficient circulation and future limb growth with vascular repair. If minimal vascular injury is present, primary repair should be the preferred technique. Autologous grafts, such as reversed saphenous vein, are preferred if primary repair is not feasible and have demonstrated the best long-term outcomes.[4] Synthetic conduits, such as polytetrafluoroethylene graft, can also be successfully used, but they are more prone to infection, and small-diameter grafts have higher thrombosis rates with poor long-term patency.[5] In our series, both synthetic and autologous grafts were used more commonly than primary repair. We advocate that vascular anastomosis be performed with interrupted sutures to accommodate growth patterns in children. Continuous suture repair may lead to arterial narrowing with progressive limb growth.

On the basis of our experience, the management of traumatic lower extremity vascular injuries in pediatric patients requires early identification and prompt surgical intervention in nearly all cases and can result in acceptable early outcomes. Surgical repair can be undertaken in older children as in adults, but it may be extremely challenging in those infants younger than 2.5 years. In this age group, there is a great potential for rapid growth of adequate collateral circulation, and conservative management with anticoagulation may be attempted initially in a nonthreatened ischemic extremity.[6] Such complex lesions should be managed in tertiary specialized care facilities with a multidisciplinary team involving trauma and pediatric surgeons and pediatricians. We look forward to seeing further clinical experience and guidelines to orient vascular and trauma surgeons in the management of such complex injuries.

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A Society changes its name: The Peripheral Vascular Surgery Society becomes the Vascular and Endovascular Surgery Society

It is not the strongest or the most intelligent who will survive but those who can best manage change.

—Charles Darwin

If you choose not to decide, you still have made a choice.

—Neil Peart

The name of any professional group should reflect the membership. Thus, after many years of discussion and debate, the Peripheral Vascular Surgery Society has changed its name to the Vascular and Endovascular Surgery Society (VESS). This Society was formulated in 1976 as the Peripheral Vascular Surgery Club and has grown during 40 years to become a national group devoted to the young vascular surgeon in his or her first 15 years of practice.

The rationale for changing the name of the Society was based on multiple elements.

1. *Peripheral vascular surgery* is considered an outdated term from the 1970s differentiating cardiac/coronary surgeons from vascular surgeons. Most current vascular surgeons and trainees perform plenty of "central" vascular surgery and intervention including thoracic, abdominal, visceral, and central venous procedures.

2. Peripheral vascular surgery does not match the Board Certification title for our field. In the recent era, all American Board of Surgery certificates are for Vascular Surgery. In addition, most practices, academic divisions, and vascular journals do not include the term *peripheral* in their title.

3. The public barely understands what a vascular surgeon does, let alone a "peripheral vascular surgeon." A consistent and cohesive name helps build the brand for vascular surgeons. "Peripheral" connotes something of less importance—certainly something we do not want to highlight.

4. Endovascular procedures are becoming a larger component of our members' practices.

The process to change the Society name appeared simple but actually was an arduous task. An ad hoc committee including the authors of this communication came up with a list of possible alternative names, performed a SWOT analysis, surveyed the

VESS Vascular & Endovascular Surgery Society
Formerly PVSS, founded 1976