

DISCUSSION

This case presentation raises a number of interesting points pertinent to false aneurysms of the subclavian arteries in general and the decision process about their treatment in particular. It is clear from our experience that duplex scanning and angiography can be complementary investigations, particularly in the context of an iatrogenic needle injury to the artery in question. Indeed, in the case presented here, the angiogram raised the suspicion that more than one arterial injury had been sustained. This finding, taken together with the description of events at the time of the original injury, not only influenced our decision on the mode of treatment but also helped guide our operative approach to the false aneurysm.

Wherever possible, we agree that the ideal treatment of iatrogenic false aneurysms should be by duplex scanning directed manual compression. However, it is clear that in certain circumstances, it is not possible to adopt such an approach because of the anatomic location of the injured vessel. The decision on the ideal management of such a lesion then lies between direct operative repair and the innovative covered stent approach described by Marin et al. Given our experience with an iatrogenic false aneurysm that had more than one associated arterial injury, we wondered whether the authors have had any experience with a similar lesion and if so, whether they have attempted its repair by an endovascular approach?

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Reply

To the Editors:

We have read with interest the letter by Chalmers, Brittenden, and Bradbury. The nonselective arteriogram in their patient fails to clearly reveal the site of arterial injury responsible for the false aneurysm. Despite the fact that we can see no firm evidence in their illustration that more than one arterial injury existed, in the presence of incomplete angiographic documentation of the site and nature of the injured artery or arteries, a traditional operative approach would appear to be reasonable and was obviously successful.

However, better arteriography with selective injection of the right common carotid and subclavian arteries probably would have more accurately defined the nature and location of the arterial injuries. Armed with this information, the authors could have treated the lacerated carotid artery with a stent graft or covered stent and the

lacerated thyrocervical trunk by subselective catheterization and coil embolization.

We have successfully used these techniques to treat individual patients but have not as yet treated this exact combination of injuries in a single patient. However, we believe that these endovascular approaches, when guided by better arteriography, will be more widely used and will become the future standard of treatment for even complex arterial trauma such as in the case that Chalmers et al. have described. Accordingly, operative morbidity rates and treatment costs will be reduced.

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Regarding "Presidential address: Transluminally placed endovascular stented grafts and their impact on vascular surgery"

To the Editors:

In his presidential address to the Eastern Vascular Society (J VASC SURG 1994;20:855-60), Dr. Veith draws our attention to the growing antagonism between vascular surgeons and radiologists. He predicts a war over the issue of transluminally placed endovascular grafts if no measures are taken to avoid an escalation of the conflict. Casually, he introduces the abbreviation TPEGs for this procedure by using it more than 50 times in his article.

We believe not only that the word TEAM is a better acronym (transfemoral endovascular aneurysm management) but that it is also a key factor for putting an end to the so-called "turf battles." In addition, TEAM is more specific than TPEGs in that it refers to only one group of indications for endovascular treatment (aneurysms).

Furthermore, we do not believe that the solution to the conflict Dr. Veith offers is one of "mutual understanding, cooperation and compromise," as he puts it. He suggests that vascular surgeons should become sufficiently competent in catheter techniques to allow them to perform endovascular procedures without interventional radiology support, unless they encounter an unusual problem. For vascular surgeons and radiologists, this would be a role reversal with regard to current balloon angioplasty and stent placement. But the taking over of vascular cases by radiologists has never been appreciated by vascular surgeons in the first place, and therefore this option smells of retaliation. Simple monopolization of the TEAM procedure will not lead to much mutual understanding.

Dr. Veith also believes that vascular surgeons can provide their own training in endovascular techniques. If cooperation is the aim, training programs in catheter guide wire-imaging-stent methods must be coordinated with interventional radiologists. Such a team approach will also improve radiology training programs.

Vascular surgeons are in no position to propose a compromise of giving up balloon angioplasty and stent placement. These procedures are out of their hands. With further development of percutaneous endovascular grafting techniques, it is unlikely that interventional radiologists will give up something that is coming their way for something they already have.

A healthy cooperative relationship can only exist if both parties benefit. In our opinion, the establishment of a vascular team composed of both specialties is the only way radiologists will regard themselves as more than just executors of other physicians' demands. Interventional radiologists and vascular surgeons together must be involved in all aspects of the treatment of vascular disease: diagnosis, imaging, intervention, and follow-up.

The complexity of vascular disease requires a multidisciplinary approach. After all, our main concern is providing our patient with the best possible treatment, not which specific treatment modality is used or who performs it.

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Reply

To the Editors:

I agree heartily with the concepts expressed in the final two paragraphs of the letter written by Dr. Blankensteijn and his colleagues. I only add that ultimately the best way to achieve a healthy cooperative multidisciplinary approach to the treatment of vascular disease is by having the various specialists work together in a combined service or department. In that way, economic considerations are less likely to cause trouble.

I also have some points of disagreement with the Blankensteijn letter. The acronym *TEAM* (transfemoral endovascular aneurysm management) is an inappropriate expression for transluminally placed endovascular grafts (TPEGs). Endovascular grafts can be used for arterial lesions that are not aneurysmal. Traumatic and occlusive arterial lesions are only two such examples.^{1,2} Moreover, the abbreviation *TPEG* was not introduced "casually" but was arrived at after much deliberation by a combined group of 17 surgeons, radiologists, and other scientists who wrote the "Guidelines for Development and Use of Transluminally Placed Endovascular Prosthetic Grafts in the Arterial System" (*J VASC SURG* 1995;21:670-85; *J Vasc Intervent Radiol* [In press]). Furthermore, I do not believe acronyms put an end to potential conflicts. Unfortunately, the world and human nature are not that simple.

The "taking over of vascular cases by radiologists" is

not what my Presidential Address to the Eastern Vascular Society was all about. The Address was given as a declaration that times and treatment techniques are changing and that vascular surgeons must evolve to adapt to these changes. One such adaptation is to work more closely with interventional radiologists as our group has always done.^{3,4} Another adaptation is to learn some basic catheter-guide wire-imaging skills because these will be required not only in TPEG placement but also in the improvements that are being made in standard vascular operations. Fluoroscopically assisted thromboembolectomy is only one example of such an improvement.

Because I and most of my colleagues in vascular surgery have always been appreciative when the management of a difficult vascular case has been facilitated by an interventional procedure performed by one of our interventional radiologists, there is no need to retaliate. This appreciation will only increase in a managed care environment in which the economic advantages of better, more efficient collaborative care are enhanced. Moreover, our track record and the combined authorship on our publications clearly demonstrate the sincerity of our interspecialty cooperation and the fact that we do not favor "monopolization" of any aspect of vascular disease treatment.^{1,4}

We also agree heartily that the best way for vascular surgeons to obtain training in catheter-guide wire-imaging techniques is by working as a member of a cooperative multispecialty group. However, at the time of my Presidential Address, this pathway to obtain such training was not widely available; hence, my other suggestions for alternative pathways whereby vascular surgeons who were competent in these techniques could provide such training.

My suggested compromise of maintaining the status quo with regard to balloon angioplasty and stent placement was designed to prevent the potential problems that might arise when and if vascular surgeons begin to use these techniques more widely. Moreover, my Dutch colleagues should realize that in many communities in the United States vascular surgeons presently perform balloon angioplasty and stent placement.

Finally, the right to use TPEGs is not something that belongs to any specialty. It is not "something that is coming their way" by God-given right to interventional radiologists alone—or to vascular surgeons alone. TPEGs are a new development that have grown out of the skills and techniques of both interventional radiology and vascular surgery. TPEGs should be used by both specialists, preferably working together collaboratively and cooperatively. My Presidential Address was specifically intended to promote precisely that sort of collaboration.

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REFERENCES

1. Marin ML, Veith FJ, Panetta TF, et al. Transluminally placed