

Response to 'Re. Spontaneous Delayed Sealing in Selected Patients with a Primary Type-Ia Endoleak After Endovascular Aneurysm Repair'

We have become dependent on imaging to define the need for and timing of interventions after EVAR. Imaging, however, is not without limitations and patients at persistent risk of rupture may frequently be misidentified. Intermittent or position dependent type-I endoleaks are a good example of the situation where absence of endoleak on CTA may not be a perfect surrogate of success.¹

In another publication, it was found that effective sealing in heavily thrombotic necks is possible as neck remodelling results in thrombus dissolution and complete graft-wall apposition in the mid-term. This occurred without any additional risk of rupture.² However in the present study, the authors believe that thrombosis was not the reason why the primary endoleaks sealed spontaneously.

The appropriate interpretation is different. Much has changed in the technology, planning and execution of EVAR since the consensus publication of 2002.³ In the case of appropriate evaluation of neck suitability, correct sizing and implantation, and consequently optimal sealing of the proximal endograft, immediate type-Ia endoleaks are most likely transitory. A watchful waiting period may be preferable to an aggressive strategy directed at immediate repair. In contrast to what is suggested, the authors defend the position that an unnecessary obsession with intra-operative correction of the picture may well result in the loss of a life.

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Re: 'Long-term Outcomes and Sac Volume Shrinkage after Endovascular Popliteal Artery Aneurysm Repair (EVPAR)'

I read the article by Piazza et al.¹ with interest, as it seems clear that endovascular exclusion of popliteal artery aneurysms (PAAs) is here to stay. There are a few issues to be considered, though.

Firstly, the suggested 20-mm threshold may be obsolete given that papers recommend a wait-and-watch policy up to a 30-mm threshold, other considerations being thrombus burden, distal embolization, inflow, and outflow vessel angulation.²

Secondly, the authors indeed highlight the fact that less than three-vessel runoff is acceptable, an important issue that some surgeons think is a contraindication, and this is a welcome point. They indicate that they never deploy below the knee joint: the radiological knee joint and the actual line of knee flexion are two completely different areas. If their endografts all landed down to the radiological joint then the graft is still across the line of knee flexion, which is actually the inter-epicondylar line.³ We readily land the distal end of endografts into the below-knee popliteal arterial segment ("P3") leaving enough for salvage bypass. As they are treating small PAAs then they likely gain the luxury of a distal neck, probably above the knee joint/flexion line ("P2"). They say nothing about their endovascular strategy for a large PAA that still has a good P3 segment to land in. However, complete deployment above the knee may lend itself to EVPAR even in younger, more active patients, something to consider in the future.

Thirdly, while they effectively summarize that their first line is open surgical repair (OSR), issues like age and lifestyle are not commented on older, sedentary patients in whom our first approach would be EVPAR as a default, including synchronous bilateral approaches.⁴

At our centre, we have had experience with both flow-modulator stents⁵ and heparin-bonded endoprostheses (Viabahn, WL Gore & Associates, Inc., Medical Products Division, Flagstaff, AZ, USA) in the femoropopliteal segment in about 30 patients in the last 4 years, with results in the later group as promising as the authors suggest. Surveillance ought to be continued for at least 5 years if not indefinitely, given specific device issues in that they lack barb fixation (as opposed to AAA endografts) and are subject to the extreme stresses that are a default of the