

6. Last but not least, many of the relatively few eligible patients simply did not want to enter the trial after 3-6 months on best medical treatment. This is perhaps not surprising, given that intermittent claudication tends to affect an elderly population, who are often socioeconomically disadvantaged and have other comorbidity.

Unfortunately, the premature closure of EXACT means that for the foreseeable future, clinicians will continue to have little or no evidence regarding the adjuvant treatment of infringuinal intermittent claudication. The question is whether a randomized-controlled trial to compare supervised exercise and balloon angioplasty in this condition is feasible and, if so, affordable.

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Regarding "Endovascular management of iliac artery occlusions: Extending treatment to TASC C and D lesions"

I read with great interest the report on the results of endovascular recanalization of iliac artery occlusions by Leville et al.¹ I had the privilege of listening to its presentation in the Society for Vascular Surgery Meeting in Chicago and have been anxiously waiting for the written report. In addition, I had the privilege of the floor and inquired about the wide discrepancy between the limb salvage and patency rates, with limb salvage being significantly lower than the patency rates in the TASC C and D groups. Interestingly, when the report was published in the January 2006 issue of the *Journal of Vascular Surgery*, the patency and limb salvage rates were very different. The 3-year primary patency, secondary patency, and limb salvage rates, as presented and published in the abstract book,² were 88%, 92%, and 100% in TASC B; 82%, 97%, and 86% in TASC C; and 70%, 97%, and 62% in TASC D lesions, whereas the corresponding numbers in the *Journal of Vascular Surgery* article were 78%, 95%, and 100% in TASC B; 73%, 93%, and 97% in TASC C; and 80%, 83%, and 95% in TASC D lesions. Although the number of patients treated for iliac disease remained at 628 for both reports, those treated for occlusions increased from 82 to 89. The number of legs treated increased from 88 to 92, whereas the total number of amputations remained at 2. Thus, these minor changes fail to explain the significant differences in patency and limb salvage rates.

I am quite surprised at the wide discrepancy in the presentation and published article. When papers are presented in Society for Vascular Surgery or other regional meetings, the impression is that the paper is submitted at the time of presentation. Although it is understandable to have some minor changes from the abstract, is it really acceptable to come up with a whole new data set and

conclusions in the later publication? Maybe papers should not be allowed to be presented in the meeting unless they are submitted in advance to the program committee, to prevent inadequately analyzed data from being presented in prestigious meetings.

I wish to emphasize that I will continue to look forward to studies coming from the well-respected institution reporting the above study and have the utmost respect for all involved.²

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Reply

We appreciate Dr Dostluoglu's interest in aortoiliac occlusive disease and his keen reading of both the Society for Vascular Surgery (SVS) abstract and the eventual *Journal of Vascular Surgery* (JVS) publication. There is a discrepancy between the table in the SVS abstract and Table II in the JVS publication. Initially, we calculated limb-salvage rates by life-table analyses and included four patients with transmetatarsal amputations. This was identified and recalculated according to SVS criteria, dramatically increasing limb salvage rates.¹ Overall primary patency at 3 years was 76%, and secondary patency was 90% according to Kaplan-Meier analyses—a bit lower than the 77% and 95%, respectively, reported in the SVS abstract. The changes in patency were due to adding an additional seven patients to the analysis and having more complete follow-up data on all patients.

We can understand any confusion that may have arisen because of the initial abstract table and Table II in the eventual publication. This can occur in rigorously analyzing any dataset undergoing peer review. However, we respectfully disagree that this represents coming up with "a whole new data and conclusions" (personal communication, April 3, 2006). The text and tables in the final JVS publication are correct. The conclusions did not change. We hope that the message is clear that endovascular recanalization of occluded iliac arteries can be accomplished with high technical success rates, low morbidity, and acceptable mid-term durability. In patients with aortoiliac occlusive disease, correcting the concomitant femoral and infrainguinal disease present extends the ability to treat this complex group of patients with endovascular methods.

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Heart of England NHS Foundation Trust. Donald J Adam. Donald J Adam. Heart of England NHS Foundation Trust Â· Vascular Surgery. 40.12. Â· MB ChB, MD, FRCSEd, FRCS (Gen Surg). Contact. About.Â· Methods: This was a cross-sectional study in a vascular surgical outpatient department of a large teaching hospital. Participants were 100 consecutive subjects presenting to a hospital View. Simon D Hobbs Andrew W Bradbury. J Vasc Surg 2006 Aug;44(2):432-3. View Article.Â· University Department of Vascular Surgery, Heart of England NHS Foundation Trust, Birmingham, UK. View Article. Download full-text PDF.Â· University Department of Vascular Surgery, Research Institute, Lincoln House, Birmingham Heartlands and Solihull NHS Trust, Bordesley Green East, Birmingham B9 5 SS, UK. View Article. Download full-text PDF. Simon D Hobbs, MBChB Andrew W Bradbury, MD. Heart of England NHS Trust University Department of Vascular Surgery Lincoln House Heartlands Hospital Birmingham, UK. REFERENCES. 1. Leng GC, Fowler B, Ernst E. Exercise for intermittent claudication.Â· Hasan H. Dosluoglu, MD. Department of Surgery SUNY at Buffalo VA Western NY Healthcare System Buffalo, NY. REFERENCES. 1. Leville CD, Kashyap VS, Clair DG, Bena JF, Lyden SP, Greenberg RK, et al. Endovascular management of iliac artery occlusions: extending treatment to TASC C and D lesions. J Vasc Surg 2006;43:32-9. 2. Leville GD, Kashyap VS, Clair DG, Lyden SP, Greenberg RK, Erzurum VA, et al.