

CORRESPONDENCE

Conservative Therapy vs. Extensive Stenting in Superior Mesenteric Artery Dissection: the Right Balance remains to Be Found

In their paper, Jia et al.¹ reported an impressive experience of bare stents with or without assisted coiling for isolated mesenteric artery dissection (IMAD) aneurysms. Interestingly, this paper questions the benefit of a more interventionist attitude in IMAD, as 35% of IMAD patients were treated by stenting for aneurysm, which contrasts with the current trend favouring conservative therapy.² This rate is much higher than that reported by Wang et al.³ in a recent meta-analysis gathering 904 symptomatic IMAD, where only 3% (29/904) of patients underwent an intervention for aneurysmal degeneration. Even though the natural course of IMAD remains unclear, especially in terms of morphological progression, the short delay of one month between onset of symptoms and endovascular treatment reported by Jia et al. would reflect a rapid aneurysmal degeneration in this population. However, as bare stents do not aim to exclude an aneurysm, it is hard to evaluate their direct effect on superior mesenteric artery (SMA) remodelling compared with the spontaneous evolution with conservative therapy.

Moreover, it would have been interesting to detail patient selection and medical treatment to better understand the indications for stenting, especially regarding their definition of IMAD aneurysm: 1.5 times the diameter of the normal SMA. Surprisingly, the overall median diameter of IMAD aneurysm was 7.5 mm (range 7–9 mm), which is much lower than diameters observed in our intestinal stroke unit. This highlights that maybe we should not apply the same morphological reading grid to define IMAD aneurysm in Asian and Caucasian patients. Although most IMAD studies come from East Asia, ethnicity is not documented in the literature, pointing to the need for morphological studies in different IMAD populations to define SMA reporting standards to guide our daily practice. A better understanding of SMA remodelling is needed to find the right balance between conservative therapy and intervention for IMAD.

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Iannis Ben Abdallah*
Department of Vascular and Thoracic Surgery, Hôpital Bichat, SURVI (Structure d'URgences Vasculaires Intestinales), Intestinal Stroke Centre, Groupe Hospitalier Universitaire Paris Nord Val de Seine (GHUPNVS), Faculté de Médecine Denis Diderot, Paris, France
Unité de Recherche en Développement, Imagerie et Anatomie, Université Paris Descartes France, Paris, France

Salma El Batti
Unité de Recherche en Développement, Imagerie et Anatomie, Université Paris Descartes France, Paris, France
Departement of Vascular Surgery, Hôpital Européen Georges Pompidou, Paris, France

Audrey Huguet, Olivier Corcos
AP-HP, Hôpital Beaujon, SURVI, service de gastroentérologie, MICI et assistance nutritive, France
Université Sorbonne-Paris Cité, Paris, France
Hôpital Bichat, Laboratory for Vascular Translational Science, Paris, France

Yves Castier
Department of Vascular and Thoracic Surgery, Hôpital Bichat, SURVI (Structure d'URgences Vasculaires Intestinales), Intestinal Stroke Centre, Groupe Hospitalier Universitaire Paris Nord Val de Seine (GHUPNVS), Faculté de Médecine Denis Diderot, Paris, France

*Corresponding author. Department of Vascular and Thoracic Surgery, Hôpital Bichat, SURVI (Structure d'URgences Vasculaires Intestinales), Intestinal Stroke Centre, Groupe Hospitalier Universitaire Paris Nord Val de Seine (GHUPNVS), Faculté de Médecine Denis Diderot, Paris 7, France.

Email-address: ian.benabdallah@gmail.com (Iannis Ben Abdallah)

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Re: “Conservative Therapy vs. Extensive Stenting in Superior Mesenteric Artery Dissection: the Right Balance has to Be Found”

I thank Ben Abdallah and colleagues for their letter. I would certainly agree that most patients with isolated mesenteric artery dissection resolve completely with conservative management. Most of the patients were treated before

2014 in our three institutions. In recent years, especially since 2015, endovascular stent placement has declined. Although bare stents do not aim to exclude an aneurysm, endovascular stenting is a favourable factor for mesenteric artery remodelling in our further study. The indications for endovascular stenting remain an unanswered challenge at present. Ben Abdallah et al. have appropriately brought this consideration to the attention of readers of the *European Journal of Vascular and Endovascular Surgery*.

Zhongzhi Jia
 Department of Interventional Radiology, The Affiliated
 Changzhou No. 2 People's Hospital of Nanjing Medical
 University, Changzhou, China
 Email-address: jjazhongzhi.1998@163.com

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Re. “Illusory Angiographic Signs of Significant Iliac Vein Compression in Healthy Volunteers”

I read with interest the article by Timme et al.,¹ which raises concerns about the currently accepted diagnosis and management of May-Thurner syndrome (MTS). The authors show that left common iliac vein compression is common and that the accepted “pathological signs” of MTS, i.e., antero-posterior compression or venographic collaterals, may, in fact, represent normality. This makes logical sense as the interface between the two moving vessels will be dynamic and positional so supine imaging may not be reflective of functional anatomy or define pathology.

More than half of all deep venous stents implanted worldwide are for MTS.^{2,3} While technical success is reported in 80–90% of post-thrombotic cases at 1–2 years,⁴ these data raise the question of whether clinicians should transpose these successes and intervene on May-Thurner (MT) anatomy. It appears that MT “syndrome” needs to be further defined. Data on patient outcomes and on those in whom stents occlude are lacking. Should we be intervening in MT anatomy outside the setting of a clinical registry or trial?

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Toby Richards

The University of Western Australia, 35 Stirling Highway,
 Perth, WA 6009, Australia
 Email-address: toby.richards@uwa.edu.au

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Response to “Re. Illusory Angiographic Signs of Significant Iliac Vein Compression in Healthy Volunteers”

We appreciate the comments concerning our recent article and would like to reply to the questions raised.

Misconceptions are likely to occur if we do not agree first on a mutual language or nomenclature. May and Thurner identified not merely compression of the left common iliac vein (CIV) when they sought the cause of the disproportionate occurrence of left sided pelvic vein thrombosis. In fact, they discovered a “spur like projection” at the mouth of the vena cava. Over the years, this original finding got lost in translation in several publications introducing the May-Thurner syndrome (MTS), inconsistently used to describe a compression of the left CIV by the right common iliac artery or a combination of ill defined complaints in the left leg caused by such a compression. To further complicate matters, “iliac vein compression syndrome (IVCS)” and “non-thrombotic iliac vein lesions (NIVL)” were introduced. However, there is no such thing as “May-Thurner anatomy.” We should instead use the term “anatomical variation.”¹

We agree that supine imaging may not encapsulate the entire problem of pelvic vein compression. Sadly, all modern imaging modalities are routinely performed in the supine position and we currently know of no acceptable alternatives.

Currently, a compression of the left CIV of 50%, especially in the presence of pelvic vein collaterals appears to be an indication for offering endovascular treatment. We raise concerns with this strategy and acknowledge the importance of clinical evaluation, rather than imaging based decision making. We are currently running a RCT to analyse the quality of life improvement after deep venous intervention compared with conservative treatment.²