

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*.

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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.,<sup>1</sup> 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.<sup>2,3</sup> While technical success is reported in 80–90% of post-thrombotic cases at 1–2 years,<sup>4</sup> 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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### 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.”<sup>1</sup>

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.<sup>2</sup>

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