papers using the term "sarcopenia" interchangeably with low skeletal muscle mass. Sarcopenia is an age related loss of skeletal muscle mass and function. It is recognised now as a disease and has its own International Classification of Diseases-10 code. It is not an equivalent of the radiologically measured surrogates of the muscle mass. Low skeletal muscle mass on the other hand is an essential component not only of sarcopenia, but also cachexia associated with chronic disease or cancer. This implies that not every patient with low muscle mass is strictly sarcopenic.

Several thresholds for low radiologically assessed skeletal muscle mass have been published, often based on relatively small cohorts not allowing for generalisation of findings.[2,3] We agree with Jones and Waduud that since muscle mass in healthy subjects correlates with age and sex (and also ethnicity), it would be very difficult to apply these thresholds if these factors are not accounted for. It is also strange that height adjustment is used in many papers. The European Working Group on Sarcopenia in Older People (EWGSOP) does not make any recommendations on adjustment for body size.[4] Derstine *et al*.[5] published cut off values for both height adjusted and non-adjusted low muscle mass and both can probably be used interchangeably. We postulate that sex, age, and ethnicity adjusted cut offs would be far more useful.

Secondly, retrospective analyses of patients treated for aneurysmal disease are tainted with a significant selection bias. It is therefore quite possible that together with inadequate assessment/adjustment of skeletal muscle mass, this factor is also responsible for the variable effect of low skeletal muscle mass on outcomes.

In an attempt to circumvent such constraints, we applied random effects models of meta-analysis and performed sensitivity and subgroup analyses, which did not demonstrate significant differences in effect estimates. Unfortunately, the reports do not present coefficients from Cox proportion hazards regression models, so that Cox hazard ratios adjusted for common confounders can be put in inverse variance meta-analysis models. Meta-analysis of individual patient instead of aggregate data in prognosis research would provide a way of baseline (prognostic) factors being adjusted for consistently across studies, prognostic models being generated and validated, and multiple individual level factors being examined in combination.[6]

Our meta-analysis based on the available evidence cannot give definite answers. However, it can inform researchers of developments and assists in designing future research. We fully support Jones and Waduud's conclusion that presented results should be interpreted with caution.

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## Endovenous Thermal Ablation for Incompetent Saphenous Veins With an Aneurysm Close to the Junction: Useful or Not?

We were interested to read the article by Hamann et al., entitled "Safety and effectiveness of endovenous thermal ablation for incompetent saphenous veins with an aneurysm close to the junction".[1] However, we have some questions.

Firstly, there were possibly insufficient numbers, and high ligation was included in the treatment, which makes the advantages and results of radiofrequency therapy in such patients questionable. One report by Harlander-Locke *et al*. pointed out that for larger diameter veins, radiofrequency

therapy with concomitant phlebectomy would reduce the incidence of venous thrombosis.[2] Secondly, any distance >2 cm from the junction and deep venous aneurysms were excluded. However, the authors did not specify the number of cases where the distance between the aneurysm and the junction was <2 cm, because the shorter the distance to the junction, the more likely are thrombotic events if radiofrequency therapy is used.[3–5] If these details are clarified, especially the incidence of venous thrombosis, the persuasiveness of the article will be enhanced.

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### Response to "Endovenous Thermal Ablation for Incompetent Saphenous Veins With an Aneurysm Close to the Junction: Useful or Not?"

We thank Drs Wu and Ma for their interest in our article and for their comments.

Regarding the first question, we acknowledge that the patient cohort was small and this was clearly mentioned as a study limitation. Aneurysms close to the saphenous junction are very rare, which makes it difficult to recruit a large group of patients with this pathology. Aneurysms exceeding 30 mm are even more exceptional and most surgeons would probably prefer to perform a high ligation (HL) and stripping in these cases. We thought it was worthwhile mentioning our experience of performing endovenous thermal ablation (EVTA) combined with HL, as we did in four cases. In our small study cohort EVTA appeared to be a safe and effective treatment for those patients presenting with a saphenous aneurysm. It is obvious this should be studied in larger groups of patients. However, we disagree with the statement about concomitant phlebectomies, which was not a conclusion of the paper cited by the authors.[1] Rather, concomitant phlebectomies increase the risk of endovenous heat induced thrombosis (EHIT).[2]

Concerning the second remark, we did not specify the exact distance from the junction, but in all cases this did not exceed 2 cm. To our knowledge, there are no studies indicating that a shorter distance between the aneurysm and the junction, for instance 1 cm or 0.5 cm, or even at the very junction, would lead to more frequent EHIT. Again, the three papers cited by Drs Wu and Ma do not mention any such statement.[3–5]

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