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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