

EDITORIAL COMMENT

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Aortoiliac occlusive disease – current approach

Almost one hundred years ago one of the “founding fathers” of contemporary Vascular Surgery, Rene Leriche, would state in a letter to the Surgical Society on the theme of occluded arteries, “the ideal treatment would be to remove the occluded zone and reestablish arterial patency but I doubt that this would ever be possible.”¹

Over the years the diagnosis of aortoiliac occlusion, the condition termed Leriche syndrome, has evolved from clinical (the classical triad of erectile dysfunction, claudication, and femoral pulse absence) to state-of-the-art computed tomographic angiography or magnetic resonance angiography with all the anatomical and hemodynamic details that is got when we add ultrasound to the equation. When it comes to treatment options, treatment has evolved from pioneering endarterectomy to aorto-femoral bypass which remains the gold standard when we search for a standard to compare with.

Endovascular intervention in the aortoiliac segment performs well and as with its open surgical counterpart achieves superior results when compared to femoro-popliteal or infra-genicular intervention. Endovascular intervention has allowed clinicians to treat high-risk patients.

Endovascular interventions used judiciously in the right situations and by the right clinicians, do not seem to preclude future open bypass options.

The management of multilevel disease is frequently seen in the older patients and when combined with open procedures in a hybrid manner provides excellent outcomes in most vascular departments.

Stent technology continues to evolve and the

vast array of stents available today means that results of endovascular interventions in the aorto-iliac segment has become the standard of care that has to be referred to. The use of covered stents in the aorto-iliac segment has proven to produce superior results compared to uncovered stents. Whilst there is no argument on the usage of endovascular techniques for the treatment of TASC A-C, its use for the treatment of TASC D lesions remains controversial but nevertheless is what is being carried out in many vascular units². The availability of re-entry devices has added another device to the armamentarium and results in improved results. Other factors such as the influence of sex seem to be far from being clear, as women are usually underrepresented in most studies of aortoiliac disease.

New concepts like concomitant sarcopenia, which is a natural happening of ageing, seems to be increasingly relevant as we are treating a progressively older³.

The increasing age of western population and an increase in the prevalence of diabetes may produce new and more complex patterns of peripheral arterial disease that can challenge our current knowledge, so valuable and good evidence is warranted to make better decisions⁴.

The algorithm that is used to treat patients depends on many things and is influenced by many factors - combination of local expertise and resources, the grade of disease and urgency of the intervention and patient's preference⁵. One must not forget that the ideal of reestablishing arterial patency in those that need it must be carried out in a manner that provides the best result with the lowest risk – using all available endovascular and open techniques.

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