**This is shared under the authors rights.**


This work is licensed under a [Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License](http://creativecommons.org/licenses/by-nc-nd/4.0/).

**The full published final version (with figures & supplements) is free to access at:**

[**doi.org/10.1016/j.ejvs.2017.07.030**](https://doi.org/10.1016/j.ejvs.2017.07.030)

**Title:**
Correspondance Re: “Lesson Learned with the Use of Iliac Branch Devices: Single Centre 10 Year Experience in 157 Consecutive Procedures” <https://doi.org/10.1016/j.ejvs.2017.03.026>

**Authors:**
Iain Roy1,2, Richard McWilliams3, Robert Fisher1,4

1. Liverpool Vascular & Endovascular Service, Royal Liverpool Hospital, Liverpool, UK
2. Institute of Ageing & Chronic Disease, University of Liverpool, Liverpool, UK
3. Department of Radiology, Royal Liverpool Hospital, Liverpool, UK
4. Department of Physical Sciences, University of Liverpool, Liverpool, UK

**Corresponding Author:**
Iain Roy iain.roy@liverpool.ac.uk

**Letter:**
We congratulate Simonte et al on their series of Iliac Branched Devices (IBD), particularly their excellent compliance with surveillance. Numbers at risk in their surveillance based outcomes are almost identical to survival analysis, representing near perfect compliance.

The device results correspond closely with our own, small, continuous series. 33 devices (32 patients) demonstrated 94% technical success. Median follow-up of 22 months detected no type I/III endoleaks and no iliac aneurysm expansion. Five IBD related secondary interventions (all endovascular) and 2 IIA occlusions occurred. These results represent our learning curve but support the encouraging data for IIA preservation.

We also use a colour duplex ultrasound scan (CDUS) based surveillance regime, in combination with plain film radiography. We discovered a limitation in the visualisation rate of the IIA. Of 84 CDUS surveillance scans, the IIA was reported patent in 39 (46%), was reported not visualised in 14 (17%) and was not mentioned in 31 (37%). Poor reporting is likely the result of not having a specific protocol for IBD devices. Even if these had all been visualised we describe inadequate imaging of the IIA in nearly 1 in 5 CDUS following IBD.

We are interested in the authors experience of non-visualisation in their analysis. Was an IIA assumed to be patent until proven occluded on CDUS? Was their non-visualisation rate for CDUS similar to our own (17%) and did these patients all receive CTA to prove patency?

We believe CDUS to be an appropriate primary surveillance technique for IBD but accept a ~20% non-visualisation rate in the absence of iliac aneurysm growth or symptoms. CTA is reserved for such cases. We would recommend an addition to the authors “lesson learnt”: Adopt a specific ultrasound surveillance protocol for IBD patients with defined indications for CTA for non-visualisation of the IIA.

The continued success of IBD is dependent on robust long-term outcomes, and the role of accurate surveillance protocols in achieving that cannot be under-estimated.