

Correspondence

Mesenteric Revascularisation

Sir,

Recently, Christensen *et al.*¹ reported their experience with revascularisation of the mesenteric arteries over a 25-year period involving 53 patients with chronic mesenteric vascular syndrome (CMVS). Two-vessel mesenteric artery disease was established in 48 patients, 42 patients having a severe stenosis of both the celiac artery (CA) and superior mesenteric artery (SMA). However, only three revascularisations of both the superior mesenteric artery (SMA) and the celiac artery (CA) were performed, in the other 47 revascularisations only the SMA was revascularised.

After a mean follow-up of 4.6 years, four patients died because of proven intestinal ischaemia, probably due to thrombosis of the reconstruction. Roughly 30% of the 53 patients had recurrent symptoms of CMVS. In summary, at least 8% of the SMA reconstructions failed, all resulting in the death of the patient and at least 30% of the patients had recurrent symptoms of CMVS. Based on this experience Christensen *et al.*¹ conclude that single vessel revascularisation of the SMA, preferably with bypass procedures is the procedure of choice for elective mesenteric artery reconstructive surgery.

We feel that this conclusion is not in accordance with results reported in the literature by others, including ourselves. Repair of only one mesenteric artery may relieve symptoms of CMVS due to the abundant collateral circulation. However, much better long-term results are obtained with surgical repair of more than one mesenteric artery. In our series² of 14 patients with CMVS, 31 of the 42 mesenteric arteries were severely obstructed, and 23 of the 31 mesenteric arteries were reconstructed. We prefer reconstruction of both the CA and the SMA by endarterectomy and/or antegrade arterial autogenous bypass techniques. Our hospital mortality was 7% (one patient with thrombosed reconstruction). Long-term follow-up (mean 11.8 years, range 4.5 to 27.2 years) was carried out on all 13 surviving patients. Who were all

asymptomatic. DSA performed on eight patients showed that 11 of the 13 (85%) visualised reconstructions were patent. Every patient had at least one patent reconstruction.

In our report,² we discussed the fact that a variety of surgical and nonsurgical techniques have been advocated for repair of the mesenteric arteries. Each of the various series, including Christensen *et al.*¹ are too small to draw any conclusion with respect to the superiority of one technique over the other. Clearly, the choice of the techniques used is based on the preference and experience of the surgeon. Progression of disease and stenosis of reconstructions are inevitable in the long term. However, two vessel revascularisation decreases the chance of the recurrence of symptoms. The morbidity and mortality of two-vessel reconstruction is no higher than reconstruction of one vessel.^{2,3}

Robert H. Geelkerken and J. Hajo van Bockel
Leiden, The Netherlands

References

- 1 CHRISTENSEN MG, LORENTZEN JE, SCHROEDER TV Revascularisation of atherosclerotic mesenteric arteries: experience in 90 consecutive patients. *Eur J Vasc Surg* 1994; **8**: 297-302
- 2 GEELKERKEN RH, VAN BROCKEL JH DE ROOS WK HERMANS J, TERPSTRA JL. Chronic mesenteric vascular syndrome; the long term results of reconstructive surgery. *Arch Surg* 1991; **126**: 1101-6.
- 3 REILY LM, RAMOS TK, MURRAY P, CHENG SWK, STONEY RJ. Optimal exposure of the proximal abdominal aorta: a critical appraisal of transabdominal medial visceral rotation. *J Vasc Surg* 1994; **19**: 375-90

Authors' Reply

Sir,

We could not agree more with Geelkerken and van Bockel that reported series on mesenteric revascularisation are too small to draw any conclusion with respect to the superiority of one technique over the