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## INVITED COMMENTARY

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The article by Michael Peck et al describes a large single-center experience of splanchnic artery stenting and as such it is valuable for all physicians taking care of patients who are presenting with this pathology.

There are four relevant take-home messages from the present report: (1) at least 10% of patients with chronic abdominal symptoms and splanchnic artery stenoses does not perceive initial benefit from revascularization; (2) the 1- and 3-year primary patency rates were 79% and 64%, respectively; (3) the 1- and 3-year symptom-free recurrence rates were 81% and 61%, respectively; and (4) due to the improved symptom-free recurrence rate of two-vessel revascularization as opposed to one-vessel, two-vessel should be pursued.

Although there is an important caveat that should be kept in mind when interpreting the results of this series, the difference between primary patency and symptom-free recurrence indicates that some patients have had (recurrent) symptoms without (recurrent) stenosis. This underscores how difficult the diagnosis of chronic splanchnic ischemia sometimes is and how essential it is for a valid functional test for assessing splanchnic blood flow. Gastric exercise tonometry, validated over the past decade,<sup>1</sup> is such a test and has the ability to differentiate between asymptomatic splanchnic disease and symptomatic splanchnic ischemia. In our opinion, a

positive function test is a prerequisite to prove the causal relationship between chronic abdominal symptoms and splanchnic artery stenoses.

Apart from the obvious downsides of a retrospective series, the validity of this study clearly suffers from lack of a uniform indication and follow-up protocol. As a consequence, it is not clear whether all patients with recurrent symptoms were identified; at least 25% of the patients could have developed asymptomatic restenosis. The observation that only 27% of the patients with appropriate radiologic follow-up were free of restenosis is a further indication that many recurrent stenoses may have been missed.

Although we agree with the authors that an endovascular-first approach to chronic splanchnic ischemia can be defended, we submit that these conclusions must be interpreted with caution as they are based on retrospective series without a complete and validated diagnostic process and without complete and objective follow-up. At this time, however, this is the best available evidence.

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