

In reply: The anesthetic technique of choice for better outcomes in high-risk elderly patients undergoing endovascular repair of aortic aneurysm

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First, I thank Dr Lippmann and colleagues for their interest in my manuscript. Given the growing number of patients who are unfit for open vascular reconstruction owing to their serious comorbidity and high age, the number of candidates for endovascular aortic aneurysm repair (EVAR), which provides endoluminal stenting of aortic aneurysm with minimal surgical trauma and physiologic stress, is currently increasing worldwide. The procedure has been reported to be associated with lower 30-day peri-operative mortality and lower incidence of peri-operative complications [1, 2], although its long-term durability and outcomes are still controversial [3, 4]. As the technique has become a mainstay in the repair of abdominal aortic aneurysm in the United States and in European countries, accounting for approximately half of elective repairs, a less invasive anesthetic technique has been proved to result in better outcomes for highly comorbid patients undergoing this elective EVAR procedure, as reported by the groups led by Dr Lippmann and colleagues and by others [5, 6]. However, in the early 2000s when a high frequency of incidence with conversion to open repair occurred, as far as I am aware, general anesthesia was preferentially used considering the safety issues, even in the United States, as Dr Lippmann and colleagues had already reported [7].

For some peculiar reasons, official approval of the commercial stent has been delayed in Japan until quite recently (in the middle of 2007) in contrast with the United

States where the Food and Drug Administration (FDA) approved its clinical use in the early 2000s. The current situation in Japan seems to be quite similar to that in the United States during the early 2000s, and most anesthesiologists participating in anesthetic management of EVAR tend to prefer general anesthesia to loco-regional anesthesia, owing to the potential risk of conversion to open repair during the surgical procedure.

As I wrote in my manuscript [8], in 2007 I introduced loco-regional anesthesia techniques to the facility on the basis of previous proved reports [5, 6], and as part of my internal review of anesthesia quality assurance I have published my outcome results providing evidence that the use of loco-regional anesthesia techniques in the anesthetic management of EVAR had, indeed, been well tolerated and had advantages over general anesthesia.

Last, and as concluding remarks, given the high prevalence of anticoagulant therapy in this population, I believe the utilization of ultrasound-guided peripheral nerve block will pave a new way for the next-generation anesthetic management of elective EVAR, as an alternative to the neuroaxial anesthesia techniques [9].

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