

Authors' reply

Sir,

We appreciate the reader's^[1] interest in our article on Transplant Renal Artery Stenosis (TRAS).^[2] As the reader has rightly pointed out, with an increasing number of patients being detected to have TRAS, there is a growing need for standardization of the definition of significant TRAS.

We would like to reply to the reader's remarks in the following lines.

1. Conclusion is disappointing: Based on the observations in our study, we had concluded that the decision regarding intervention was largely based on clinical assessment. The flow chart in Figure 6 indicates that even though 22 of 25 patients were symptomatic, seven of them did not undergo angiogram, as they were clinically stable, with their blood pressure well under control with drugs. Only those patients, who also had a refractory hypertension apart from being symptomatic, were subjected for angiogram. Also, not all those who had an angiogram in this symptomatic group needed subsequent intervention.
2. Patients with high PSV alone should not be labeled as TRAS: With an increasing availability of Doppler and Magnetic resonance angiography, more patients are being diagnosed to have TRAS. Ferreiros *et al.* (Ref no: 4) have broadly classified TRAS as symptomatic and asymptomatic varieties. Most of such patients who have an isolated high PSV have been labeled as the asymptomatic subtype and do not require any further treatment.
3. Authors do not provide data on the reason for a low incidence of TRAS in deceased donors: Majority of patients (94%) in our study have received kidneys from live related donors. The relatively higher incidence of TRAS in live donor group may also partly be due to the higher percentage of live related transplants. Of the 543 patients, only 32 were from deceased donors. Moreover, as the reader has pointed out, the mean cold ischemia time was also relatively shorter, as most of the kidneys were harvested in our own center.
4. To stress that graft dysfunction is mandatory for the diagnosis of significant TRAS: Most authors have considered TRAS to be significant or not, based on the radiological criteria (Ref no: 12-16). While it is difficult to stress on the fact that graft dysfunction is mandatory to make a diagnosis of significant TRAS, it would not be inappropriate, if we could argue that graft dysfunction is mandatory for deciding on the need for subsequent intervention. Figure 9 in our article would suggest that

the mean increase in the creatinine clearance following intervention was as high as 24.21 ml/min ($P = 0.000$), justifying the need for intervention in this subgroup of patients who have an associated allograft dysfunction.

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