Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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REFERENCES

1. Lavingia KS, Dua A, Rothenberg KA, Fredericson M, Lee JT. Surgical management of functional popliteal entrapment syndrome in athletes. J Vasc Surg 2019;70:1555-62.
2. Coraci D, Giovannini S, Loreti C, Fusco A, Padua L. Management of neuropathic pain: a graph theory-based presentation of literature review. Breast J 2020;26:581-2.
3. Coraci D, Giovannini S, Fusco A, Loreti C, Padua L. Low back pain: literature review based on graph theory. Pain Pract 2020;20:946-7.
4. Bastian M, Heymann S, Jacomy M. Gephi: an open source software for exploring and manipulating networks. International AAAI Conference on Weblogs and Social. Proceedings of the International AAAI Conference on Weblogs and Social Media 2009. p. 361-2.
5. Stager A, Clement D. Popliteal artery entrapment syndrome. Sports Med 1999;28:61-70.

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Reply

We appreciate the opportunity to respond and comment on the letter to the editor by Coraci et al[1] regarding our report on the treatment of functional popliteal artery entrapment syndrome (PAES) in athletes.[2] As they astutely pointed out, the relative lack of data surrounding PAES has provided an opportunity for open dialogue regarding the management of this disorder. Fundamentally, the treatment of anatomic PAES is much less controversial, because patients with congenital embryologic variants will likely be limited in early adulthood and will present to vascular surgical providers. The challenge with functional PAES, especially in athletes, is that patients without traditional vascular risk factors will present with lifestyle-limiting claudication and pain, which can often lead to delays in management as musculoskeletal conditions are evaluated.[2] Recognizing these presentations is important for our sports medicine, orthopedic, and rehabilitation colleagues. Also, improved collaboration with our specialty and those who care for an active, young population is necessary to better understand functional PAES. Our experience has allowed for such a collaboration, with patients freely flowing from their clinic to ours, with a good local understanding of the outcomes. We hoped in our report[2] to share these outcomes with our readership.

Regarding their letter[1] and our analysis,[2] we are intrigued by their suggestion that the language used in peer-reviewed studies covering functional PAES should focus on "rehabilitation," "pain," and "claudication." We wholeheartedly agree and are impressed by their unique word cloud analysis to confirm this bias. Given the overall goal of contemporary surgical literature to provide patient-specific outcomes, the act of simply relieving popliteal entrapment should be confirmed by the improvement in disabling symptoms, and this sort of precision medicine to ensure the right operation is applied to the right patient should become a standard that we strive for. Overall, we appreciate the attention brought to our report and encourage others to confirm our findings in their series locally as we treat these often challenging and functionally disabled patients.

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REFERENCES

1. Coraci D, Loreti C, Fusco A, Giovannini S, Padua L. Functional popliteal artery entrapment syndrome: a brief overview of literature based on graph theory. J Vasc Surg 2021;74:342-4.
2. Lavingia K, Rothenberg KA, Dua A, Fredericson M, Lee JT. Surgical management of functional popliteal artery entrapment syndrome in athletes. J Vasc Surg 2019;70:1555-62.

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Terminology for vascular access devices

We read with interest the report by Jasinski et al.[1] The Italian Group of Venous Access Devices has recently suggested clinical recommendations for optimizing the practice of insertion and management of vascular access devices (VADs) in patients with coronavirus disease 2019 (COVID-19).[2,3]

We totally agree that non–critically ill patients with COVID-19 often will not require a central VAD. In contrast, patients with COVID-19 admitted to the intensive care unit will often require a central VAD.[1-3] However, the protocol suggested by Jasinski et al[1] could lead to some confusion in the terminology and, thus, to an inappropriate use of the devices. Jasinski et al[1] proposed trimming a triple-lumen peripherally inserted central catheter (PICC) such that the tip cannot reach the superior vena cava. However, by definition, such a device will no longer be a PICC but a peripheral VAD.

According to the most recent data,[4,5] peripheral VADs include short peripheral cannulas (<6 cm long), long peripheral catheters (6-15 cm long; so-called short midline catheters), and midline catheters (16-25 cm long; so-called midclavicular catheters, because the tip is in the axillary vein or subclavian vein). The "modified PICC" proposed by Jasinski et al[1] should be classified as a peripheral catheter and included in the category of midline catheters.

However, 20- to 25-cm, 4F to 5F, single-lumen and double-lumen catheters (ie, midline catheters) already exist and are commercially available; thus, no need exists to modify a PICC. These VADs are appropriate for patients with COVID-19 when a central VAD is not specifically needed.[2,3] If we required a 20- to 25-cm, 5F to 6F, triple-lumen catheter (which has been quite rare), we might even trim a PICC; however, we should be careful to name it properly, as a "midline" catheter.

The unnecessary off-label modification of the length of a catheter is a very dangerous practice. Its use could generate confusion for clinicians, because they might erroneously use the "modified PICC" as a central catheter, leading to several local and systemic complications (eg, phlebitis, thrombosis, extravasation, and, even, severe tissue damage).

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REFERENCES

1. Jasinski PT, Tzavellas G, Rubano JA, Rutigliano DN, Skripochnik E, Tassiopoulos AK. A protocol for central venous access in patients with coronavirus disease 2019. J Vasc Surg 2020;72:1507-9.
2. Scoppettuolo G, Biasucci DG, Pittiruti M. Vascular access in COVID-19 patients: smart decisions for maximal safety. J Vasc Access 2020;21:408-10.
3. Pittiruti M, Pinelli F; GAVeCeLT Working Group for Vascular Access in COVID-19. Recommendations for the use of vascular access in the COVID-19 patients: an Italian perspective. Crit Care 2020;24:269.
4. Qin KR, Pittiruti M, Nataraja RM, Pacilli M. Long peripheral catheters and midline catheters: insights from a survey of vascular access specialists. J Vasc Access 2020 Oct 20. [E-pub ahead of print].
5. Qin KR, Nataraja RM, Pacilli M. Long peripheral catheters: is it time to address the confusion? J Vasc Access 2019;20:457-60.

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More randomized controlled trials are needed to support the use of endovascular treatment in common femoral artery atherosclerotic lesions

We read with interest the study reported by Boufi et al,[1] titled "Systematic review and meta-analysis of endovascular versus open repair for common femoral artery atherosclerosis treatment." The authors of the study performed a systematic review and meta-analysis to evaluate the outcomes after endovascular repair vs open surgery for common femoral artery atherosclerotic disease. This is a timely review as we are encountering an increasing number of patients with common femoral artery disease who are poor candidates for open surgery. In these high-risk patients, endovascular repair might be a safer, yet effective, alternative treatment modality.

On closer scrutiny of the meta-analysis, although Boufi et al[1] had included a total of 28 studies, it is apparent that only 2 of the studies were comparative and had evaluated the use of open common femoral endarterectomy vs endovascular repair for the treatment of common femoral artery atherosclerotic lesions. The nature of endovascular repair, however, differed between the two studies. Linni et al[2] used a self-expanding poly-L-lactic acid bioabsorbable stent, and Gouëffic et al[3] used a self-expanding stainless steel permanent stent. Moreover, the study design and patient population of both trials varied widely. Linni et al[2] included only patients with