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## Re to Commentary “To Clamp or Not to Clamp: That is the Question!”

We are grateful for the encouraging comments by Schwein and Georg, who have recognised the ease and atraumatic nature of our soft feeding tube approach to facilitate anastomosis in calcified vessels.<sup>1,2</sup> We would like to add a complementary note in this regard. As the size of the catheter (6 or 8 F) corresponds to an outer diameter of 2.0 and 2.6 mm, respectively, we have not experienced a catheter related obstruction. On the contrary, this is why they have to be double encircled with a vessel loop in order to ensure sealing. Obviously, successful intraluminal insertion of the tube does not guarantee the absence of distal stenosis, as it could easily pass, for example, through a 50% stenosis of a 6 mm popliteal artery. Therefore, the manoeuvre is not to substitute the need for proper vascular imaging, but only to prevent inadvertent damage to a clamped calcified vessel and avoid stenosis at the tip of the anastomosis.

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## Re “The Effect of Mode of Anaesthesia on Outcomes After Elective Endovascular Repair of Abdominal Aortic Aneurysm”

We noted this study by Dovell *et al.*<sup>1</sup> comparing post-endovascular aneurysm repair (EVAR) outcomes in the context of whether regional (RA) or general anaesthesia (GA) had been used, based on the convenient and robust UK National Vascular Registry (NVR). As indicated, the way anaesthetic details are captured in the NVR is not entirely accurate: RA could imply any of a plethora of options ranging from combined spinal epidural anaesthesia, single shot spinal anaesthesia, and as indicated, use of local anaesthesia infiltration may well be confounded by supplementary use of opioid analgesia.

Our own approach has evolved to peri-arterially infiltrating a mixture of 1% lidocaine (10 mL) and 0.25% l-bupivacaine (20 mL) under ultrasound guidance, with an intravenous bolus of midazolam (1–3 mg) and a target controlled infusion of remifentanyl (1.0–2.5 ng/mL, plasma) for percutaneous infrarenal EVAR (median length of stay (LOS) 1 day, 2015–2020); this allows verbal contact with the patient, including breath holding for aorto-iliac angiography, as well as reducing the monitoring requirements associated with spinal anaesthesia. Such protocols can be applied to a day case EVAR programme.

Regardless of the results in the rupture scenario favouring RA, and the ill-received NICE guidelines tending towards open repair and thus a default GA, there may be another lingering factor that will drive the need for both local/regional anaesthesia and EVAR, and that is the COVID-19 pandemic. This correlates with the need to reduce aerosol generating procedures, namely endotracheal intubation, intensive care unit stay, and respiratory complications including, of concern (perhaps even leading to patient refusal to have a GA) the risk of hospital acquired SARS-CoV-2 infection.

A repeat audit going forward to look for any post-pandemic changes in EVAR anaesthetic practice may therefore be useful.

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