LETTERS TO THE EDITORS

EDITORS' NOTE: In the selection of an article for publication, the orthodoxy of the author's opinions is generally accepted to be the least consequential and scientific validity or plausibility to be the foremost criterion of assessment. Since opinions may differ and judgment of validity may be fallible, the Editors invite readers to submit letters commenting on opinions or conclusions to which they take exception and pointing out errors they detect. The length of such letters should not exceed 500 words. If the letter is a critique or correction, the author criticized or corrected will, of course, have the privilege of response. Needless to say, the Editors retain the right to judge the suitability of a letter for publication.

CT-guided fine needle aspiration of a periaortic collection

To the Editors:
In the May issue of the Journal (1987;5:762-4) there appeared a case report of a CT-guided fine needle aspiration of a periaortic collection. The authors were remiss in not acknowledging the support and assistance of Dr. Harold Stern whose patient was referred to us for the needle aspiration. As an extremely accomplished and senior thoracic and vascular surgeon, Dr. Stern's participation to the manuscript should have been publicly acknowledged. No discourtesy was meant. The authors apologize for this unintentional oversight.

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Can carotid duplex scanning supplant arteriography in patients with focal carotid territory symptoms?

To the Editors:
In their effort to contrast the benefits of duplex scanning with the shortcomings of angiography, Goodson et al. (J VASC SURG 1987;5:551-7) overstate the liabilities of angiography.

To quote data that were accumulated in 1961 through 1965 and reported in 1968 showing that "1 in 200 patients dies of complications and 12 in 1000 patients suffers serious complications from angiography" is a misrepresentation of modern angiography. Most of the procedures reported in that article involved direct carotid artery puncture, with a few involving direct puncture of the vertebral artery or left cardiac ventricle. The early days of angiography, with direct common carotid puncture, more toxic contrast agents, and less sophisticated catheters and guide wires, should not be compared with the methods in routine use today.

If the quoted complications of Faught, Trader, and Hanna were duplicated at our institution, cerebral angiography would undoubtedly be undertaken much less frequently and with much trepidation. They report a 6.8% frequency of transient cerebral dysfunction and a 5.4% frequency of permanent cerebral dysfunction resulting from cerebral arteriography in 147 patients. However, there are reported series much larger than this that have markedly different results. Mani et al. reported a series of 5000 cerebral arteriograms in which the frequency of permanent or transient neurologic deficit was 0.04% and 0.86%, respectively. They had one death (0.02%).

Unfortunately, authors not infrequently quote data from the literature that will dramatize their thesis but that are at marked variance with the norm. The least that such authors should do, in our opinion, is to indicate that such quoted data deviate markedly from usual or accepted norms. Better yet, a range or mean of published data currently available should be presented. The approximately 0.3% frequency of transient neurologic deficits in our own angiographic experience supports the concept that cerebral arteriography can be performed with low risk in patients suspected of having cerebral ischemia.

In addition, the data presented in the Journal seem to be comparing duplex scanning with less than ideal arteriography. How is it that only 48% of their arteriograms were "excellent" quality? According to their definition of "excellent" (complete and detailed visualization of arch, cervical, and intracerebral vasculature), virtually all such studies performed with standard catheters and conventional filming now days should be so classified. If only 48% were "excellent" quality, it is no wonder that duplex scanning compared favorably. We have no doubt that angiography is not a totally reliable indicator of arterial ulcerations. However, to support the benefits of carotid duplex scanning by the above methods is misleading and, therefore, a disservice to readers of the Journal.

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REFERENCES