Editorial note about the invited commentaries on 'Infrainguinal bypass using varicose veins with external scaffolding', by N. Montelione, et. al.

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The paper being analysed discusses[1] a significant 30-year experience with using pathologic great saphenous veins (GSV) for creating infrainguinal bypasses, which has not been matched by any other reports regarding the number of patients (51) or outcomes (62% primary patency, 72% assisted patency). In recent literature[2-5], just single or limited case studies can be found, making the experience of the Spinelli school unique.

Unfortunately, external prosthetic support for the vein grafts mentioned in this article is nowadays provided just by a single manufacturer [6, 7]. Thus, the potential market for this procedure should be encouraged and improved, in order to allow this useful conservative opportunity to survive .

Saphenous sparing in varicose veins patients' treatment is the objective of a group of phlebologists that for 40 years supported the avoidance of saphenous ablation, for the saving of the best material for arterial bypasses, but also for the preservation of the natural venous drainage, the reductions of possible anarchic recurrences, the simplification of the procedures and the limitation of overtreatments. JVTAR devoted several 2022 and 2023 issues (DOI: 10.24019/issn.2532-0831) to conservative treatments of the GSV.

While GSV elimination is the traditional treatment for incompetence, any debate is limited to how to do it in the most convenient way (for surgeons, patients, and insurance).

In the present Invited Commentaries, several colleagues from four important Vascular Surgery Schools[2-5]commented positively on the potential use of a pathologic GSV, challenging the traditional trend by which such a revolutionary proposal is impossible.

However, a constructive solution could be suggested by analysing the question of how vein-sparing recommendations – as suggested by the Montelione report[6]- could be effectively integrated into a routine clinical practice.

GSV ablation may be avoided in certain cases, such as when the vein calibre is 6 mm or smaller, when the contralateral vein is absent, in patients at risk for cardiomyopathy, in those with arteriopathy, in metabolic at-risk patients, in cases with a family history of arteriosclerosis, and in individuals over 60 years of age, among other situations. By considering these factors, 30-40% of cases could potentially be included in the treatment model, demonstrating its possible beneficial outcomes, and leading to an evolution in routine practice.

Here is a good research subject for the Academic leaders, if the interest of the study would be really directed, as it should be, just to the patients' benefit.

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