The conclusions we have reached are still valid and it is very clear from the results that there was a significant lack of knowledge about CDI amongst healthcare professionals particularly among consultants and nurses at the time of the study. Since then, there has been much publicity about hospital-acquired infections and all hospitals have been required to take measures to increase the awareness of their staff about CDI; this is reflected in the nationally reduced incidence of hospital-acquired CDI.¹

Reference

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COMMENT ON

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M Field, J Blackwell, A Jaipersad, M Wall, MA Silva, RH Morgan, AD Pherwani. Distal revascularisation with interval ligation (DRIL): an experience. *Ann R Coll Surg Engl* 2009; **91**: 394–8

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Treatment of ischaemic steal syndrome resulting from vascular access surgery

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Arteriovenous fistulas (AVFs) at times shunt blood away from regions distally. To treat the resulting ischaemic steal syndrome, the authors used distal revascularisation with interval ligation (DRIL). However, we should consider:

1. The DRIL technique involves the ligation of a previously normal artery. The flow in the distal part of the ligated artery will now rely on a bypass.
2. The authors use a segment of basilic vein for the bypass. In such patients, we believe the veins should be considered precious, and preserved as long as possible for other surgeries (*i.e.* re-do AVF).

In consideration of this, we do not use the DRIL technique. Instead, with the aim of reducing the steal syndrome, we use a banding on the distal part of the AVF for the following reasons:

1. This will increase the pressure inside the AVF, treating the stealing syndrome without jeopardising the artery.
2. During the banding procedure, an echo-duplex control on the distal artery will monitor the reduction on the steal syndrome, defining the best degree of banding.
3. The technique can be performed using either a small segment of vein or a prosthetic material (*i.e.* Teflon).

AUTHORS' RESPONSE

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While we agree that the DRIL technique does involve ligating a previously normal artery and that arterial supply will now run off a graft, we have not experienced any problems with this aspect of the operation and there are no reported cases of this causing a problem.

While we agree that venous 'real estate' is of paramount importance in any renal patient, the DRIL procedure allows an already proven mature fistula to continue to be used. The basilic vein can be harvested in the same incision as for the DRIL procedure itself which is an advantage over the saphenous vein; however, in cases where there is concern about future access issues, we would support the use of the saphenous vein as a bypass conduit.

We sparingly advocate the banding of fistulas. Even with the use of duplex scanning, it is extremely difficult to measure accurately the degree of banding required to treat symptoms of steal, as other intra-operative factors may affect blood flow.

A recent review of 64 DRIL procedures in the US supports our view that DRIL should be considered as first-line surgical intervention for ischaemic steal, although it is always important to have more than one technique available.¹

Reference

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