Notice of Duplicate Publication: "Mechanical Bowel Preparation for Elective Colorectal Surgery: A Meta-analysis" (*Arch Surg.* 2004;139:1359-1364)

As corresponding and senior authors of this article (Mechanical bowel preparation for elective colorectal surgery: a meta-analysis. *Arch Surg.* 2004;139:1359-1364), we wish to draw attention to our omission therein of any reference to our previous paper (Does mechanical bowel preparation have a role in preventing postoperative complications in elective colorectal surgery? *Swiss Med Wkly.* 2004;134:69-74). The latter paper carried the results of an earlier stage of our continuing meta-analysis of the outcome of the preoperative bowel cleansing procedure. Although the additional data, reported for the first time in the *Archives of Surgery*, brought further statistical solidity to our conclusion that preoperative mechanical bowel preparation is unnecessary and possibly harmful, we acknowledge that without this cross reference the reader was not in a position to evaluate correctly the extent to which our second paper represented an advance over what had gone before. We express our sincere apologies to the editors of the 2 journals and to their readers.

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Spiral Vein Graft Replacement of Portomesenteric Vein Using Saphenous Vein

Fleming et al[1] are to be commended for the excellent technical presentation of portal vein reconstruction using clear art work and intraoperative photographs. Their experience with 120 portomesenteric vein reconstructions spoke for the superiority of this autograft over the jugular vein, which is thin and difficult to handle.

With the development of liver and pancreas transplantation (more than 19 765 cases performed to date in the United States as reported by the United Network for Organ Sharing),[2] the portomesenteric system has been approached very aggressively and the donor common iliac vein and other banked allograft vessels have been used successfully.

But for only 5 cm of superficial femoral vein replacement, another technique is available and seems more appropriate—the spiral vein graft described by Chiu[3] et al and used by others.[4,5] This entails the removal of the superficial saphenous vein with minimally invasive surgery, ie, by endoscopic technique if available, followed by the versatile creation of any size vein to reconstruct. Fashioning the spiral vein graft over a 30F chest tube is not time consuming despite the vascular suturing. This would avoid (1) the extensive surgery shown in Figure 5 in Fleming et al's article, (2) the Doppler study of the limb to assess the superficial femoral vein patency and size prior to surgery, (3) the potential injury to the saphenous nerve, (4) the deep venous hypertension in 13% of the patients requiring long-term compression stockings, (5) the postoperative deep venous thrombosis in 22%, and (6) the requirement of anticoagulation in 5% of patients.

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1. Fleming JB, Barnett CC, Clagett GP. Superficial femoral vein as a conduit for portal vein reconstruction during pancreaticoduodenectomy. Arch Surg. 2005; 140:698-701.
2. United Network for Organ Sharing Web site. Available at http://www.unos.org. Accessed July 19, 2005.
3. Chiu CJ, Terzis J, MacRae ML. Replacement of superior vena cava with the spiral composite vein graft: a versatile technique. Ann Thorac Surg. 1974; 17:555-560.
4. Doty DB, Baker WH. Bypass of superior vena cava with spiral vein graft. Ann Thorac Surg. 1976;22:490-493.
5. Nghiem DD. Spiral gonadal vein graft extension of right renal vein in living renal transplantation. J Urol. 1989;142:1525.

In reply

We appreciate Dr Nghiem's interest in our recent article in the ARCHIVES *titled "Superficial Femoral Vein as a Conduit for Portal Vein Reconstruction During Pancreaticoduodenectomy." His comments are insightful and bring into focus our rationale for this surgical approach. Although we have not identified published literature describing the use of spiral vein grafts to replace the superior mesenteric and portal vein, it is a well-described approach for vein reconstruction for various indications and could possibly be applied in this setting.*

We, however, chose to use the superficial femoral vein (SFV) for the following reasons:

1. Although the dissection for SFV harvest is more involved than smaller caliber veins (eg, saphenous), we use a 2-team approach that minimizes additional operative time. With this approach, the harvest and vein reconstruction adds 30 to 45 additional minutes to pancreaticoduodenectomy without reconstruction.