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#### DISCUSSION

DR. HUGH H. TROUT III (Bethesda, Maryland): President Ochsner, Dr. Jones, Members and Guests: In situations in which contamination is likely, it now seems that it is reasonably safe to proceed with *in situ* prosthetic graft insertion when no previous prosthetic graft has been placed. Such settings include a primary aortoenteric fistula with a communication between an abdominal aorta aneurysm and the duodenum. Another instance would be infected aortic aneurysms as presented by Dr. Gomes. One other instance in which *in situ* replacement seems possible is the setting of a prosthetic graft infected by bacterial biofilms such as coagulase-negative staphylococcus, as has been recently reported. For all other vascular contamination situations in my view, however, *in situ* grafting should be avoided if at all possible. Appropriate therapy in these instances should be a remote bypass such as an axillobifemoral bypass, followed by removal of the contaminated graft.

I have one question. Now that polytetrafluoroethylene (PTFE) is available in bifurcation form, do you believe because of reduced quan-

titative bacterial adherence that PTFE has an advantage over Dacron as a prosthetic replacement graft? I want to thank Dr. Gomes for providing me with a copy of his excellent manuscript and to congratulate him on a thorough presentation helping to define further those instances in which *in situ* grafting may be safely employed. Thank you for the privilege of the floor.

DR. MARIO N. GOMES (Closing discussion): I would like to thank Dr. Trout for the kind comments. I do believe that the use of a PTFE graft in this setting may further decrease the possibility of graft infection, but it is more important to make the diagnosis of IAA in early phase and be fairly certain that the periaortic involvement is not present. In these circumstances, the potential problem of graft infection should not be significant, but the use of a PTFE graft may be advantageous. I am fairly confident that an early diagnosis of IAAA will lead to a safe graft interposition, which is not the case when extensive periaortic infection is present.