looks quite different depending on one's perspective. From the aortic or ventricular side, the AML clearly begins immediately below the semilunar attachment, whereas from the atrial side, because of the thickness of the LA itself, the base of the AML seems to be well below the attachment of the aortic valve cusp. The muscle of the LA essentially folds down over the base of the AML.

Again we thank Drs Nežić, Knežević, and Borović for their interest and welcome the debate. What could be more fun than spirited disagreement among colleagues!

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Endovascular treatment of mycotic aortic aneurysms To the Editor:

We read with interest the article by Hsu and Lin¹ in which they retrospectively reviewed their patients who received surgical treatment for infected aortic aneurysms at the aortic arch. Mycotic aortic aneurysm treatment is a challenging issue. Since the beginning of modern cardiovascular surgery, surgeons have searched for better treatment options because of the high mortality and morbidity rates of the classic surgical methods. The authors' results also confirm this.¹

With the increasing experience and refinements in graft technology, endovascular grafts are frequently used in the treatment of

aneurysms at critical segments of the aorta, such as thoracic and arch levels,² and even to the ascending aorta by means of hybrid therapy or alone.³

On the other hand, although it seems completely opposite to the nature of the treatment of infected aneurysms, endoluminal stent grafting is also applied for the treatment of mycotic aneurysms. Although the long-term results are not presented, the short and mid-term outcomes of this treatment modality have been promising when compared with conventional surgical techniques (ie, extensive debridement and artificial graft replacement or extra-anatomic bypass procedures).^{4,5}

We believe that endovascular stent graft repair of mycotic aortic aneurysms, especially at the critical segments of the aorta and in debilitated patients, is an attractive alternative option with low mortality and morbidity rates in the midterm. However, long-term results are definitely required before this becomes the standard therapy. It would be helpful if the authors would have commented on this issue in their article.

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Reply to the Editor:

We appreciate Dr Ugurlucan's comments on the issue of mycotic aortic aneurysms treated by endovascular approach. We believe that the endovascular stent graft is superior in some ways to open surgical repair for the treatment of mycotic aortic aneurysms, especially in the emergency setting for debilitated patients with critical aortic segment involvement. In a recent published literature review by Kan and colleagues,¹ the endovascular treatment strategy was noted to have 30-day and 2-year survivals of 89.6% and 82.2%, respectively. To date, however, there is still no level I evidence to convince us that endovascular treatment is the criterion standard for mycotic aortic aneurysm.

In Taiwan, the abdominal aortic stent graft was approved by Department of Health for clinical use only after July 2005, and the thoracic stent graft was approved after November 2006. In our published article,² patients were treated through 2006, before the endovascular stent graft era in Taiwan. Since 2006, we have performed endovascular stent graft placement in patients with ruptured mycotic aortic aneurysm. In our preliminary data, there have been 4 patients with ruptured mycotic abdominal and thoracic aortic aneurysms treated by the endovascular technique. Of these, 1 patient required a total visceral artery debranching procedure for the ruptured suprarenal mycotic aneurysm simultaneously with the stent graft placement. The pathogen is similar to our published database² as nontyphoid *Salmonella*. There was one in-hospital death with new development of aortoduodenal fistula. There was another death later than 30 days from the non-aneurysm-related cause of uncontrolled septic shock. The other 2 patients require long-term oral antibiotic therapy. There were no cerebral vascular events or stent graft-related deaths among these 4 patients.

This seems to be a result comparable to that of open surgical repair. We are still not sure, however, whether for those with aorto-esophageal aneurysm, aortobronchial aneurysm, or residual abscess in the image study further débridement and elective open surgical grafting will be necessary after stent graft placement, once the patient condition has been stabilized. In addition, for mycotic aneurysms involving the aortic arch or visceral arterial segment, the hybrid debranching procedure or fenestrated