particularly women. Other studies, particularly with transcatheter aortic valve replacement, have demonstrated why the investigation of sex-based differences in procedural outcomes is critical.\(^3,4\) Although the first publication of results with the Relay device featured gender parity with 52.6% being men, of the 26 patients who required iliac conduits in that study, 21 (80.8%) were women, with 1 woman ultimately being deemed anatomically unsuitable.\(^2\) Conduits were only required in 2 patients (2.9%) with the RelayPro and technical success was achieved in 100% of patients.

This all goes to show that the constant evolution of medical technologies is not only important for the goal of continuous improvement in clinical outcomes in general, but also for the principle of providing high-quality care to the wide variety of patients that we treat, regardless of sex, age, or race (see Figure 1).

**References**


110 patients with 39% Asian and 37% female participants, who typically tend to have smaller access vessels. The second-generation device is 3-4 French smaller compared with the previous generation with a technical advantage in navigating smaller access vessels apart from a shorter longitudinal curved nitinol wire that might have a better conformation to arch angulation and aortic curves. The newer-generation device compares well with the previous generation with significant improvement in major adverse events (6.4% vs 20%) and 100% technical success. Apart from smoother delivery of the device, lower profile and conformability can also reduce arch manipulation and the risk of subsequent stroke. The second-generation RelayPro device has a non-bare stent version that might have a further advantage in reducing the stroke risk by eliminating the bare stent across the arch vessels.

Reduction in the profile often raises concerns for device integrity. Although the stent diameter and design was not modified in the new generation, tightly woven polyester fabric was used in reducing the profile. Although we all welcome lower profile devices to avoid access-related complications, we hope it will not be at the expense of device integrity as learned from other devices mentioned in the report by the authors. Hence, we urge the authors to report their long-term data at 3, 5, and 10 or more years by creating a registry. Also, 2 important aspects of this 1-year study outcomes are worth highlighting. Despite the lower profile device the cohort still had a 5.5% vascular access complications rate despite being performed by experienced surgeons. Also the primary effectiveness at 12 months was 89.2%. Despite meeting study design parameters, it highlights the importance of patient selection because these complications will stay with us despite advances of stent graft design and lower profile.

Reference