Renal Therapy and Fishing: Let's Catch More King Salmon

Many of even my closest friends do not know this, but I used to be a fisherman. My mind was fixated on fishing during my childhood. Fishing was exciting. You plan and think well beforehand, seek the best tools, pick the ideal location, cast the bait at the right depth, and hope for the best. Despite all your efforts, however, sometimes you catch nothing. Even if the planning and execution are perfect and you hook a fish, you never know what you have until you reel it in. Sometimes it's a king salmon, but sometimes it's not the fish you intended (we call this "*Gedo*" in Japanese, and we often use this word in settings like dance parties).

Renal intervention is one of my favorite procedures. Like many of you, I have cured many hypertensions and anginas but taken only a handful of patients off hemodialysis. The reward is truly gratifying. However, just like fishing, despite the careful selection of tools, indication, and execution, you never know what you are going to get. It would be so much nicer if we could always catch the king salmon. Today, from a technical and technology standpoint, I believe we are at a satisfactory level, but we still need a better understanding of patient selection and the indications for intervention. I hate to put in all the effort only to find out that I caught a carp instead of a king salmon, or even worse, to get shipwrecked. If we keep missing the king salmon, it could put a bad name on the procedure, and in fact, the results of some ill-designed clinical trials have worked negatively against this very rewarding and often life-saving procedure.

To begin our cover feature section this month, we have asked Drs. Rajesh Dave, Matthew Edwards, and Thomas A. Sos to participate in a roundtable discussion of the current issues in renal therapy. Their insights on when to intervene, the use of embolic protection, the respective roles of today's devices, and reimbursement concerns are an excellent reflection of the state of renal intervention.

We are also happy to showcase a series of case studies that illustrate important teaching points. Pranav M. Patel, MD, and colleagues have contributed a case report detailing technically difficult cannulation and angioplasty for renal artery stenosis. This article shows some commonly encountered (though no less difficult) challenges in the renal arteries, as well as how careful technique and limited manipulation can yield favorable outcomes. Dr. Yoshiaki Yokoi from Japan presents a case in which revascularization of a CTO lesion led to recovery of renal function and improvement of refractory hypertension. The details of this case illustrate the challenges inherent in treating renal CTOs endovascularly, a procedure that is being performed with increasing frequency. Dr. Gustav R. Eles and colleagues describe a case of renal artery aneurysm exclusion, in which previous attempts at therapy were unsuccessful, but use of a new covered stent provided a good result. This case analysis provides a solid overview of renal aneurysm intervention and shows that percutaneous technologies may reduce the need for surgery in these patients. Next, Drs. Nanjundappa and Dieter outline the complications associated with endovascular renal therapy. In order to provide optimal care for our patients, we must fully understand the potential outcomes when procedures do not go according to plan. Finally, despite the recent focus on endovascular options for treating renal artery disease, we must maintain an understanding of the surgical options that have stood the test of time. Drs. Thomas A. Abbruzzese and Richard P. Cambria provide an excellent overview of the relevant surgical data and the key considerations when choosing the ideal therapy.

This month, we also interview Dr. Plinio Rossi, who is recognized worldwide as a founding father of interventional radiology. We hope you find this first issue of 2007 helpful in your approach to treating renal artery disease, and that we can all catch king salmon with increased frequency. ■

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