

**PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY WITH STENTING FOR RENAL ARTERY STENOSIS**

**To the Editor:**

The article "Screening, diagnosis, and treatment of renal artery stenosis by percutaneous transluminal angioplasty with stenting" by Kobo et al. published in *IMAJ* 2010;12(3):140-3, raises serious questions, both regarding its treatment algorithm and its final conclusions, which are contrary to contemporary recommendations. Its publication in a peer-reviewed journal should have included editorial comments.

The indications for treatment of renal artery stenosis (RAS) are questionable at best. The more established ones are uncontrolled hypertension, deteriorating renal function and flush pulmonary edema. Anatomic stenosis, by itself, is not an indication for this treatment. Current data on the clinical efficiency of stents in RAS are scarce, and controlled trials do not support the use of this procedure. Risk factor modification with medical treatment has an advantage over stent insertion to the renal arteries [1]. The ASTRAL investigators stated "We found substantial risks but no evidence of a worthwhile clinical benefit from revascularization in patients with atherosclerotic renovascular disease" [2].

Many, if not most, patients now being subjected to endovascular stenting of renal arteries show only limited benefits, either regarding blood pressure response or improvement in kidney function [3]. The American Heart Association guidelines state that the usefulness of percutaneous revascularization of an asymptomatic unilateral hemodynamically significant RAS in a viable kidney is not well established and is presently clinically unproven [4].

The work by Kobo et al., published in the March issue of *IMAJ*, presents a group of patients treated with percutaneous transluminal angioplasty and stenting of the renal arteries, based on angiographic stenosis of 70% alone. The patients were

selected from a group undergoing coronary catheterization, yet one of the indications for selective bilateral renal artery injection was the presence of coronary artery disease regardless of the location of the stenosis, the patients' blood pressure or kidney function.

The discrepancy between the accepted clinical guidelines and the recommendations of Kobo's group is striking. We believe that patients should be treated according to evidence-based medicine or accepted clinical guidelines and not according to notions. The best approach, as we see it, is the creation of a multidisciplinary team composed of a nephrologist, internist with special interest in blood pressure control, interventional radiologist and a vascular surgeon, who will discuss in detail the indications for treatment for this selected group of patients.

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**TIME TRENDS IN AUTISM**

**To the Editor:**

It may assist your readers to know of a reliable data source for the prevalence of autistic spectrum conditions (ASCs) in Israel. Two letters published in your September 2009 edition [1,2] debated widely diverging estimates from other sources (1.9 per 10,000 in 2004 versus 36 cases per 10,000 children born in 2001–2004).

However, other data were obtained from diagnoses of 17 year olds called up for conscription by the Israel Draft Board for military national service. Results were published in the study "Advancing Paternal Age and Autism" [3] (the "Paternal Age" study).

A figure of 8.4:10,000 autism cases was obtained from a cohort of 132,000 Israeli citizens born during 6 years ending no later than 1988. The Paternal Age figure suggests that until 1988 there were few cases of Asperger syndrome in Israel. The authors state that they had additional evidence indicating that most of the diagnoses were autism (here meaning "autism" under DSM IV/ICD10 or what is sometimes referred to as "classic," "typical," "infantile," "Kanner," "childhood" autism). The figure is also likely to be more reliable than others.

The diagnostic methods and criteria applied are contemporary ones under ICD 10 and therefore applicable to present-day conditions. The diagnoses were made in the period between 1997 and 2005 using contemporary diagnostic methods and criteria.

The population under consideration is likely to be representative of each annual birth cohort. The Israeli military will presumably take efforts to ensure that all eligible conscripts are drafted for military service while ensuring those physically or mentally unsuited are not.

The same data source may also assist in tracking the changing prevalence of ASCs in Israel. It is also in good accord with other formally published estimates

applicable to the mid-1980s, including Israel.

The seeming low prevalence of Asperger syndrome might appear surprising when compared with figures for later born birth cohorts in England. However, a comparison with England for autism suggests there has been a real increase in incidence and prevalence of all autistic conditions internationally since the mid-1980s.

Approximately 30% of English autistic conditions are autism and 70% are Asperger syndrome. Baird and co-authors in 2006 [4] established a benchmark for the mid-1990's prevalence in English child populations. This concerned 56,946 English children aged 9-10 years

born in a 2 year period ending no later than 1996. For classic autism Baird et al. provide two estimates:

- 24.8:10,000 (17.6-32.0) for narrow definition autism
- 38.9:10,000 (95% CI 29.9-47.8) for autism

The narrow definition figure meets autism criteria under DSM IV/ICD10, but also on both ADI and ADOS plus clinical judgment (personal communication: Prof. Gillian Baird 20 September 2006).

For all other autistic spectrum conditions (ASCs) Baird et al. 2006 provide an estimate of 77.2:10,000 (52.1-102.3). Baird 2006's total figure for all autistic conditions (i.e., including classic autism) is 116.1:10,000 (90.4-141.8).

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