avoid potentially contacting the disease or exposing others to the disease. Older patients with comorbidities are at particular risk of developing severe infection with COVID-19. Many people on anticoagulation are older and have significant comorbities.[1]

In many countries, including Turkey, governments have imposed restrictions on travel from home to limit the spread of COVID-19. Although so-called "sheltering in place" is proving to be an effective way to decrease community transmission, patients receiving vitamin K antagonist (VKA) treatment, like warfarin, may be harmed by such policies. Routine reporting of patients to outpatient clinics of hospitals or laboratories for checking their international normalized ratio (INR) places them at risk for community-acquired infection from COVID-19, whereas not traveling for INR checks places them at risk for a complication of over- or under-anticoagulation as INR levels can be labile in many patients on VKAs.

According to the current national and international guidelines, although therapy with novel oral anticoagulants (NOACs) is suggested over VKAs, due to reimbursement problems, many people with deep vein thrombosis of the leg or pulmonary embolism are still receiving VKA therapy.[2,3] VKAs are also used after venous stenting procedures in patients with chronic venous occlusion syndromes to avoid stent thrombosis. Although there are no definite recommendations about anticoagulation after venous stenting, many patients are receiving VKAs.

Patients with mechanical heart valve replacement also need to use VKAs for long-term anticoagulant therapy to avoid thrombosis. Current guidelines for the management of valvular heart diseases favor VKAs for long-term therapy after valve replacement surgery.[4]

Therefore, many patients need to travel to hospitals or laboratories to screen their INR levels, and it makes them more susceptible to the COVID-19 infection.

If possible during the current COVID-19 pandemic, patients requiring anticoagulant therapy for deep vein thrombosis, venous stent therapy, and nonvalvular atrial fibrillation should be converted to NOACs for decreasing their need to travel from home to avoid COVID-19 transmission without increasing their risk for anticoagulant therapy-related complications.

For patients with mechanical heart valves or who are unable to be treated with an NOAC therapy, INR in-home testing machines can be a convenient alternative method and allow patients to check their INR levels without a need for frequent visits to hospitals or laboratories. Thus, a decrease in hospital visits leads to minimizing COVID-19 transmission. Patients need to consult their doctors for interval of tests and results for adjusting VKAs.

As a result, considering that COVID-19 is transmitted by inhalation and close contact, the in-home INR test method and consulting the results by phone may be favorable. For those who are suitable for NOACs should be converted from a VKA to an NOAC. Such measures are important precautions to prevent the spread and inevitable consequences of disease in patients under anticoagulant therapies.

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Stenting procedure of nonthrombotic femoral or iliac vein stenotic lesions

We read with interest the article by Aurshina et al.[1] Chronic venous insufficiency of the lower extremities is a common vascular problem. Iliac venous system obstruction and superficial venous reflux are known as the main etiologic reasons.[2] Stenting of iliac venous obstruction with guidance of intravascular ultrasound is a promising treatment modality in recent years.[3]

We have some doubts concerning the manuscript. In the Results, 16 patients' Clinical, Etiology, Anatomy, and Pathophysiology classification is C5 and C6. There are no clear data about these patients' ulcer diameter regression during the follow-up period. Was there any benefit to the ulcers after stenting of culprit stenotic lesions?

In this study, percutaneous access was obtained in the ipsilateral femoral or common femoral vein with 10F sheath for all patients. The length of this sheath may extend to the common femoral vein stenosis. If the authors used a distal segment venous access (popliteal vein, saphenous vein) site, would it be an easier procedure for patients with common femoral vein stenosis?

The authors placed Wallstents in four patients for the common femoral vein stenosis. During the stenting procedure, Wallstents for the common femoral vein may increase stent thrombosis or fracture because of the inguinal crease[4]; dedicated venous stents with high flexibility and strong radial force have been developed for this purpose.[5] Were there any stent complications, such as stent thrombosis or fracture, especially in common femoral vein stenting patients?

We congratulate the authors on their valuable and safe treatment method. We would also like to hear the authors' opinions on these matters.

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Shall we focus on the additives of glue for phlebitis-like abnormal reaction?

I have read the case report on complications after cyanoacrylate closure (CAC) of the great saphenous vein using the VenaSeal closure system (Medtronic, Minneapolis, Minn) by Nasser et al[1] with great interest. I would like to thank them for actively citing my research as reference.[2]

Physicians who have experienced this complication will immediately notice that these phlebitis-like abnormal reactions (PLARs) are characteristic complications clearly different from existing phlebitis that occurs after thermal ablation. The author also experienced cases accompanied by painful swelling with pain score reaching 5 to 6 and severe rashes.[2] Although the occurrence of such PLARs cannot be avoided, preventive intravenous dexamethasone or oral antihistamine medication has been reported to significantly help lower its severity.[2]

First, the definition of PLAR is the most important. I believe the main clinical feature of PLAR is rash or pruritus over the treated area, which differs from typical phlebitis after thermal ablation. Rarely, generalized urticaria may be seen. A study by the author[2] reported that the incidence rate of PLAR is 25.4%; however, Gibson et al,[3] in their analysis of patients examined by six physicians during 5 years, observed hypersensitivity reaction in 6% patients, whereas 7% of patients presented with pain, tenderness, and swelling without erythema or itching, consistent with treatment of vein phlebitis without evidence of hypersensitivity reactions. I have observed that some patients do not report such experiences to their physicians because most PLARs resolve naturally. Consequently, in-depth history taking according to a unified definition appears to be important to accurately survey the occurrence of PLAR.

Tissue adhesives typically contain additives, such as dyes, plasticizers, polymerization inhibitors, and formaldehyde, in addition to pure *n*-butyl cyanoacrylate (NBCA).[4] Therefore, additives other than NBCA, which is a well-known allergen, should be considered in PLAR. Additives in these NBCA closure systems are not clearly revealed; therefore, it is unknown whether PLAR can be triggered by these additives. Moreover, PLAR cannot be defined as totally delayed hypersensitivity[5] as antibody-mediated hypersensitivity against various additives, other than NBCA, is possible. In particular, cases of PLAR occurring within 3 days have been clinically observed.[2]

CAC is an innovative treatment modality with numerous advantages over the traditional thermal ablation. However, I believe that to define the cause of PLAR, we must investigate the various substances included in tissue adhesives. I hope that many physicians and research institutions that treat chronic venous insufficiencies with the CAC system may achieve great results.

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