The Vascular Surgeon

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From the President.....

Richard Green, M.D.

Dear SVS Member;

As we move forward with our reorganization we are addressing the critical issues facing vascular surgeons. Our immediate goals are to redefine our specialty, recruit attractive candidates, retrain our workforce, reclaim our leadership in the diagnosis and treatment of non-coronary vascular disease and remain financially viable. Each of these goals is attainable with help from all of you.

This has been a busy summer. The legal process to merge the two societies has gone forward and we are now one. The Executive Committee has appointed members to fill the three new councils as well as the Fellows Council. We are working on preparations for Vascular 2004 next year's annual meeting in Anaheim. For the first time programming will be coordinated with the SVMB, the SVU and the PVSS.

We are committed to using the new organization and centralized office to meet the needs of our membership. The three new councils will address advocacy, educational, and research related activities and will be led by Bob Zwolak, Julie Fleishlag and Bauer Sumpio respectively. Enrico Ascher will coordinate all the committee activities. Greg Sicard is actively working with Rebecca Maron on the strategic plan.

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SVS Leadership Retreat

Six strategic initiatives were identified at an SVS strategic planning retreat in September attended by the Board of Directors and nearly twenty additional stakeholders from the vascular surgery community. The following initiatives will be initiated by SVS within the next one to six months. We will share additional details as implementation plans are developed.

1. Lead an effort to modify the current vascular training paradigm.
2 Enhance SVS educational offerings.
3. Create a comprehensive plan to increase public awareness of vascular health and the role of the vascular surgeon in vascular disease.
4. Strengthen the SVS government relations program.
5. Prepare the appropriate legal documents, business plan and infrastructure to create one foundation for vascular surgery.
6. Develop a strategy to coordinate and centralize relations with vascular industry.

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SVS
SOCIETY FOR VASCULAR SURGERY

From the New SVS Executive Director....

Rebecca Maron, CAE

Greetings from your new headquarters office in downtown Chicago! Since the merger of SVS and AAVS in June, there have been a number of exciting changes in how your Society is managed.

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Meet the New Members of the Council .....

Gregorio A. Sicard, M.D.
President-Elect

Dr. Sicard is Professor and Vice-Chairman of the Department of Surgery and Chief of the Division of General Surgery and Section of Vascular Surgery at Washington University School of Medicine, Barnes-Jewish Hospital in St. Louis, Missouri. In addition, he is Program Director of the Vascular Surgery Fellowship program at Washington University School of Medicine.

Dr. Sicard received his undergraduate degree from Saint Louis University and his Medical Degree from the University of Puerto Rico School of Medicine, where he graduated Cum Laude in 1972. He completed his internship and general surgical residency at Barnes-Jewish Hospital and was a Renal Transplantation Fellow from 1977 to 1978 at Washington University School of Medicine.

Dr. Sicard joined the faculty of Washington University School of Medicine as an Assistant Professor of Surgery in 1978, was appointed Chief of the Section of Vascular Surgery Service in 1983, Chief over the Division of General Surgery in 1998 and recently, appointed as Vice Chairman over the Department of General Surgery.

Dr. Sicard's basic and clinical research interests are primarily in the field of renal function preservation. His current clinical efforts are focused in the area of endoluminal vascular technology. In the latter, he is the principal investigator of three FDA trials in aortic and iliofemoropopliteal endoluminal vascular stent graft devices.

Dr. Sicard is a member of various editorial advisory boards and has published more than 150 journal articles and over 45 book chapters.

Enrico Ascher, M.D.
Vice President

Vice President Dr. Enrico Ascher completed his vascular residency training at the Albert Einstein College of Medicine in 1982 under the mentorship of Frank J. Veith, M.D. Soon thereafter, he joined the surgical faculty at Montefiore Medical Center until 1989, when he moved to Maimonides Medical Center in New York to head the Division of Vascular Surgery Services and to be the Chairman of the Vascular Institute of New York®.

Dr. Ascher is a prolific writer who has made numerous important contributions to vascular surgery, particularly in the field of limb salvage and carotid disease. In addition to having an extremely busy clinical practice, he finds time to run a basic science research laboratory. He has authored approximately 150 scientific papers and 60 book chapters. Dr. Ascher is also the Editor-in-Chief of the 5th Edition of Haimovici's Vascular Surgery: Principles and Techniques. His scientific work has been recognized worldwide and he has lectured extensively in Europe and South America.

Dr. Ascher has organized several well-attended national and international scientific meetings, including the now well-established Pan American Congress on Vascular and Endovascular Surgery.

In Dr. Robert Hobson's introduction to Dr. Ascher's election, he emphasized two important aspects of Dr. Ascher's career, namely his creative abilities and leadership qualities. One of Dr. Ascher's important goals for the SVS is to ensure that the vascular surgeon is acknowledged as a complete vascular specialist (surgeon, clinician, and interventionist).

Kenneth Ouriel, M.D.
Recorder

Dr. Kenneth Ouriel is presently the Chairman of the Department of Vascular Surgery at the Cleveland Clinic Foundation, and a Professor of Surgery at the Cleveland Clinic Lerner College of Medicine at Case Western Reserve University. Dr. Ouriel obtained an undergraduate degree at the University of Rochester, received his M.D. with Honors from the University of Chicago Pritzker School of Medicine, and then returned to the University of Rochester for his general surgical residency and vascular surgical fellowship. Dr. Ouriel stayed on the faculty in Rochester for 11 years before he was recruited to the Cleveland Clinic as its 4th Chairman of Vascular Surgery.

Dr. Ouriel is an active clinical surgeon, with interests that span the spectrum from percutaneous catheter-based interventions to the open repair of thracoabdominal aortic aneurysms. His research interests have centered on the minimally invasive solutions to vascular disease, and he has organized and participated in a wide variety of multicenter clinical trials on thrombolytic therapy, endovascular aneurysm repair, and carotid stenting. The training of vascular surgical fellows has always been a priority for Dr. Ouriel, currently the director of the program at the Cleveland Clinic. Among his 28 former fellow trainees are 2 editors of the *Journal of Vascular Surgery*, one vascular surgical program director, and one vascular surgical division chief.

WELCOME NEW MEMBERS

Ahmad Abu Ghaida, M.D.
Baltimore, Maryland
Omran R. Abul Khoudoud, M.D.
Memphis, Tennessee
Riad Adoumie, M.D.
Torrance, California
Donald L. Akers, Jr., M.D.
New Orleans, Louisiana
Christopher M. Arismendi, M.D.
Stockton, California
Frank R. Arko, M.D.
Stanford, California
Gregg D. Azin, M.D.
Bend, Oregon
Frederick P. Beavers, M.D.
New York, New York
Thomas R. Bernik, M.D.
Tenafly, New Jersey
Joaquim J. Cerveira, M.D.
Newark, New Jersey
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Roslyn, New York
David P. Christenberry, M.D.
Camden, South Carolina
Daniel G. Clair, M.D.
New York, New York
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Tripler AMC, Hawaii
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Rochester, New York
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Grants Pass, Oregon
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Cleveland, Ohio
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Jacksonville, Florida
Allen D. Hamdan, M.D.
West Roxbury, Massachusetts
William W. Harkrider, M.D.
New Iberia, Louisiana
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Baltimore, Maryland
William M. Shafer, Ph.D.
Decatur, Georgia
Richard Whitney, III, M.D.
Baltimore, Maryland

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Medicare in 2004

Robert M. Zwolak, M.D.

Congress has come no closer to fixing the broken fee schedule payment formula. According to the proposed 2004 Medicare payment rule, published by CMS in mid August, physicians caring for Medicare beneficiaries will see a 4.4% across-the-board pay-cut on January 1st . The value of one RVU will fall from the 2003 level of $36.78 to just over $35.00. Only a direct action by Congress can block this formula-based reduction, and the likelihood of that is unclear. The House included a 1.5% conversion factor increase in its version of the Medicare Prescription Drug bill, but there is no parallel language in the Senate bill. Currently little progress is being made by aides trying to hammer out the differences between House and Senate versions of this bill, and concern exists that the White House may not have the horsepower to push the effort to fruition. If the bill fails to pass, or if the House conversion factor clause is negotiated out, physician payment and Medicare patients will lose. The potential for another Medicare pay-cut and further reduction in beneficiary access to care lies directly ahead.

The SVS has begun to pursue a Medicare aortic aneurysm screening benefit. This will require an act of Congress, and the Society is following two potential avenues. First, a provision in the House Energy and Commerce Committee report on the Medicare Prescription Drug Bill would require the Agency to establish an AAA screening program as long as the United States Preventive Services Task Force deems this a worthy preventive service. The Task Force is scheduled to review AAA screening this fall. The second approach to achieve Medicare AAA screening is via a specific bill, and the Society has identified several willing co-sponsors. Bill language has been created, and economic analysis is underway. This is an extremely exciting and progressive project. While it may not come to fruition immediately, AAA screening is a laudable goal with the potential to save 15,000 American lives per year.

Several new vascular CPT* codes should appear in the CPT Manual for 2004. Final decision regarding these codes and their descriptors will be announced by the CPT Editorial Panel this fall, and Medicare payments for new services should be published by CMS in early November. The final codes and payments will be announced on www.vascularweb.org when available. An interim progress report on our CPT applications is summarized here.

CPT 34805 is a potential new code to report endovascular repair of an infrarenal abdominal aortic aneurysm using an aorto-uni-iliac device. Prior to 2004 placement of an AUI graft has been reported with the Emerging Technology Category III code 0002T. In April 2002 the FDA granted approval to the Guidant Ancure AUI graft, allowing SVS and SIR to apply for conversion to Category 1 status. This is actually the first Category 3 to Category 1 conversion ever accomplished by CPT, and we were disappointed that no expedited pathway exists for the maneuver. Nevertheless, 34805 may join and expand the existing family of Category 1 endovascular infrarenal AAA repair codes, CPT 34800, 34802, and 34804. Coding for the AUI graft will follow established endovascular component coding rules.

Currently, the only means to code an upper extremity bypass graft is with the unlisted vascular surgery code 37799, and payment has been extremely variable or even nonexistent. CPT 35510, 35512, 35533, and 35525 may be approved to represent a family of new codes for upper extremity bypass grafts using vein conduit. This family of codes should solve the problem for most vein conduit procedures. If there is significant need for upper extremity bypass graft codes to reflect synthetic conduit use, SVS can apply for those in a subsequent year.

Likewise, there has never been a code or any reimbursement, to report reimplantation of an inferior mesenteric artery in the unusual situation where the surgeon must do so to prevent ischemic necrosis of the colon. CPT 35697 will hopefully be approved to report reimplantation of a visceral artery during open aortic reconstruction operations, e.g. AAA repairs and aorto-bifemoral bypass. Although this code will not pay much, it will at least reflect the fact that there is high-intensity work that must be done when this situation is recognized. This code should also be reportable when an accessory renal artery is reimplanted during infrarenal aortic surgery.

Distal revascularization and interval ligation (DRIL) has been shown as an effective means to treat hemodialysis access steal syndrome while allowing retention of the dialysis access itself. CPT 36838, if approved, will be used to report DRIL. Currently there is no formal means to report this complex operation.

Finally, CPT 37765 and 37766 may be approved to report stab phlebectomy of varicose veins. The first potential code would represent an operation involving 10-20 incisions on one limb, while the

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LIFELINE ENDOGRAFT REGISTRY:
AAA & TAA Data Reporting and Surveillance Programs

Rodney A. White, M.D., Lifeline Registry Steering Committee

The Lifeline Registry for Aneurysm Repair was established in October 1998. It has developed various clinical and data collection protocols through the efforts of key key experts and independent consultants to address the introduction of new EVAR (endovascular aneurysm repair) technologies. The registry was initiated through a unique collaboration involving clinical investigators, the medical device industry and representatives of both FDA (Federal Drug Administration) and CMS (Center for Medicare and Medicaid Services). Two key organizations are the Lifeline Foundation of the SVS as the organizing body and source of clinical information, and NERI (New England Research Institutes, Inc.), the registry data and statistical center.

The Lifeline Registry for Endovascular Aneurysm Repair offers two unique data reporting options: 1) 5 year surveillance fulfilling manufacturers post-market approval requirement on patients presented in PMA studies at the time of FDA approval, and 2) a clinical registry for commercial devices implanted following FDA approval, and for devices being implanted as part of FDA approved Investigator IDE's.

At present, the PMA surveillance cohort data consists of patients participating in the Medtronic Aneurx and Guidant Ancure studies that lead to commercialization of these products. Data from the Gore Excluder and Cook Zenith devices that were recently approved are being prepared to entry into the Registry. Plans to add the Medtronic Talent and Endologix device data following their approvals is anticipated. Additional future commitments from other manufacturers to submit their data to the Registry and to perform surveillance through the Registry has been accomplished, promising to make the Lifeline Registry a very comprehensive and valuable source of information regarding the introduction and long-term function of EVAR technologies. The PMA cohort currently consists of approximately 1800 patients with 3 to 7 year follow-up. In light of the high compliance reporting rate (approx 80%) for this data, as it represents the information from mandated FDA reports, the information is a unique and valuable information source on the performance of currently approved AAA endograft devices.

A manuscript published recently in the Journal of Vascular Surgery reviews the history, mechanisms of operations and the future perspectives for the Lifeline Registry Program.[1] An additional publication in the Journal of Vascular Surgery has initiated the reporting of data from the PMA patient data sets, with periodic reports to be updated in the future JVS publications.[2]

The second function of the Registry is to offer a surveillance and reporting mechanism for commercial patients receiving devices following FDA approval, and for approved FDA Investigator IDE's for AAA (abdominal aortic aneurysms) and TAA (thoracic aortic aneurysms). Physicians and hospitals adopting EVAR are being confronted by an escalating need to develop cost-effective, reliable means to not only select appropriate patients, but provide post-implant surveillance. A post market feasibility study was conducted by the Lifeline Registry which is analyzing a method to provide reliable electronic storage of data that would fulfill not only the clinical need for rapid, accessible and reliable data for sequential patients visits, but also potentially make this data available to centers around the world electronic transmission, if needed. The surveillance concept is applicable to all patients with endoluminal devices and has been found to be very helpful in identifying patient variables that enhance successful selection of patients for the procedures. The global benefit of a cost-effective registry and surveillance program promotes not only more rapid and appropriate development of the technology, but also enhances appropriate patient selection and assures recognition of problems that develop that require reintervention.

A clinical device surveillance component of the Registry offers qualified clinical centers an option to utilize a standardized Investigator IDE protocol and reporting forms with patient data, and selected images being stored on a secured Registry website. Centers complying with FDA approvals using the Registry format can fulfill appropriate portions of annual reports using standardized mechanisms established by the Agency and the Registry. The site has also been developed to provide an efficient surveillance and data storage mechanism for practicing clinicians.

In summary, the Lifeline Registry for Aneurysm Repair establishes a new mechanism for assessing the success of endovascular prostheses used in FDA approved trials and in clinical practice with the goal being to enhance technology development and to offer an efficient surveillance and data storage option.

References

1. Lifeline Registry: Collaborative evaluation of endovascular aneurysm repair. J Vasc Surg 2001: 34:1139-46.
2. Lifeline Registry of Endovascular Aneurysm Repair: Registry data report. J Vasc Surg 2002; 35:616-20.

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Highlights of VASCULAR 2003 - SVS Scientific Session

Arguably the most important future training challenge to the vascular society membership was discussed by President-elect Richard Green in the E. Stanley Crawford Issues Forum: "Keeping Current, New Technologies for New Procedures". Multiple endovascular procedures have found a place in the treatment algorithm of vascular diseases that were traditionally treated with open vascular surgical procedures. With the results of the most recent carotid angioplasty and stent placement trials, a majority of the vascular surgeries may become endovascular therapies in the very near future. Dr. Green focused on the endovascular skills of the current vascular surgery workforce and the Society's plans for training the vascular surgeon.

Richard Green, M.D., President

The importance of having advanced endovascular training and skills was underlined in the plenary session by the results of the SAPPHIRE multicenter randomized trial of carotid endarterectomy versus stenting with emboli protection. 307 patients with "high risk" medical co morbidities (history of heart failure, recent myocardial infarction, unstable angina, coronary revascularization, chronic pulmonary disease or chronic renal insufficiency) or anatomic risk factors (prior radical neck dissection or radiation therapy, recurrent stenosis, high carotid lesion, or carotid lesion below the clavicle) were randomized. The overall combined death/stroke/MI rate was significantly lower in the stent group (5.8%) compared to the CEA group (12.6%). The subgroup with medical comorbidties had a significantly lower combined death/stroke/MI and stroke alone rate in the stent group (2.8% and 0%) compared to the CEA group (15.5% and 7%). Patients with anatomic risk factors had no significant differences between the two therapies, but stroke appeared higher after CEA. Dr. Ken Ouriel, Dr. Jay Yadav and the SAPPHIRE Investigators concluded that carotid stenting with emboli protection was associated with improved outcome compared with endarterectomy in high-risk patients.

Other endovascular papers on the SVS plenary session focused on the treatment of abdominal or thoracic aortic aneurysms. The results of the prospective, multicenter trial of the balloon expandable, modular bifurcated stent-graft Lifepath System for endovascular aortic aneurysm repair in 182 patients were presented. The successful implant rate was 98% and initial endoleak rate was 12% (4 Type I and 17 Type II), with only one persistent Type II endoleak at 24 months following either spontaneous resolution or secondary interventions. The authors reported a significant reduction in AAA sac diameter and volume, a low endoleak rate, and potential advantages of precise placement and high radial force with the balloon expandable design. The results from the Zenith multicenter prospective trial were presented on the outcome of patients with endograft oversizing at the aortic neck. Patients with >30% endograft oversizing (4/28, 14.3%) had a significant ($p<0.001$) increase in migration compared to <30% (0.9%, 2/230), despite suprarenal barb fixation. At 24 months, the endoleak rate was also increased in patients with >30% endograft oversizing (18.2%, 2/11) compared to <30% (4.9%, 95/103), but did not reach significance ($p=0.08$). SVS recorder K. Craig Kent and colleagues presented the patient outcome of endograft (n=729) and open (n=1204) AAA repair during 2000 and 2001 from the New York state database. On a statewide experience endograft repair had a marked decrease in length of hospital stay with 55% of patients discharged less than 3 days and a superior mortality rate (1.5% vs. 4.9%) as compared to open repair. SVS secretary Rodney White and colleagues reported their experience with 58 emergent or high-risk patient endograft repairs of TAA or dissections (mortality rate 14% and 9%, respectively). During follow-up 18 patients had secondary endovascular procedures (14 endoleak, 3 recurrent or pseudoaneurysm, 1 AAA endograft repair). They concluded that endograft repair of TAA or dissections in emergent or high-risk patients had improved outcomes compared to traditional open repair. SVS President Jack Cronenwett and associates analyzed the CT scan anatomic characteristics of 112 ruptured and 122 electively repaired AAA's. Even matching for maximum AAA diameter, ruptured AAA's had significantly larger supraceliac aorta diameter (29 vs. 26 mm, $p<0.001$) and larger infrarenal aorta diameter (29 vs. 24 mm, $p<0.001$). They concluded that the majority of ruptured AAA's could undergo endovascular repair with endografts having >30 mm diameter and suprarenal fixation. Work supported by the 2002 SVS Marco Polo Award on transcutaneous, non-invasive, intrasac pressure monitoring following endograft repair on a porcine AAA model was also presented. Type II and III endoleaks were detected with this new, promising miniaturized pressure-monitoring device.

Anthony Imparato, M.D. received the Distinguished Service Award.

Highlights of VASCULAR 2003 - SVS Scientific Session

The SVS plenary sessions had several papers focusing on the diagnosis, risks and treatment of cerebrovascular disease, in addition to the SAPPHIRE trial discussed above. AAVS President Thomas Riles and colleagues presented the results of a community-based stroke screening program of 610 patients in which >50% carotid artery stenosis was significantly more prevalent in patients with known hypertension (12.7%, p<0.05), heart disease (18.2%, p<0.0001), and both risk factors (22.1%, p<0.0001) as compared to those without (8%). They suggested that carotid screening could be performed in a cost-conscious manner, with the direct cost less than $75 per patient in their study. The General Infirmary at Leeds, United Kingdom analyzed the changes in carotid plaque echomorphology with grey scale medians after a neurological event reporting that symptomatic plaques (n=61) do remodel after 1-3 months but continue to have significantly more echolucency and heterogeneity as compared to asymptomatic plaques (n=47), suggesting an increased stroke risk. The University of Michigan reported that the risk of stroke following non-carotid artery vascular surgeries (2551 AAA, 2616 aortobifemoral bypasses, 6866 lower extremity bypasses, 7442 major amputations) was 0.5%, with the need for reoperation, postoperative myocardial infarction, prior stroke or TIA, and pre-operative ventilation as independent risk factors. Patients with postoperative stroke had significantly increased perioperative mortality (16%, p<0.001) as compared to without (2.5%) and had a 48% increase in length of stay. Leicester University, United Kingdom reported that heparin administered for carotid endarterectomy on 41 patients significantly increased platelet aggregation (in response to arachidonic acid by aggregometry) during and beyond 4 hours post-operatively, one potential explanation for cardiovascular events following major vascular surgery. The University of Pittsburgh presented the results of contralateral carotid artery surveillance in 279 patients after carotid endarterectomy demonstrating an annual rate of any progression of 8.3% and of progression to severe or occluded of 4.4%. Clinical and demographic factors were not predictive of progression in this study. CREST Office/UMDNJ studied carotid duplex scan criteria performed within 3 days after carotid artery stenting and documented increased peak systolic velocities in the absence of stenosis. They suggested that the elevation in velocities may be related to increased stiffness of the stented internal carotid artery and proposed new velocity criteria, PSV≤150cm/sec = 0-19% stenosis.

Jack L. Cronenwett, M.D. Past President

Dennis Harkins, M.D. (left) received the Resident Research Prize from James S.T. Yao, M.D.

K. Wayne Johnston, M.D. (left) and Robert Rutherford, M.D. were recognized for their editorial contributions.

The SVS plenary session papers on the management of venous disease included three prospective controlled trials. Dr Frank Padberg presented the results of a structured exercise program in 77 patients with severe chronic venous insufficiency, resulting in significantly improved calf muscle function and strength. Following 6 months mean ejection fraction and residual volume fraction improved to the normal range, but no change in reflux. They concluded that physical conditioning of the calf muscle might help patients with CVI. St. James Vascular Institute in Dublin, Ireland presented the results of a randomized trial comparing conventional varicose vein surgery (n=100) to Trans-illuminated Powered Phlebectomy (TriVex TM, n=88). TriVex limbs had a 7 to 1 decrease in the number of incisions compared to conventional surgery. They reported no significant difference in pain, bruising, cellulitis, nerve injury and overall satisfaction perioperatively or recurrent veins and cosmesis at twelve months. The Netherlands reported the results of a randomized, multicenter trial comparing ambulatory compression therapy (n=97) to Subfascial Endoscopic Perforating Vein Surgery (SEPS, n=103) in patients with venous ulcers, CEAP C6. With a mean follow-up of 29 months, ulcer healing and recurrence rate was 83% and 22% for SEPS and 73% and 23% for compression, respectively. By sub-group analysis ulcers size (area>250) and duration (>4 months) were independent factors significantly influencing healing and recurrence, and the authors concluded that SEPS offers better results in these selected cases.

Other topics on the SVS plenary session included blue toe syndrome, peripheral arterial occlusive disease and dialysis access. The Mayo Clinic studied

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Highlights of VASCULAR 2003 - AAVS Scientific Sessions

In a paper from the Netherlands, results from a study undertaken to assess whether there were differences in midterm outcome of EVAR in patients with small, medium and large aneurysms, the authors concluded that aneurysms of 6.5 cm or larger were more frequently associated with higher preoperative risk, and with an increased rate of postoperative device- or procedure-related complications. The midterm outcome of large aneurysms was associated with increased rates of death-from all causes, aneurysm-related death, more frequent need of conversion, and a higher rate of post-EVAR rupture. Reports on EVAR should stratify their outcomes according to the diameter of the aneurysm. Large aneurysms need a more rigorous post-EVAR surveillance schedule than patients with smaller aneurysms.

Dr. Greenberg and colleagues from the Cleveland Clinic, evaluated the technical and physiologic outcomes of an endovascular graft that incorporates the visceral aortic segment with graft material and concluded that the procedure was technically feasible. The incidence of endoleaks was exceptionally low. Migration may become an issue and will require more patients and extended follow-up.

Accurate endoleak detection and classification is critical for the follow-up of patients who have undergone EVAR. A study by Dr. Stavropoulos and colleagues from the University of Pennsylvania determined that CT angiography (CTA) lacks the diagnostic accuracy to provide accurate endoleak classification. CTA is limited, as it cannot determine flow direction, which is vital for proper endoleak categorization. The change in endoleak classification based on DSA in comparison to CTA resulted in a significant change in management in 21% of patients.

Steinmetz and colleagues from Washington University School of Medicine reviewed the treatment strategies of Type II endoleaks (T2EL) following endovascular AAA Repair (EVAR) to determine a safe and cost-effect approach. Some investigators have recommended early intervention, while others have suggested that selective intervention in patients with persistent endoleaks and aneurysm enlargement is a safe and cost-effective strategy. The authors found that persistent T2EL was graft dependent. The authors concluded that selective intervention for patients with T2EL that persist for 6 months and are associated with aneurysm enlargement is both a safe and cost effective approach.

A study from France, which include our 2002 Marco Polo Award Recipient, examined the outcomes of secondary interventions following EVAR. Their analysis demonstrated that one out of four patients treated by EVAR required secondary intervention(s). The primary indication for secondary intervention was endoleak. The high failure rate of coil embolization (57%) for type II endoleak warrants a search for new treatment approaches. The impact of secondary interventions on long term survival remained negligible in this series.

Kieffer and colleagues evaluated early and late results of allograft replacement for infrarenal aortic graft infection in 179 patients from 1988 to 2002. Early post-op mortality was 20.1% and was highest in those with aortic-enteric fistula and septic shock. The authors concluded that early and long-term results of allograft replacement compare favorably with those of other methods to manage infrarenal aortic graft infections. Follow-up remains mandatory because of a significant number of late events. Cryopreserved allografts seem preferable to fresh allografts especially in terms of late allograft complications.

Williams and colleagues at Johns Hopkins tested the hypothesis that an angiographic search for the major artery supplying the spinal cord would prevent paraplegia. They concluded that preoperative intercostal angiography is of value in patients having extensive fusiform thoracoabdominal aortic aneurysms. Individual anastomosis of one or two intercostals pairs may be more reliable than in the case of aortic dissection because associated mural thrombus mandates collateral formation of those remaining patent.

The group at Massachusetts General Hospital concluded that long-term clinical success in the preservation of renal function can be predicted by the initial response to surgical renal artery revascularization (RAR) as well as anatomic factors, in particular, bilateral repair. While extreme (mean cr ^{3} ^{3}3.2 mg/dl) renal dysfunction generally predicts a poor long-term outcome, a subset of patients will experience favorable results even to the extent of rescue from dialysis. These results facilitate clinical decision making in the application of RAR for renal function salvage.

One of the most important tenets of vascular surgery is risk stratification in order to weight the benefit of surgical intervention. A study from the University of Minnesota determined the predictive value of Adenosine Stress Thallium Imaging (ASTI) for perioperative mortality and long-term mortality. The authors concluded that contrary to previous studies, myocardial perfusion defects detected by ASTI are not predictive of either postoperative or long-term mortality in patients who underwent a vascular procedure. The relatively high mortality observed in patients with negative studies highlight its poor predictive value in the vascular population that suffers from a high prevalence of coronary disease. The authors concluded that routine ASTI was not useful.

The superficial femoral vein (SFV) has proved to be a versatile autogenous conduit for arterial reconstruction. Although late venous complications are unusual, SFV harvest may induce severe venous hypertension and predispose the limb to acute compartment syndrome. A study, from the University of Texas Southwestern

Highlights of VASCULAR 2003 - AAVS Scientific Session

Medical Center, was conducted to define the frequency of fasciotomy in patients undergoing SFV harvest and to identify clinical predictors of the need for fasciotomy after SFV harvest. Modrall and colleagues concluded that nearly one in five patients undergoing SFV harvest for aortoiliac reconstruction may be expected to develop acute compartment syndrome and require fasciotomy. The risk appears to be greatest in patients with severe lower extremity ischemia and in patients undergoing simultaneous GSV and SFV harvest. Prophylactic fasciotomy may be appropriate in patients with both risk factors, but vigilance for the development of compartment syndrome after SFV harvest is required in all patients undergoing SFV harvest for aortoiliac reconstruction.

Using the reporting standards for dialysis access, Cull and colleagues from South Carolina, conducted a study to determine the infection, patency rates, and factors that affect the outcome of prosthetic thigh AV access. Their conclusion was that prosthetic AV access in the thigh is associated with higher morbidity compared to that reported for the upper extremity and should be considered only if no upper extremity AV access option is available. Early access failure and the requirement for an increased number of interventions to maintain access patency are more common in patients with diabetes mellitus and obesity. Hemodialysis via a tunneled cuffed catheter in preference to a thigh AV access may be appropriate in selected patients with those risk factors.

Reed and colleagues at Montefiore Medical Center have developed and evaluated a system to aggressively reduce vascular length of stay (LOS), critical for optimal utilization of hospital resources. Key to this system is the appointment of a committed LOS officer with major specific daily responsibilities for decreasing length of stay and discharging patients. Length of stay in 2000 averaged 8.5 days compared to 5.9 days in 2001 and 5.6 days in 2002. All decreases in length of stay were statistically significant and there were no significant changes in readmission rates. This resulted in a 31-33% cost saving to the hospital without negatively impacting on patient care.

Cardiovascular disease is prevalent in first-degree relatives of young adults with premature-onset peripheral arterial occlusive disease (PPAD), but it is not known whether the genetic influence is independent of other atherosclerotic risk factors, the most prevalent of which is smoking. Valentine and colleagues at the University of Texas Southwestern Medical Center set out to determine the relative contributions of genetic factors and smoking in the development of occult PAD in siblings of patients with premature PAD. The authors concluded that family history is a major determinant of PPAD and is at least as important as standard atherosclerotic risk factors. Smoking and family history act additively to increase the risk of PPAD, but PPAD is likely to be present even in the absence of smoking in relatives of patients with PPAD.

Infrainguinal bypasses for limb salvage are often complicated by prolonged recovery and multiple reoperations and readmissions. In this study, surgeons from the University of Arizona attempted to answer the question, “Have we underestimated the expenditure of effort required to attain limb salvage?” In a retrospective analysis, they found that nearly half of patients require readmission within six months, and over 40% require repeat leg surgery, usually further attempts to heal the foot. Diabetes, renal failure, CHF and native American ethnicity all significantly increased the risk for prolonged recovery. Prolonged time-to-healing, need for repeat surgery, and need for hospital readmission are all associated with significant health care costs and patient morbidity. Traditional reporting standards for limb salvage

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Members enjoy the Gala Reception at the Art Institute of Chicago

The Vascular Surgeon

AVA Update

Robert W. Hobson, II, M.D.

Current AVA activities include:

Fund-raising for the AVA continues at a successful pace. A breakfast meeting with contributors and interested company representatives and AVA Board members was held during the June vascular meetings in Chicago. Programs were reviewed and interest was high among a group of 10 representatives, some currently supporting AVA financially and another group considering support. Currently available funds will cover expenses for AVA programs including the Task Force on Public Education (Screening) and the clinical research organization (American Vascular Research Organization, AVRO).

The AVA Task Force on Public Education and its Screening Program, as chaired by Dr. Bill Flinn conducted a successful national screening program May 17, 2003 at 78 centers from this effort was presented (see AVA Screening Program report next page). Data from this effort were presented at the vascular meetings in Chicago. The American Heart Association, the Vascular Disease Foundation, and our membership have expressed great interest in the utility of screening and have requested follow-up information on this year's program. A budget for this expanded program has been reviewed and approved by the AVA Board of Directors.

The AVA American Vascular Research Organization (AVRO), chaired by Dr. John Blebea is now composed of representatives from 98 clinical sites. An investigators' meeting was held at the annual vascular meeting in Chicago on Sunday, June 8th. The agenda included selection of a leadership committee as well as notification of manufacturers interested in participating with this clinical research group. A first-year budget has been approved by the AVA Board, which will re-evaluate AVRO's future success.

Discussions have been held on the potential merger of programs currently managed by the American Vascular Association and the programs of the Lifeline Foundation. Dr. Green is supervising this activity.

2004 Wylie Scholar Award In Academic Vascular Surgery

The Pacific Vascular Research Foundation Is Accepting Applications For The 2004 Wylie Scholar Award In Academic Vascular Surgery. The Wylie Scholar Award was established by the Pacific Vascular Research Foundation to honor the legacy of Edwin J. Wylie, MD, by providing research support to outstanding vascular surgeon-scientists.

Purpose:

The Award is designed to enhance the career development of academic vascular surgeons with an established research programs in vascular disease. The award consists of a grant in the amount of $50,000 per year for three years. Funding for the second and third years is subject to review of acceptable progress reports. This three-year award is non-renewable and may be used for research support, essential expenses, or other academic purposes at the discretion of the Scholar and the medical institution. The award may not be used for any indirect costs.

Eligibility:

The candidate must be a vascular surgeon who has completed an accredited residency in general surgery and who holds a full-time appointment at a medical school accredited by the Liaison Committee on Medical Educators in the United States or the Committee for the Accreditation of Canadian Medical Schools in Canada.

How to Apply:

The applications are due by February 1, 2004 for the award to be granted July 1, 2004. Applications may be obtained by writing to: Pacific Vascular Research Foundation, Wylie Scholar Award, 3627 Sacramento Street, San Francisco, CA 94118 or via email at info@pvrf. org.

Pacific Vascular Research Foundation

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October 2003

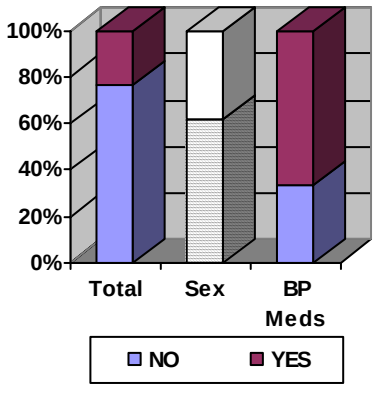
AVA Screening Program

William R. Flinn, M.D.

The 2003 American Vascular Association National Screening Program was performed this May at more than 60 centers representing 22 states nationwide. During this year's program almost 3000 older Americans were tested for carotid disease, AAA, and PAD. The AVA Screening Program has established itself as the largest, most comprehensive population based screening for vascular disease ever performed. It is anticipated that this program will, now and in the years to come, provide unique and unparalleled information about the prevalence of vascular disease in our population and its current level of treatment – information that will be crucial to future health care planning.

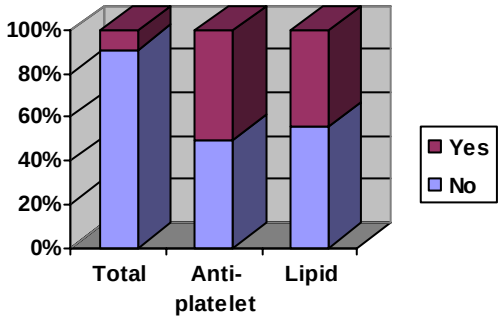
The results of this year's program strongly confirm the observations recorded from the 2002 inaugural screening.

Hypertension - BP > 160



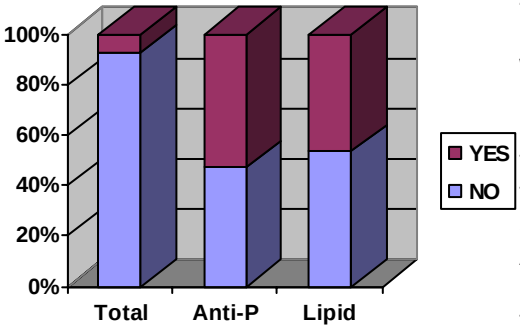
23% of those screened had a systolic BP > 160 mmHg. More than one third of those with hypertension reported that they were not being treated with antihypertensive medications. More than half the people found to have hypertension were women. People found to have PAD, carotid disease, and AAA were significantly more likely to have hypertension at the time of screening.

PAD - ABI < 0.85



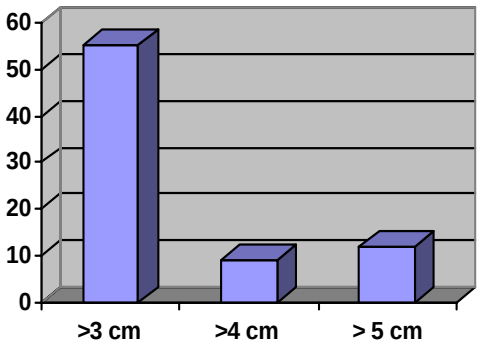
Almost 10% of people screened were found to have PAD (ABI < 0.85). PAD was significantly more prevalent in men than women (12% vs 9%) but the ratio of men to women with PAD was only 1.4:1, far below historic assumptions about the gender prevalence of atherosclerosis. People found to have PAD were also more likely to have hypertension at the time of screening. Almost half the people found to have PAD reported that they were not receiving antiplatelet medications, and more than half said they were not receiving lipid-lowering treatments.

Carotid Disease



ICA stenosis >50% was found in 7.4% of people screened. Critical ICA stenosis (80-100%) was found in 1% of older Americans. Carotid disease was more prevalent in men (9% vs 6.3%) but once again this ratio of 1.4:1 was considerably less than would have been predicted. People found to have carotid disease were also more likely to have hypertension at the time of screening than those without carotid disease. Like PAD, almost half the people with carotid artery disease reported that they were not taking antiplatelet medications that might reduce the risk of stroke, and more than half said they were not receiving lipid-lowering treatments.

AAA



AAA were discovered in 2.8% of the more than 3000 older Americans who participated in the AVA National Screening Program. Aneurysms were detected in 4.5% of men tested. Most AAA had not been detected prior to the screening where more than 80% of people with AAA reported they had never had a previous abdominal ultrasound. Most AAA detected were small (3-5 cm.), but more than 15% of the aneurysms found were > 5 cm. diameter; some as large as 10 cm. Almost one third of the people found to have AAA also had hypertension at the time of the screening, and almost one quarter of these reported that they were not receiving antihypertensive treatments.

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The Vascular Surgeon

American Board of Vascular Surgery: Current Status

James C. Stanley, M.D.

The American Board of Vascular Surgery (ABVS) was incorporated in 1996 by the Presidents, Immediate Past Presidents, Presidents Elect, and Secretaries of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery-North American Chapter (subsequently the American Association for Vascular Surgery). The needs and rationale for this action were clearly stated in a document signed by the executives and council members of these two organizations, as well as the officers of the Association of Program Directors for Vascular Surgery (APDVS). That statement was published in the *Journal of Vascular Surgery* in 1997. It was also the subject of four subsequent presidential addresses before the SVS and AAVS. At the onset, the vast majority of vascular surgeons supported this effort to become the newest member of the American Board of Medical Specialties (ABMS). Nevertheless, this movement was vigorously opposed by the American Board of Surgery (ABS), who subsequently created a Sub-Board in Vascular Surgery and attempted to address many of Vascular Surgery's concerns. Unfortunately the substantive issues of Vascular Surgery being a primary pillar (now an essential training component) of general surgery residency and true autonomy with our own Residency Review Committee for Vascular Surgery were not resolved.

In 2001, the SVS and AAVS leadership surveyed all North American vascular surgeons in an independent poll conducted by Deloitte and Touche. One unambiguous question was asked: "Should Vascular Surgery seek an ABMS-approved independent specialty Board?" Among the respondents, 66% answered yes, and 79% of those in practice less than 10 years took an affirmative position. Following this poll and with sponsorship from all the national and major regional Vascular Societies, an application to become an ABMS-approved independent Board of Vascular Surgery was submitted in May 2002.

The application was addressed in a hearing before the Liaison Committee for Specialty Boards (LCSB) on December 18, 2002. The LCSB is comprised of four members representing the AMA and four additional members representing the ABMS. At that time, the Chairman of the LCSB, representing the AMA, was James Borland Jr, a gastroenterologist from Jacksonville, Florida. The other AMA representatives were Richard Allen (Obstetrics-Gynecology), Emmanuel Cassimaitis (Psychiatry) and Rebecca Patchin (Anesthesia-Pain Management). The ABMS representatives were David Nahrwald (Surgery), Harvey Meislan (Emergency Medicine), John Strauss (Dermatology) and Nicholas Vick(Neurology).

The sole basis for establishing an independent ABMS-approved ABVS is to better serve the public and profession in the surgical care of patients with vascular disease.

Subsequent to this meeting a letter dated December 20, 2002 was received from Dr. Stephen Miller, Secretary to the LCSB, denying the application. This was followed by an ABVS letter dated December 26, 2002 requesting specific information as to the shortfalls of the application, such that a decision regarding an appeal might be made on a rational basis. That request was followed by a two sentence-single paragraph letter dated December 30, 2002 from the LCSB, stating that the application had been denied based on a "totality of criteria". No specific shortcomings were provided regarding the denial. However, we believe differences of opinion within our own surgical community regarding the need for a new Board were relevant to the application's initial failure.

An appeal has been requested and will be heard by an Appeal Board that is advisory to the LCSB. It is important to try every possible approach within the ABMS system to gain their approval for a new Board. In addition, in the interest of our profession and patients with vascular disease, it seems reasonable to encourage the ABMS to meet its responsibility to Society by enhancing specialty care. A committed ABVS Board of Directors cannot do this alone. The process will require a major effort over the next several years and, most importantly, it will require the commitment of all vascular surgeons.

Many of the Vascular Surgery community do not understand the reason for the Board movement and the conflict it has generated. It is reasonable to readdress the issues surrounding the ABVS actions, in hopes of removing any vague rhetoric from future discussions about the need for a new Board.

The sole basis for establishing an independent ABMS-approved ABVS is to better serve the public and profession in the surgical care of patients with vascular disease. To accomplish this task an independent Board will be required to provide more timely and responsive development of standards for training and certifying vascular surgeons, an effort that will be markedly enhanced by creation of a Residency Review Committee for Vascular Surgery to evaluate and

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Watch for a NEW VascularWeb

K. Wayne Johnston, M.D.

VascularWeb is currently undergoing a major revitalization. Brought about by the challenge we faced when our Web provider declared bankruptcy in the spring, the Society reviewed the current site and developed a strategic plan for reestablishing our Web presence. With the help of many individuals, the revised and revamped VascularWeb will strengthen our Web presence.

Step 1. Appointment of Management Committee and Editor

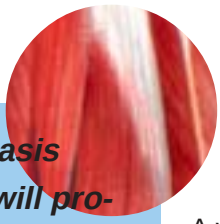
A management committee has been formed to provide advice on operational issues. It is chaired by Bill Pearce and includes members of the Publications Committee (Joe Archie, Jr., Peter Gloviczki, Craig Kent, and Joe Mills). The role of this committee is to determine policy, deal with contractual issues, review the ongoing business affairs of VascularWeb, seek consultations as appropriate, and report on the findings. I have taken on the editorial responsibilities—a role that is clearly separate and different from the management function.

Step 2. Clarify role of VascularWeb

Unlike the *Journal of Vascular Surgery*, which has an encyclopedic function, VascularWeb is more analogous to a "newspaper". On a regular basis it will provide information to medical professionals and patients that supports the strategic goals of the Society for Vascular Surgery and the affiliated societies in the areas of clinical care, research, education, government relations, etc.

Step 3. Solicit opinion of Web Consultant

In taking on the role of Editor and not being an expert on the Web, the Management Committee and I believed it was important to obtain an independent consultant's opinion about the products that would suit our needs. Specifically, we wanted advice on the value of a content management program to organize the publication of our Web site documents and track requests for submissions. In essence, such a program accepts input in the form of templates, processes the input, and publishes the content "automatically." When a content management program is set up, the workflow is defined and each individual's tasks are specified. When templates are used, the requirements for input and the style are standardized, and content can be entered by individuals with little computer expertise.



On a regular basis VascularWeb will provide information to medical professionals and patients that supports the strategic goals of the Society for Vascular Surgery and the affiliated societies in the areas of clinical care, research, education, government relations, etc..

With a content management program, the time spent dealing with the technical aspects of Web content management are reduced. The division of responsibilities among different individuals is easier and is an advantage. For example, the site for each affiliated society can be managed by its executive director, with little intervention by the VascularWeb staff.

A vendor was selected and through interviews with users and a workshop with members of the Management Committee, PRRI, and me, two choices were presented: buy a commercially available content management program and deploy it internally or outsource the work. We have chosen to purchase a solution.

Step 4. Selection of content management program

Several vendors demonstrated their products and we worked through case examples and potential scenarios that demonstrated the capabilities of the program for designing a Web page, using the workflow and approval process, and other functions. A selection was made based on our requirements.

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AVA Screening Program Update

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The AVA National Screening Program has convincingly demonstrated that there is a significant amount of undiagnosed vascular disease in the elderly population of this country. Like heart disease in this country, more women are affected by vascular disease than has been reported in the past. Many people of both sexes continue to have poorly controlled risk factors like hypertension, and one third to one half of them are not receiving effective medical treatments that might prevent of worsening of their vascular disease or significantly reduce the risks of major adverse cardiovascular events like heart attack and stroke. While few people screened have critical vascular disease or large aneurysms, detection of those lesions could be lifesaving since early diagnosis of these problems is known to reduce deaths and disabilities, and also to significantly reduce health care costs.

The AVA Screening Program is first and foremost, a public awareness-public education initiative. The 2003 program allowed the AVA to broadly expand the delivery of our message regarding the critical importance of vascular disease to an exponentially increasing number of our older citizens in the at-risk population. It is also becoming increasingly clear that through this program we will promote increasing physician awareness concerning vascular disease, its diagnosis, and its effective prevention and treatment. The AVA Task Force on Public Education has termed this part of our overall strategic plan **"Vascular Awareness 2005"**. The AVA believes that the growth of the national Screening Program through 2005 will create the highest awareness of, and education about vascular disease ever seen among our citizen and our physicians – perhaps even equal to that of "heart disease" in the past.

The AVA believes that increasingly accurate and more comprehensive information about the true prevalence of disease in our populations will establish vascular disease as a national health care priority. We believe these efforts will create a mandate for more focused and aggressive strategies for diagnosis and preventative treatments in well defined high risk populations that we will help identify. This will soon translate into a measurable reduction in adverse cardiovascular events.

- Fewer people will suffer disabling strokes due to undiagnosed carotid artery disease !
- Fewer men and women will suffer rupture of an undiagnosed aortic aneurysm.
- There will be a reduction in the rates heart attack and stroke in people with PAD.

All these outcomes are measurable and attainable ! The AVA believes that Vascular Awareness 2005 will allow us to attain our ultimate goal – **"Healthy Vessels 2010".**

Medicare in 2004

(continued from page 6)

second would be used to report >20 incisions per limb. No formal code or payment will be established for <10 incisions. In the past, the National Correct Coding Initiative Edits have blocked simultaneous reporting of saphenous vein stripping and varicose vein cluster excision. Every effort has been made in the CPT application for these new stab phlebectomy codes to point out that this operation and greater saphenous vein stripping are separate and distinct procedures that should not constitute a correct coding edit pair exclusion. The SVS Government Relations Committee will pursue this issue as much as necessary if a CCI Edit pair exclusion is proposed.

The SVS Government Relations Committee is interested in new CPT codes that may be needed. Please send your suggestions to Rebecca Maron at SVS headquarters in Chicago.

*CPT codes and their descriptors are property of the American Medical Association.

New Correct Coding Edits

Medicare implemented almost 4,000 new Correct Coding Edits (bundled payment exclusions) in version 9.2 of the National Correct Coding Initiative on July 1. About 200 of the exclusionary code pairs involve vascular surgery, but almost none of them will affect your daily practice. Nevertheless, one family of exclusions is important to note. There is a new CPT code in 2003 (CPT 34834) to report "Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis...". While it might seem reasonable that open brachial artery exposure should be reimbursed whenever it is required during vascular intervention (e.g. renal or mesenteric stent placement by open arm access), CMS makes it clear by way of these new edit exclusions that they will restrict payment for 34834 to cases of endovascular aortic or iliac aneurysm repair.

American Program Directors in Vascular Surgery

Frank W. LoGerfo, M.D.

The annual meeting of the Program Directors in Vascular Surgery was held in conjunction with the Research Initiatives in Vascular Disease meeting in Bethesda, Maryland, on April 5, 2003. This was the second time there was a joint meeting of these two groups, and it was highly successful. Funds raised by the APDVS were supplemented by funding from the Society for Vascular Surgery to provide for travel expenses for all vascular trainees to attend the full joint meeting.

One of the attractive features of our current meeting is that it provides an opportunity for all program directors and trainees to congregate in a setting of minimal distractions.

At the Research Initiatives component of the meeting, 12 abstracts were presented by vascular surgery fellows or surgery residents, allowing for a sophisticated audience to hear the presentations, including several representatives from the NHLBI staff. In addition, the vascular fellows forum was popular and well attended. On Friday afternoon, the vascular fellows heard presentations on various aspects of the transition from fellowship to practice. These included subjects such as billing, the elements of a contract, setting up a noninvasive diagnostic laboratory, etc. The second session on Saturday morning was attended only by vascular fellows and consisted of a series of presentations by the vascular fellows. Many of these were individual case reports or descriptions of "how we do it." By all indications, the vascular surgery fellows are highly enthusiastic about this meeting format.

For the coming year, it has been agreed that funding will be provided for all interested vascular surgery fellows to attend the meeting, provided they come for the entire meeting, including the Research Initiatives portion of the meeting. One of the attractive features of our current meeting is that it provides an opportunity for all program directors and trainees to congregate in a setting of minimal distractions. It is an opportunity for networking, for a relatively small group of trainees to get to know each other, and for discussions of issues specifically related to the transition to practice and related career decisions.

A special presidential gavel for the APDVS was presented by Dr. Jon Towne. Dr. Towne fashioned the gavel from an old cane that belonged to Dr. John Porter. In addition, a plaque was constructed, containing a miniature gavel from the same cane, that will be maintained in the office of the President of the Association. As part of this presentation, Dr. Bill Baker discussed the history of the Association, paying a special tribute to Dr. John Porter.

For the coming year, the APDVS will continue the joint meeting with the RIVD conference, with plans to add an afternoon session on Saturday with a specific educational focus for the vascular surgery fellows and the option for them to stay until Sunday morning. The APDVS Executive Committee will continue its work on completing a formal series of topics for a clinical curriculum, available on our website. Hopefully this will be helpful to programs as they undergo review for accreditation. The APDVS has initiated a project with Greg Moneta to create a noninvasive laboratory training course that would be available as a resource for all of our trainees. This project will move forward in collaboration with the Society for Vascular Surgery. Dr. Doug Wooster will continue work on an in-training examination for self-assessment program, also in conjunction with the Society for Vascular Surgery.

Dr. Seeger has laid the groundwork for full implementation for on-line applications to our vascular surgery training programs this coming year. The APDVS continues to work with the Residency Review Committee for Surgery toward implementation of the early specialization program. The early specialization program is built around the paradigm of four years of general surgery training followed by two years of vascular surgery training with ultimate certification in both specialties.

At the same time, the APDVS has expressed concern that the implementation of the program has been slow and related concerns have been expressed to the RRC-S as we continue to strive for more rapid, broader and flexible implementation of the training paradigm.

Dr. Richard Cambria was elected as a Councilor-at-Large for the Association. Dr. Elliot Chaikof and Dr. John Eidt were appointed to the Issues Committee. The Executive Council of the APDVS will meet at the ACS in October to plan the Spring 2004 meeting.

ABVS: Current Status

(continued from page 10)

approve training programs.

Expanding technology in vascular surgery clearly mandates the need for longer training programs to adequately educate practitioners in new endovascular therapies, imaging modalities, and the nonoperative management of vascular diseases. These subjects are extremely relevant to all of our practices, and have been incorporated into the recommended "Guidelines for Hospital Privileges in Vascular Surgery" published in 2002 in the *Journal of Vascular Surgery*. Unfortunately, the American Board of Surgery (ABS) and the Residency Review Committee for Surgery (RRC-S) have addressed this issue by adding to the length of existing vascular training. That change has simply compounded the many years of postgraduate education and indebtedness required for a young trainee to become a vascular surgeon. This extension of training evolved at a time the pool of fellowship applicants has markedly decreased, and by some measures it appears that the quality of applicants is less than that of those entering other surgical disciplines not requiring the completion of a general surgery training program. The disciplines of neurosurgery, orthopedics, otolaryngology, and urology have not seen the same impact on their residencies as has vascular surgery. This is a major issue for the vascular surgery community.

The training required to have competency in Vascular Surgery clearly cannot be integrated easily into the present educational paradigm without extending training beyond the existing 5+1 and 5+2 programs. Efforts to establish a 4+2 program were hoped to be widely implemented as a step towards reducing the lengthy training required for individuals to be eligible to be certified in Vascular Surgery. This new paradigm was supported by an educational task force composed of members from the SVS, AAVS and the APDVS. They also proposed a 3+3 integrated program as a pilot study, with individuals matching into this training directly from medical school. The latter would have gone a long way towards addressing ABVS concerns, but such has not been possible under the current ABMS-ABS bylaws requiring certification in the primary specialty (ie General Surgery) before subspecialty (ie Vascular Surgery) certification occurs. In regard to the 4+2 program, the APDVS requested that the RRC-S review the relatively rigid exclusionary criteria that will prevent its widespread introduction, but they were unwilling to alter their stance. Unfortunately many believe the 4+2 program will not meet the perceived need to make Vascular Surgery more desirable and less of a burden during training. Furthermore, having a two-tract system of training general surgeons within the same residency has not met with favor by many Program Directors in General Surgery.

The ABVS has proposed a 3+3 integrated track of training that would allow individuals, not desiring to practice general surgery, to be fully trained as vascular surgeons. Such a training paradigm does not simply take individuals after 3 years of "core general surgery" residency and place them in an isolated vascular surgery fellowship, but like other integrated programs, it would include rotations during the 4th, 5th, and 6th years on certain general surgery services, such as trauma, in a manner that would result in a broadly trained mature surgeon at the completion of the fellowship. Importantly, the ABVS also proposed a training paradigm similar to that backed by the ABS that would allow individuals to be certified in both General Surgery and Vascular Surgery, with a realization that this training would be longer in duration. Given the extreme pressures being placed on all surgical training programs regarding limited work hours one must consider the additional impact on the relatively short duration but intense training in the surgical specialties like Vascular Surgery. In our case, with the loss of open cases because of endovascular interventions, individuals will be exposed to many fewer open procedures and their competence may be less than desired. Earlier entry into vascular specialty training with a longer period of time to be exposed to needed open and endovascular procedures would go a long way to address this issue. This is a major concern in a considerable number of programs.

Expanding technology in vascular surgery clearly mandates the need for longer training programs to adequately educate practitioners in new endovascular therapies, imaging modalities, and the nonoperative management of vascular diseases.

Practitioners should be concerned about the loss of interest by many bright young individuals in the specialty of Vascular Surgery. Opportunities for established vascular surgeons to recruit into their practices individuals who have been trained with skills to apply new technologies to patient care are currently sparse. The inability to provide the broadest care for patients with vascular disease has already been sensed by many vascular surgeons "in the real world" and the pressures to improve and expand one's therapeutic capabilities will not be less in future years.

Four Ad Hoc committees of the ABVS have been formed to carry out strategic efforts of the Board during the next few

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ABVS: Current Status

(continued from previous page)

years. Opportunities for all vascular surgeons to serve the ABVS exist on: 1) the Public Affairs Committee whose purpose is to disseminate information regarding the ABVS to lay members of the public. Enrico Ascher MD is the Chair; 2) the Medical Affairs Committee whose purpose is to develop relations with other medical organizations regarding the ABVS. Robert W. Hobson II MD is the Chair; 3) the Financial Affairs Committee whose purpose is to develop fundraising and oversee ABVS budgetary matters. James C. Stanley MD is the Chair; and 4) the Legal Affairs Committee which will advise on legal issues affecting the ABVS. Thomas F. O'Donnell Jr MD is the Chair. The ABVS represents all of Vascular Surgery, both academicians and private practitioners, and values the diversity of both groups in helping its committees.

The Vascular Surgery community deserves respect for having gathered the support and momentum to complete an application to become an ABMS board. It was disappointing to have the LCSB initially deny the application, and thus prevent its consideration by the entire voting members of the ABMS. The tenets of the ABMS must be respected, but we should appropriately question the pressure that has been placed on the LCSB by others to avoid what we believe is an important responsibility to the public and our profession at improving the care of patients with vascular disease by more rigorous specialty training and certification processes. The issue of training adequate numbers of physicians to provide competent care of patients with vascular disease will not go away, nor will the ABVS. The Directors of the ABVS believe that it is in the best interest of Vascular Surgery to persist in pursuing an independent Board, and we ask all vascular surgeons to volunteer their time and support to the effort.

Highlights of the SVS and AAVS Merger

The AAVS and SVS have merged to form a single organization called The Society for Vascular Surgery, with an inclusive membership consisting of all members of both societies. The governing Board of Directors has broad representation and the Fellows Council will organize designated academic activities. Three new Councils (Research, Education and Clinical Practice) will coordinate activities in these areas, and each council will consist of four elected members, with a four-year term to provide continuity, and create new opportunities for younger society members.

The Chair of each Council is a voting member of the Board of Directors. The Board of Directors governs all affairs of the society. The Executive Committee of the Board of Directors manages day-to-day activity and questions arising between meetings of the Board of Directors, but is subject to oversight and approval by the entire Board of Directors, which is the governing body of the Society.

The Board has voting representative from the same societies that were previously represented on AAVS Council:

- American Venous Forum
- Canadian Society for Vascular Surgery
- Eastern Vascular Society
- International Society of Endovascular Specialists
- Midwestern Vascular Surgical Society
- New England Society for Vascular Surgery
- Peripheral Vascular Surgery Society
- Society for Clinical Vascular Surgery
- Southern Association for Vascular Surgery
- Western Vascular Society
- Association of Program Directors in Vascular Surgery.

The primary benefits from a merged, single Society include:

- increased efficiency of management;
- improved coordination of the numerous activities of the Societies;
- clearly defined responsibilities for each officer and committee with reduced overlap;
- less duplication;
- more effective planning and implementation of important initiatives;
- coordinated financial planning;
- eliminated need for resolving differences of opinions between two Councils;
- creating a large unified membership base for providing CME and dealing with government issues and other specialties that are competing for vascular patients;
- involving representatives from regional and other national vascular societies to further improve communication and coordination of activities;
- and increased visibility of vascular surgery on the national level.

Previous SVS members are designated as "Distinguished Fellows" in the new SVS, and future members are eligible for this distinction if they meet current SVS membership criteria. It is anticipated that becoming a "Distinguished Fellow" of the new SVS will rapidly take on the same importance as a member of the current SVS.

New Administrative Office

(continued from page one)

Transition to Freestanding

Effective September 1st, the SVS headquarters is now located in downtown Chicago in the American College of Surgeons building. Over the next several months, the Society's administrative functions will transition to the Chicago office from PRRI, the association management company that so ably managed SVS in the past. Our goal is to make this management transition as seamless as possible, but we know glitches are inevitable. We hope you'll be patient with us during this transitional period.

(left to right) Melissa Kabadian, Office Administrator; Patricia Burton, Director of Operations; and Rebecca Maron, CAE, Executive Director.

Meet The New Administrative Staff

Three experienced association staff now work full-time for SVS in the Chicago office: Melissa Kabadian as office administrator, Patricia Burton as director of operations and myself as your executive director.

Melissa Kabadian is responsible for the day-to-day office administration, everything from telephones to meeting planning. Melissa has worked for several associations, including the American Association of Diabetes Educators and the American College of Foot and Ankle Surgeons. She holds an MA in counseling psychology from Boston College. You can reach Melissa at MKabadian@vascularsociety.org.

Initially, Patricia Burton will be responsible for setting up our membership database and processing systems. She also has a strong background in educational planning, including online learning, and will help develop continuing education programs for the Society. Patricia comes to us from the American Society for Healthcare Food Service Administrators, where she was executive director for the last seven years. She holds an MS in Health Care and Community Nutrition from Western Kentucky University. You can reach Patricia at PBurton@vascularsociety.org.

As your executive director, I will be working closely with the SVS Board of Directors to develop and implement the Society's strategic objectives. I have nearly thirty years of experience in association management, most recently as director of operations at the American Hospital Association. Earlier, I was director of the division of health policy, research and communications for the American Academy of Orthopaedic Surgeons and was directly involved in the dynamic growth of that organization during that period. I have also worked for the American College of Surgeons and the American Medical Association. I hold an MBA degree from Northwestern University and am a certified association executive (CAE). You can reach me at RMaron@vascularsociety.org.

Now that we're settled in our new Chicago office, we'd be pleased to have you visit whenever you're in Chicago. Simply call our toll free number 1-800-258-7188 to arrange a visit.

Society for Vascular Surgery
633 North St. Clair. 24th Floor
Chicago, Illinois 60611
(800) 258-7188 / Fax: (312) 202-5007

VascularWeb Will Be Back

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Step 5. On-site training and professional consultation

Representatives provided training for the individuals at PRRI (Alyssa Awe and Max Rossin) who will develop the Web site. I took the 4-day course along with them to gain an understanding of the program's capabilities and structure. Understanding the program options proved very useful in grasping what the program could do; however, the intensive course proved to me that my best programming days are behind me!

Step 6. Moving content to the new program

PRRI obtained the original files from the previous vendor, and at present, the old content is being moved into the content management program. This step should be completed by mid-September.

After mid-September, the content will be rearranged to fit with the new structure, which will consist of three major sections. The **Patient and Family Information** section will emphasize the key strategic focus of each of our societies. In the **Societies** section, there will be information on the plans, business, and meetings of the Society for Vascular Surgery and each of the affiliated societies. The **Health Care Professionals** section will contain information on clinical, research, and education issues; meetings; government relations; job postings; members; industry partnerships; and other topics of interest.

Step 8. Go live

We hope to go live with the new site and start posting new content by mid-fall 2003.

Step 9. Implement content management program

As we become ready to start posting new content, the editors will need to learn the details of using the content management program that will allow them to solicit content over the Internet, track submissions, send reminders to delinquent authors, and use the predefined templates to post the content on the Web. Each person will be assigned specific authorization based on his or her role within the Web site. For example, administrative assistants for the affiliated societies will only be able to enter or revise information related to the society they represent.

We are working hard to re-introduce a Vascular Web that will meet our need to provide information in a timely fashion to both patients and professionals.

President's Report

(continued from page one)

We are working with industry to provide CME training opportunities for vascular surgeons in catheter-based techniques at every level. We recognize that our skills vary from beginner to advanced and that different programs and techniques will be necessary to reach our goals. Our revamped website will soon list those opportunities. We are particularly encouraged by the progress we are making in getting surgical sites prepared for the eventual FDA approval of carotid stenting. Our plan is to have at least 30 sites around the US prepared to train other vascular surgeons by the time FDA and CMS approval and payment become commercially available in 2005.

We are particularly encouraged by the progress we are making in getting surgical sites prepared for the eventual FDA approval of carotid stenting.

Our new office will officially open on October 1, 2003. Rebecca Maron has been working since early July. She will be an important advocate for vascular surgeons. I encourage each of you to stop by the office when you visit Chicago and meet our staff.

As many of you know our Advocacy Group led by Bob Zwolak is increasingly active in Washingon DC on our behalf. Many of you have come forward with suggestions of legislators to contact. Some of these have been instrumental in our activities regarding reimbursement for AAA screening. We encourage your participation in this effort and support for our political action committee.

This will be an exciting year. We encourage your comments and suggestions either to me via email Richard_Green@urmc.rochester.edu) or to Rebecca Maron (rmaron@vascularsociety.org). We will make every effort to keep the lines of communication open.

Highlights of VASCULAR 2003 - AAVS Scientific Session

(continued from page 9)

operations need modification in order to reflect the true outcome of such procedures.

American Heart Association guidelines recommend medical therapy for patients with systemic atherosclerosis, including statins, angiotensin converting enzyme inhibitors (ACEI), and antiplatelet therapy. Patients undergoing operative therapy for peripheral vascular occlusive disease (PVOD) represent an indication for such therapy. The study by Henke and colleagues from the University of Michigan concluded that patients undergoing infrainguinal bypass are undertreated with respect to cardioprotective medications. ACEI use is associated with lower mortality and statin use is associated with better graft patency and limb salvage, suggesting that these agents should be considered for all patients with operative PVOD.

Lam and colleagues from Oregon Health & Science University, studied the placement of autogenous infrainguinal bypass (AIG). In patients with prosthetic inflow (PI), the proximal anastomosis of autogenous infrainguinal bypass (AIB) can be placed on the PI or on a distal native vessel in the groin. This study concluded that a proximal AIB anastomosis located directly on PI is an independent risk factor for decreased AIB patency of equal or greater importance than current smoking, hypertension, or post-operative warfarin therapy. The proximal anastomosis of an AIB in a patient with an ipsilateral PI should be placed on a distal native artery.

A study from Baltimore was performed to determine if intraoperative arteriography, done as an integral part of revascularization, is a viable option. Queral and colleagues at the University of Maryland studied 455 patients requiring lower extremity revascularization evaluated with physical examinations and duplex scanning. Their conclusions clearly show that routine preoperative arteriography is not mandatory for the majority of patients requiring lower extremity revascularization. The combination of duplex scanning and intraoperative arteriography is highly effective from both a scientific and cost effective perspective.

Another study from the Maryland group reviewed experience with endovascular therapy for TransAtlantic InterSociety Consensus (TASC) Type B disease. Stenosis free patency was used as an objective endpoint to evaluate the hemodynamic outcome. The authors concluded that endovascular therapy for TASC B femoropopliteal lesions is safe and technically feasible. However, the length of time that a treated arterial segment remains free of stenosis is limited. Adjunctive stenting did not improve the one year stenosis free patency. Successful application of endovascular therapy for femoropopliteal disease may require further refinement in patient selection and the development of new intraluminal treatment technology.

Kresowik and colleagues from the University of Iowa reviewed the impact of community wide performance measurement and feedback on key processes and outcomes of carotid endarterectomy (CEA). Complete medical records (hospital chart) review for indications, care processes and outcomes was performed on a random sample of Medicare patients undergoing CEA in ten states during baseline and remeasurement 12 month time periods separated by a 3 year interval. The conclusions supports community wide quality improvement initiatives with performance measurement and confidential reporting of provider level data to improve care processes and outcomes.

Scientific documentation of neurological improvement following carotid endarterectomy has not been established. A study from the Asian Medical Center in Korea, investigated whether CEA performed for flow limiting lesions was accompanied by the improvement in cerebral perfusion at the cellular level and gait of patients with gait disturbance. Gait improvement was noted in 80.2% of the patients after CEA who had preoperative gait disturbance. Marked gait improvement was obtained in patients who had improvement of in perfusion on SPECT after CEA in comparison to patients with no change.

Brown and colleagues from the William Beauport Hospital in Michigan compared the quality and reliability for patient management of carotid duplex ultrasound examinations done in an outside non-accredited vascular laboratory with subsequent findings in an ICAVL accredited laboratory. Their data suggest that carotid duplex ultrasound examinations performed in vascular laboratories not accredited by ICAVL are unreliable in treatment planning, specifically in determining whether patients with carotid artery atherosclerotic disease are candidates for surgical intervention.

Carotid Artery Stenting (CAS) may be comparable to Carotid Endarterectomy (CEA) as a durable and effective procedure in stroke prevention. Concern, however, remainsabout the incidence of restenosis after stenting and its management. A joint effort by physicians in the Netherlands and at Stanford University evaluated the surgical management of restenosis after carotid artery stenting. They concluded that the optimal treatment of in-stent restenosis has yet to be defined, but standard CEA with removement of the stent appears to be feasible.

In an eloquent Presidential Address, Dr. Tom Riles enumerated the many changes over the years in surgical and interventional strategies to treat vascular disease. He concluded that because of the solid foundation provided by out leaders in the specialty of vascular surgery, the future was bright with many rewarding opportunities for generations to come.

Highlights of VASCULAR 2003 - SVS Scientific Session

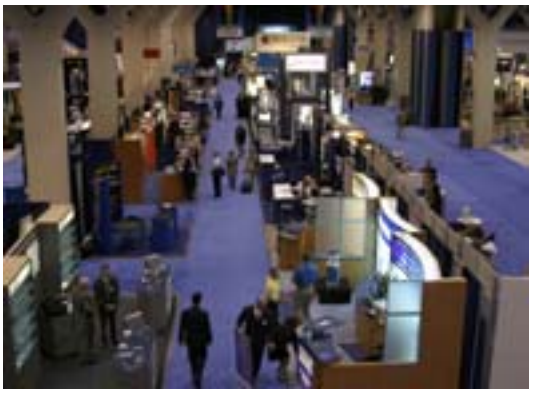
(continued from page 7)

23 patients with blue toe syndrome with transesophageal echocardiography, identifying mobile debris in the ascending aorta (4%), aortic arch (39%), and descending aorta (87%) of patients that were treated conservatively with aspirin and/or coumadin. Seven patients had recurrent emboli, all died. With a median follow-up of 13 months only 7 patients were alive. The authors recommended TEE in patients with blue toe syndrome to detect mobile aortic debris, a poor prognostic indicator. The Albany group asked the question "Is the vein really saved" in 672 patients who had above knee prosthetic reconstructions. Only 62% of patients in follow-up had an adequate ipsilateral greater saphenous vein for secondary operation. Dr. Keith Calligaro and associates reported their results in managing infections of prosthetic dialysis access grafts. They recommended total graft excision in patients with sepsis and subtotal or partial graft excision in all others, with 74% resulting in wound healing and preservation of the access site.

Amongst all the science, several honors and awards were also given during the SVS Plenary session. Dr. Anthony Imparato, professor of surgery at New York University Medical School, received the Distinguished Service Award. Dr. Wayne Johnston and Dr. Robert Rutherford were recognized for their outstanding service and contributions as editors of the Journal of Vascular Surgery the past six years. The Lifeline Foundation presented Dr. John Matsumara with the E.J. Wylie Traveling Fellowship, Dr. Dennis Harkins with the Resident Research Prize and Dr. Peter Faries with the William J. von Liebig Award.

The SVS officers, program committee members, moderators and presenters for Vascular 2003 on the SVS plenary session, concurrent sessions, and postgraduate courses are all to be congratulated for their hard work, professionalism and commitment to an outstanding program on vascular diseases. Vascular 2004 to be held June 3-6 in Anaheim, California should be even more challenging and exciting, because for the first time the joint annual meeting will add the Society for Vascular Ultrasound (SVU) and the Peripheral Vascular Surgery Society (PVSS) to become the world's largest meeting on vascular diseases.

Many Thanks to all of our Exhibitors and Industry Sponsors.....



2004 Annual Meeting Preview - *An Interview wth Program Chair, Kenneth Ouriel, M.D.*

In 2004, the Society for Vascular Surgery will welcome the Peripheral Vascular Surgical Society, the Society for Vascular Medicine and Biology, and the Society for Vascular Ultrasound to the Vascular Annual Meeting, making this the world's premier annual meeting for specialists who are focused on vascular disease.

How will the addition of the three 'other' societies' meetings enhance the educational experience for SVS Members?
This, obviously, will provide a means for the surgeons to interact with the vascular medicine practitioners- an important educational feature since most institutions do not have vascular medicine programs. Thus, issues such as vascular wall biology, anticoagulation, prevention, and arteritides, topics sometimes unfamiliar to many vascular surgeons, will be presented and discussed. In the case of the lab tech meeting- this will provide an opportunity for a greater portion of the vascular "team" to be at the same meeting. This will increase the academic and educational exposure for the vascular laboratory technologists and nurses, concurrently providing a means for the surgeons to expand their knowledge in the area of noninvasive diagnosis as well.

What are some of the exciting developments being planned? Any new or "first-time" offerings?
We are in the midst of conducting surveys to determine exactly how the meeting will be structured. For the first time in many years, we have been given a "clean slate" by our President, with the charge to develop a meeting that will be both educationally stimulating and interesting. We will also seek to increase the attendance from our European colleagues.

This is the first time in several years that the meeting is being held on the West Coast. How will this benefit attendees? What does the area offer to attract participants?
Anaheim offers exceptional recreational activities for family and spouses and provides the opportunity to combine the meeting with a family vacation. In addition, the weather will be great and the area offers superb meeting facilities. These advantages overshawdowed the obvious downside of the potential increase in travel time for vascular practitioners who live in the east and Midwest.

Who should attend the meeting and why?
My personal goal with the 2004 annual meeting is to continue to attract the academically inclined university-based and private-practice vascular surgeons, but supplement this core group of 1000 or so individuals with a broader-based contingent of the following:

- **Clinical vascular surgeons**
- **The "vascular team":** Vascular nurses, Vascular noninvasive technologists, Operating room nurses, Fellows and residents
- **Vascular medicine practitioners**
- **Radiologists and cardiologists** with a focus in peripheral vascular disease.

ELECTRONIC SUBMISSION OF ABSTRACTS
DEADLINE: Friday, January 9, 2004

All Abstracts for the Vascular 2004 Annual Meeting must be submitted electronically via the official abstract submission website: www.vascularweb.org. The site will be available beginning Monday, October 20, 2003.
Please note that paper abstract submissions will not be accepted.

SVS
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