SVS / AAVS Newsletter

Volume 6, Number 2 Spring 2001

Vascular Board Talks Continue

AAVS President Dr. Robert Hobson and SVS President Dr. Ramon Berguer recently met with American Board of Surgery Chair Dr. Frank Lewis and ABS Executive Director Dr. Wallace Ritchie to review the results of the vascular societies' independent board survey and to discuss possible solutions to the declining interest in general surgical residency and vascular surgery fellowship programs. The following ABS communication provides insight into vascular surgery's progress:

March 28, 2001

Robert W. Hobson, II, M.D.
Chief Section of Vascular Surgery
UMDNJ-NJMS
185 South Orange Avenue, MSB G532
Newark, NJ 07103

Ramon Berguer, M.D.
Harper Hospital
Division of Vascular Surgery
3990 R
Detroit, MI 48201

Dear Bob and Ramon:

Thanks for a good lunch.

To try to encapsulate what I believe we agreed upon as a plan of action: first, you would create a document outlining the reasons you believe that the present paradigm of training and certification is impacting in a negative and immediate way on Vascular Surgery. Secondly, in that document, you would outline your suggestions for a tracking system for Vascular Surgery from the present five plus two to a two plus four schema. Thirdly, you would also outline your aims as well as the structure and function for creating an independent Board which you wish the ABS to support. These documents will then be presented, along with any comments the two of you wish to make, at the VSB (ABS) meeting in April and to the entire Board of Directors in June for their consideration and for action as appropriate. In the interim, I will pulse the ABMS about their position on certifying in a specialty without initially certifying in the basic discipline.

All of that information will then be presented to the Board of Directors in June for their consideration as an action item. If your recollection is substantially different than mine, please let me know.

I look forward to hearing from you at your earliest convenience. Again, thanks for the healthy discussion and the not-so-healthy meal.

As ever,

Wallace P. Ritchie, Jr., M.D., Ph.D., Executive Director, The American Board of Surgery

ANNUAL MEETINGS

June 10-13, 2001
Hyatt Regency Hotel/
Baltimore Convention Center
Baltimore, Maryland

June 9-12, 2002
Marriott and Westin Hotels/
Hynes Convention Center
Boston, Massachusetts

Resume of Vascular Surgical Questionnaire Results

Drs. Berguer and Hobson distributed results of this year's questionnaire on submission of an application to the American Board of Medical Specialties for an independent American Board of Vascular Surgery. Of the total 2,340 responses, 66% responded YES. Responses differed significantly by organizational membership (P=.0005), time in practice (p<.0001), age (p=<.0001) and group (p=.0035). The following data were reviewed and will be discussed at the meetings in Baltimore:

Table of ORG/VOTE

Organization	YES	NO	TOTAL
SVS Only	85 (56.29%)	66 (43.71%)	151
AAVS Only	536 (69.88%)	231 (30.12%)	767
Both SVS/AAVS	278 (60.70%)	180 (39.30%)	458
None	586 (67.28%)	285 (32.72)	871
TOTAL	1485	762	2247

Statistic	DF	Value	Prob
Chi-Square	3	17.8810	0.0006
Likelihood Ratio Chi-Square	3	17.6026	0.0005

Table of PRACTICE/VOTE

Years in Practice	YES	NO	TOTAL
< 5 years	244 (84.14%)	46 (15.86%)	290
5-10 years	191 (73.18%)	70 (26.82%)	261
> 10 years	1053 (61.76%)	852 (38.24%)	1705
TOTAL	1488	768	2256

Statistic	DF	Value	Prob
Chi-Square	2	62.1350	<.0001
Likelihood Ratio Chi-Square	2	67.9929	<.0001

Table of AGE/VOTE

Age	YES	NO	TOTAL
30-40 years	292 (79.56%)	75 (20.44%)	367
41-50 years	455 (72.11%)	176 (27.89%)	631
51-60 years	384 (59.38%)	249 (40.62%)	613
> 60 years	381 (58.26%)	273 (41.74%)	654
TOTAL	1492	773	2265

Statistic	DF	Value	Prob
Chi-Square	3	69.8612	<.0001
Likelihood Ratio Chi-Square	3	72.1986	<.0001

Table of GROUP/VOTE

Group	YES	NO	TOTAL
Foreign	26 83.33%)	5 (16.67%)	30
Fellows	39 (81.25%)	9 (18.75%)	48
Junior	190 (70.90%)	78 (29.10%)	266
National	1245 (64.57%)	683 (35.43%)	1928
TOTAL	1499	776	2274

Statistic	DF	Value	Prob
Chi-Square	3	13.5767	0.0035
Likelihood Ratio Chi-Square	3	14.6968	0.0021

SVS NOMINATION OF OFFICERS

In response to members' concerns regarding membership participation in the activities of the Council and opening leadership positions up to younger members, the SVS Council did consider modifying the nomination process. However, this would require a change in the SVS Bylaws. The Council has agreed to request nominations from the floor, rather than close the nominations after the slate is suggested by the Nominating Committee.

Society for Clinical Vascular Surgery (SCVS) and Eastern Vascular Society (EVS) Endorse Proposal for an Independent American Board of Vascular Surgery

At its annual meeting in March, 2001, the council and membership of the SCVS endorsed the proposal for an independent ABVS, recommending that ideally, this would be in collaboration with the American Board of Surgery.

At its May, 2001 annual meeting in Washington, DC, the council and membership of the EVS endorsed a similar proposal. The EVS recommended negotiations with the ABS to assist in accomplishing this goal.

Other national and regional societies are scheduled to consider similar proposals throughout the year. Active discussions of the proposal are also anticipated at the Joint Annual Meeting in Baltimore, June 10-14, 2001.

FROM THE SECRETARIES.....

Society for Vascular Surgery

Richard M. Green, M.D.

The Council has been very active this year and a summary of its activities prior to the June meeting follows:

1. A Board of Technology and Clinical Studies was created to assist industry, the FDA, HCFA and vascular surgeons. There is a great deal of interest from the regulatory agencies and industry with a common goal of bringing safe products to market in a timely fashion in the US. Dr. Greg Sicard has been appointed as chair for a five year term. Others board members are Drs. Berguer, Moore, White, Makaroun and Veith.

2. The Marco Polo Scholarship program was established to fund two vascular surgeons from North America to train in Europe for a six-month period, with support to be provided by the SVS at $45,000 per fellow. The European Society for Vascular Surgery has agreed to sponsor a similar program for Europeans to study in North America. Dr. William Abbott will announce the application process in June.

3. There is a proposed by-law amendment that would expand the SVS Council to include, as non-voting members, the Chair and SVS representative to the Vascular Surgery Board of the ABS, the president of the Lifeline Foundation, the chair of the ABVS, and a vascular surgery representative to the RRC-S. These additions are related to the SVS responsibilities in the areas of training and certification, and research activities. Another by-law amendment establishes an Executive Committee that shall consist of the president, president-elect and secretary that is authorized to act on behalf of the Council between regularly scheduled meetings.

The Marco Polo Scholarship Program was established to fund two vascular surgeons from North America to train in Europe for a six-month period, with support to be provided by the SVS at $45,000 per fellow.

4. An independent statistician analyzed data obtained from the interactive polling devices at last year's Crawford Forum. Statisticians reviewed the design of each question and the pattern of responses and concluded that there were two questions asked and answered in a manner that allowed for a statistical evaluation: 1) "Which is the most important issue facing vascular surgery?" asked by Dr. Pat Clagett and 2)"Which governance system would be best for vascular surgery?" asked by Dr. Frank Veith. 38.9% of respondents believe that endovascular training and credentialing is the most important issue. This choice prevailed regardless of the age, years in practice or society affiliation of the respondent. With 95% confidence, we can say that the true percentage lies between

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American Association for Vascular Surgery

Thomas S. Riles, M.D.

In June of 2000, the membership of the North American Chapter of the International Society for Cardiovascular Surgery requested that changes be made in the structure and focus of the organization. In response, the name of the organization was changed to the American Association for Vascular Surgery to indicate the broadened reach of the organization. In addition, the AAVS leadership has restructured its objectives and developed the following new Mission Statement :

The American Association for Vascular Surgery is an inclusive society dedicated to the interests of vascular surgeons and their patients. As such, the AAVS is committed to the continuing medical education of vascular surgeons and to the development of the scientific and technical aspect of vascular surgery. As a broad based society, the AAVS provides a unified voice to address socio-economic issues and a forum for public awareness and education.

AAVS is committed to the continuing medical education of vascular surgeons and to the development of the scientific and technical aspect of vascular surgery.

AAVS leadership recognized that the current website was not sufficient to achieve the objectives of its newly defined mission. In particular, the website could not facilitate an expanded AAVS/SVS presence in educating the public on vascular disease and the role of the vascular surgeon. Dr. Bill Pearce has led the effort to create an entirely new and dramatically improved website—VascularWeb. (More information on VascularWeb can be found on page 6.)

Dr. William Flinn has been asked to design an aggressive public education agenda for the Association to include community outreach, public awareness and development. To encourage industry funding, the AAVS has incorporated a subsidiary tax-exempt organization, the American Vascular Association (AVA). The purpose of the AVA could also be used to facilitate the SVS plans to develop a Board of Technology.

AAVS anticipates an increase in membership during 2001-2002 as the result of changes in membership requirements and categories. The Society has initiated a new category for candidate members to welcome our younger vascular surgeon colleagues and to retain them as members throughout their careers. Sensitive to the potential impact of these changes on the regional and national vascular societies, AAVS leadership met with representatives of the other vascular groups to ensure consistency and cooperation.

AAVS continued its support of the Vascular Surgery Board of the American Board of Surgery and enthusiastically supported the promotion from its previous "subboard" distinction, and carefully monitored general surgery's efforts to define the scope of general surgery.

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AAVS and SVS Comment to HCFA

The American Association for Vascular Surgery and the Society for Vascular Surgery recently provided comments to the Health Care Financing Administration (HCFA) to point out that many severe inequities persist in the Medicare Fee Schedule (MFS). Specifically, the Societies were requesting "an explanation about how the 17.7% increase in practice expense base rate resulting from our supplemental survey brought about no identifiable change in practice expense RVUs."

"Medicare beneficiaries comprise the majority of our patient population because vascular diseases affect the elderly. In fact, 60-70% of a typical vascular surgeon's practice serves Medicare patients. Consequently, without exaggeration, our specialty exists or perishes by the provisions of the Medicare Fee Schedule ("MFS"). Despite this reality, we were not invited to participate in the original Harvard/Hsiao studies that formed the basis of RBRVS and without such representation we have been fighting a difficult catch-up battle ever since to ensure reasonable and equitable payment for vascular services. At this juncture, the future of vascular surgery is gravely concerning as fewer and fewer qualified applicants are seeking positions in our training fellowships which ultimately will translate into limited access to vascular surgery services for Medicare beneficiaries."

The following is a summary of the comments made in the correspondence:

1. Despite changes brought about during the initial 5-year review and the new vascular surgery PE base rate, the Medicare Fee Schedule still provides woefully inadequate payments for vascular surgery.
2. We appreciate Lewin's guidance during our supplemental practice expense data collection this past summer, and we agree with the conclusions in their report.
3. We appreciate HCFA's willingness to incorporate our PE survey data in the MFS.
4. No increase occurred in fully-implemented PE RVUs for vascular surgery procedures despite a 17.7% increase in the PE hourly base rate from $63.80 to $75.10.
5. The PE RVU software is so complex that HCFA personnel have not yet been able to explain why no increase occurred.
6. Huge inequities still exist in the CPEP value files, and vascular surgery remains undervalued.
7. Major inequities remain in the fully implemented facility PE RVUs, and vascular surgery remains undervalued.
8. New codes 34812 and 34820 need pre-service clinical time in the CPEP value file.
9. New codes 34830, 34831, and 34832 need more appropriate post-service clinical units.
10. CPT 36833 has an anomalously low PE RVU compared to similar procedures CPT 36831 and 35832.
11. Use of the –62 co-surgeon modifier has reportedly been excluded from use with the new endovascular AAA repair codes. We believe this is inappropriate.
12. We request that no changes be made in the "zero work pool" until a methodology can be developed that accurately captures TC costs.
13. We suggest the most appropriate method to achieve budget neutrality in the five-year review is through adjustment of the Conversion Factor.
14. We request that HCFA adopt the RUC recommendations for vascular surgery work RVUs in the 5-year review.

For the complete text of the letter to HCFA, please visit the Societies' website: www.vascsurg.org

Vascular Lab Supervision Regulations Finalized by HCFA

The Health Care Financing Administration has recently released Program Memorandum B-01-28 specifically outlining physician supervision requirements for almost 1,000 CPT codes, including all noninvasive vascular lab studies. HCFA supervision definitions include the following: "General Supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's immediate presence is not required. "Direct Supervision" in the office setting means the physician must be present in the office suite and immediately available during procedure performance. "Personal Supervision" means the physician must be in attendance in the room during performance of procedure.

The Program Memorandum requires all routine diagnostic vascular laboratory studies to be performed under "General Supervision" while therapeutic procedures such as pseudoaneurysm compression require "Personal Supervision". The full text of the Program Memorandum is available on the AAVS Website: www.vascsurg.org.

The vascular community became involved in this issue in 1998 when HCFA published notification in the Federal Register that all noninvasive vascular lab studies would require Direct Supervision. The SVS/AAVS appealed this ruling, noting that Direct Supervision was not the standard of practice and that regulation would be unlikely to improve the quality of noninvasive studies. A more effective approach would be to pursue quality markers such as ICAVL lab accreditation and RVT-credentialed technologists. SVS/AAVA also pointed out that direct supervision would limit the practice of noninvasive vascular technology to physicians who could ensure office presence at all times.

REIMBURSEMENT

by Robert M. Zwolak, M.D.

NEW CPT CODES - The Government Relations Committee was successful in introducing the following three CPT codes for year 2000:

CPT 35879 revised LE bypass graft with vein patch
CPT 35881 revised LE bypass graft with vein interposition
CPT 36819 Basilic Vein transposition AV dialysis fistula

New Endovascular AAA Repair CPT codes for 2001 - The new family of CPT codes for endovascular AAA repair became effective on January 1, 2001. The following are the 14 new codes that will be used in conjunction with existing codes to report these operations. Coding for endovascular AAA repair will follow the established guidelines for component coding, meaning that multiple codes will be required to accurately describe an operation. A typical endovascular repair will require four codes, while additional codes will be added to reflect more complex procedures.

The AAVS has written a set of coding guidelines that are available on the website www.vascsurg.org. The guidelines describe each new code in detail and they provide a straightforward "recipe" for reporting endovascular AAA repair. In addition, several examples are provided

34800 Endo AAA repair, tube graft, 90 day global
34802 Endo AAA repair modular bifurcated graft, one docking limb, 90-day global
34804 Endo AAA unit body bifurcated graft, 90-day global
34812 Femoral Exposure for Endo AAA repair, unilateral, 90-day global
34820 Iliac Artery Exposure for Endo AAA repair, 0-day global
34808 Placement of Iliac artery occlusion device, ZZZ add-on code
34813 Femoral-femoral bypass during Endo AAA repair, ZZZ add-on code
34825 Extension Cuff placement during Endo AAA repair, first cuff, 90-day global
34826 Extension Cuff placement during Endo AAA repair, additional cuff, ZZZ add-on code
75952 Radiologic supervision and interpretation of endovascular AAA repair, XXX global
75953 Radiologic supervision and interpretation of extension cuff placement, XXX global
34830 Open surgical AAA repair "rescue" tube graft after failed endo, 90-day global
34831 Open surgical AAA repair "rescue" using aorto-biiliac graft, 90-day global
34832 Open surgical AAA repair "rescue" using aorto-bifem graft, 90-day global

A typical bifurcated modular endovascular repair will be coded using the following:

34802 Endo AAA repair modular bifurcated graft
34812 Unilateral femoral artery exposure (use -50 modifier if bilateral)
36200 Introduction of catheters into aorto (existing code, use -50 if bilateral)
75952 Radiological supervision and interpretation

New Codes for 2002

The Government Relations Committee has been successful in introducing the following codes for 2002.

CPT 35646 - This code is currently defined as aortofemoral or bifemoral. In 2002 CPT 35646 will be defined as "Bypass Graft, with other than vein; aortobifemoral." A new CPT code, 3564X will be "Bypass Graft, with other than vein; aortofemoral."

CPT 3568X1 - Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (list separately in addition to code for primary procedure). (Use 356X1 in conjunction with codes 35656, 35666, 35671.) This is an "add-on" code to represent extra work of the patch/cuff.

CPT 3568X2 - Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)(list separately in addition to code for primary procedure.)(Use 3568X2 in conjunction with codes 35556, 35566, 35571, 35583, 35585, 35587, 35623, 35656, 35666, 35671.) This is also an "add-on" code to represent the extra work of creating a distal AV fistula.

3682X - Arteriovenous anastomosis, open, by forearm vein transposition.

36002 - Thrombin injection for post-catheterization pseudoaneurysm. Use in conjunction with CPT 76942 ultrasonic guidance for needle placement, imaging supervision and interpretation.

Southern California Medicare To Reimburse S&I - Vascular surgeons attempts to collect **Supervision and Interpretation codes for angiograms, venograms, and endovascular procedures** have been disallowed in many parts of the country, but due to the efforts of vascular surgeons in southern California, the local intermediary has approved reimbursement. The most frequent reason for denial has been HCFA's general belief that only hospital-based physicians should be reimbursed for S & I codes. After many attempts to rectify this situation, physicians brought their argument to Southern California Carrier Medical Director to address this problem. *The Medical Director reviewed the problem and has ruled that S& I coding can now be reimbursed if surgeons use the modifier -26.* Interventional Radiology Coder, 1999 Edition, presents additional details on billing using the S & I codes. For more information on how Southern California Vascular Surgeons succeeded, physicians are encouraged to contact Bob Oblath, MD.

Make Sure Your Designation is "Vascular Surgeon" in Medicare Program - According to the Medicare database, vascular surgeons perform only 25-40% of what we consider benchmark vascular surgery cases. On January 1, 2001 HCFA applied the practice expense data we collected last summer, and the PE base rate for vascular surgery is higher than that of general surgery. Since the PE RVUs are determined based on a blend of the PE base rates associated wiht the specialties that perform each operation, *it is to our great detriment to have vascular surgeons erroneously assigned as general surgeons on the Medicare roles.* Since HCFA assigned a new and better PE rate for vascular surgery, our next effort must be to correct vascular surgeons' enrollment status.

Members are encouraged to contact their local Medicare Carrier to determine their enrollment status and to make sure they are listed as "vascular surgeons".

PUBLIC EDUCATION

AAVS President Robert Hobson, M.D. has led a yearlong effort to develop the American Vascular Association, a new division of the AAVS. This new, not-for-profit organization was created to help the Association realize its long term public education program goals. In the short term, the AVA will also be central to the Association's website and development programs. "Over time, I think the AVA will grow to be the trusted and expert source of information on vascular disease and its treatment," said Dr. Hobson.

The website development, led by Dr. Bill Pearce, with equal AAVS/SVS financial contributions totalling over $350,000, will establish a vehicle for communication among members and to the public. The Task Force on Public Education, chaired by Dr. Bill Flinn will develop a strategic plan to broaden public awareness of non-cardiac vascular diseases. There will be a focus on prevention, early detection, and effective treatments.

The Task Force will initially seek to define and refine a public image for the "vascular surgeon". The Task Force will also develop programs to clarify and enhance the public awareness of the important role of vascular surgeons and other specialists in the diagnosis and management of patients with all forms of vascular disease.

The Task Force will include: A Public Awareness Committee to develop and enhance the image of Vascular Surgery through web-based and other communications media; A Community Outreach Committee to design public education programs based upon regional, community-based need and clinical screening for vascular disease; and a Development Committee, headed by Thomas O'Donnell MD, Boston, Massachusetts.

Energetic fund-raising will be necessary to support public education and the website. The membership is urged to participate in these AVA activities.

COMING IN JULY..

AAVS / SVS Website to Get A New Look- www.VascularWeb.org

Over the last 10 months, the Society for Vascular Surgery and the American Association for Vascular Surgery have conducted a vigorous review of the current SVS/AAVS website and its ability to meet the future needs of vascular surgeons. "After careful examination of the website and the needs of our members, we determined that vascular surgery needs a more robust website," explained Dr. Ramon Berguer, SVS President. "The new site will be designed to expand service to members, facilitate member-to-member communication, and launch patient education programs," continued Dr. Berguer.

"The new site, VascularWeb.org, will demand a substantial commitment of societal resources and member energies to successfully implement," stressed Robert A. Hobson, M.D., AAVS President. "Over the next three years the societies will combine resources to make a significant financial investment in VascularWeb.org's development, as well as a significant commitment of 'manpower' resources," stated Dr. Hobson.

The most essential ingredient for ensuring VascularWeb's success is volunteer time and expertise commitment. Over the next few months Dr. William Pearce will continue his leadership of the program and will begin tapping many colleagues as VascularWeb contributors. If you are contacted, we hope you will agree to participate.

The Societies have contracted with MedBiquitous, a Baltimore website development company, to build the new website, VascularWeb.org. MedBiquitous is responsible for the development of, CTSNet, the website built under the direction of a worldwide coalition of cardiothroraicic surgery associations. "CTSNet has the website functionality we seek for vascular surgery and has contributed to a stronger worldwide cardiothoraicic surgery community," siad AAVS President-Elect William Pearce. If you are interested in seeing what the future VascularWeb.org site will look like, visit www.CTSNet.org.

"The Societies are developing an aggressive industry outreach campaign to raise funds to increase the usuage of the site and to make it financially self-sustaining," said Dr. Berguer. "The CTSNet model has shown that judicious industry partnering can be a rewarding experience."

AAVS and SVS have taken the lead in the bringing about the creation of VascularWeb, but it will be an open platform for all vascular society sites. AAVS is soliciting regional, national and international VascularWeb partner societies and requests your assistance in communicating this opportunity.

For more information on VascularWeb, please contact Dr. William Pearce: wpearce@nmh.org.

FDA Public Health Notification: *Problems with Endovascular Grafts for Treatment of Abdominal Aortic Aneurysm (AAA)*

Dear Colleague:

This letter is to inform you about serious problems that have occurred with two endovascular prosthetic graft devices used to treat infrarenal AAA, and to make recommendations concerning their continued use. The two products, both of which were approved for marketing in the U.S. in September 1999, are:

Ancure Endograft System
(Guidant Endovascular Solutions, Menlo Park, CA) and
AneuRx Stent Graft System
(Medtronic AVE, Santa Rosa, CA).

BACKGROUND

Endovascular repair of AAA is an important new technology. It represents a useful therapeutic option for carefully selected patients whose only previous treatment alternative was open surgical repair of their aneurysm. For patients who are at high risk for adverse outcomes with conventional open surgery, endovascular repair provides an alternative to "watchful waiting". Since this is a rapidly evolving technology, it is critical that physicians who evaluate and treat AAA patients have the information needed to make informed decisions on patient selection, device selection, and follow-up management.

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REPORT OF THE AAVS REORGANIZATION

Thomas S. Riles, M.D., Secretary

Over the past year, through a series of meetings and conference calls, the Council of the AAVS has taken a series of actions aimed at making fundamental changes in our Society—a change in the membership, the name of the Society, the governing structure and the purpose for which the Society exists.

The general philosophy guiding these changes has been that the AAVS should be a broad based group that represents the interests of all vascular surgeons in the US and Canada on issues pertaining to government relations, public relations and practice issues including our relationships with radiologists, cardiologists, hospitals and vascular laboratory personnel.

Last fall, the Council voted to change the requirements for membership. Each year we receive 30-40 applications for membership, yet our vascular residencies are graduating 100 new vascular surgeons each year. Therefore, the Council deleted the references to publications in the guidelines for membership.

The Council has proposed that membership be based on a commitment to vascular surgery. The following may evidence commitment:

1. Completion of an approved vascular residency program;
2. Achieving a certificate for special qualifications in vascular surgery;
3. Significant contributions to education and research;
4. Demonstration of a commitment to the practice of vascular or endovascular surgery;
5. Participation in the Regional or Local Vascular Societies;
6. Participation in the American College of Surgeons.

In addition to these guidelines, favorable letters of recommendation from 3-4 members of the Society will continue to weigh heavily in the decision by the Membership Committee.

The Council has also proposed draft Bylaws to create a Candidate Membership for vascular residents and vascular surgeons just completing their training programs.

At last June's meeting, the membership approved changing the Society's name to the American Association for Vascular Surgery. This change is central to the new direction of the Society. As we extend our outreach to the public and other organizations it is critical that they understand the Society's core mission is to advance vascular surgery. In interacting with government and other groups in the public policy arena, we have come to recognize that our name must be as clear and focused as our objectives.

In addition to studying ways to streamline our present Governance, the Society has reached out to the rest of vascular surgery and have proposed bylaw changes to create permanent seats on the Council for each of the five major regional vascular societies, as well as national surgical groups: Peripheral Vascular Surgery Society, Society for Clinical Vascular Surgery, Venous Forum and the Canadian Vascular Surgery Society. The governance plan will be presented to the membership for its approval in June 2001.

2001 Joint Annual Meeting
June 10-13, 2001

The Baltimore Convention Center / Baltimore, Maryland

Society for Vascular Surgery 55th Annual Meeting
American Association for Vascular Surgery 49th Scientific Meeting

The 2001 Joint Annual Meeting of The Society for Vascular Surgery and The American Association for Vascular Surgery will commence Sunday, June 10, 2001 with two Postgraduate Courses from 8:00 a.m. to 12:00 Noon and the Lifeline Foundation® Research Forum from 8:30 a.m. to 12:00 Noon. The Society for Vascular Surgery's Annual Meeting begins on Sunday afternoon at 1:30 p.m. and continues through Monday, June 11th. The American Association for Vascular Surgery's Annual Meeting commences on Tuesday, June 12th and continues through Noon on Wednesday, June 13th.

PROGRAM HIGHLIGHTS

SVS/AAVS/SVT VASCULAR LABORATORY INTERPRETATION COURSE

LIFELINE FOUNDATION® RESEARCH FORUM

E. STANLEY CRAWFORD CRITICAL ISSUES PROGRAM

Vascular Surgery's Identity Crisis at the Millennium: Who Are We? Where Are We Going? Do Patients Really Care?"

SVS SCIENTIFIC SESSION

AAVS SCIENTIFIC SESSION

POSTGRADUATE COURSES

Endovascular Surgery Symposium
Operative Management of Carotid Endarterectomy
Lower Extremity Ischemia

SIMULTANEOUS CONTINENTAL BREAKFAST SESSIONS

held each morning from 6:30 a.m. until 8:15 a.m.

MEMBER BUSINESS LUNCHEON MEETINGS

SVS Member Business Luncheon Meeting
12:00 Noon-1:45 p.m.
Monday, June 11th

AAVS Member Business Luncheon Meeting
12:00 Noon-1:45 p.m.
Tuesday, June 12th

The luncheon meetings are open ***only*** to members of each Society and the correct badges must be warn. Tickets for the luncheons are $25.00 U.S. per person.

PHYSICIAN LUNCHEONS IN EXHIBIT HALL

Monday, June 11 and Tuesday, June 12, 2001
12:00 Noon - 1:45 p.m.

A complimentary luncheon for physicians will be available on Monday and Tuesday in the Exhibit Hall from 12:00 Noon to 1:45 p.m. This luncheon will give physicians and exhibitors another opportunity to interact and socialize.

ADDITIONAL INFORMATION & REGISTRATION FORMS:

SVS/ AAVS Administrative Office
13 Elm Street
Manchester, MA 01944
Phone: 978) 526-8330 / Fax: (978) 526-4018 / fax
www.vascsurg.org / E-Mail: jvs@prri.com

2001 SVS Program Committee

John W. Hallett, Jr., MD, Co-Chairman
Hisham S. Bassiouny, MD
Thomas M. Bergamini, MD
Edward B. Diethrich, MD
Timothy M. Sullivan, MD
Jack L. Cronenwett, MD, Ex-Officio
Richard M. Green, MD, Ex-Officio
K. Craig Kent, MD, Ex-Officio

2001 AAVS Program Committee

Thomas S. Riles, MD, Co-Chairman
Eliott L. Chaikof, MD
Kim J. Hodgson, MD
William C. Krupski, MD
Joseph L. Mills, MD
Joseph P. Archie, Jr., MD, Ex-Officio

2001 Local Arrangements Committee

William R. Flinn, MD
Bruce A. Perler, MD

FDA Public Health Notification

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SPECIFIC PROBLEMS WITH ENDOVASCULAR GRAFTS

The two devices have very different designs, and there are different reasons for the current concerns focused on each.

ANCURE SYSTEM (GUIDANT)

This device has a flexible, unsupported fabric graft prosthesis that is actively fixed in place on the ends by wire hooks that penetrate the vascular tissue. On 3/16/01, Guidant suspended production and announced a recall of all existing inventory. The company reported to the FDA that they had failed to report many device malfunctions and adverse events, including severe vessel damage associated with problems with the deployment of the device. There were also manufacturing changes that were not properly reported to the FDA. The manufacturer told FDA that an internal audit revealed problems with their complaint handling system, manufacturing quality systems, documentation procedures and training. The FDA is reviewing the firm's Corrective Action Plan that addresses these problems. Once we receive evidence that the firm has appropriately changed their systems and procedures, and the FDA has reviewed their regulatory submissions, we will assess whether the product can be returned to the market.

ANEURX SYSTEM (MEDTRONIC AVE)

This device has a fabric graft supported along its entire length by a series of metal rings sutured to the graft. The endograft is held in place by the radial force applied by the rings to the patient's aorta. FDA is concerned about reports of approximately 25 aneurysm ruptures, as well as other serious adverse events, in patients who have received AneuRx. Factors thought to be associated with the adverse events, including aneurysm ruptures, include: sub-optimal placement of the graft; endoleak (inadequate proximal seal, collateral vessel retrograde flow, persistent perigraft flow); migration of the main body of the device as well as any attachment cuffs, possibly associated with continuing aortic dilatation; problems with device integrity, due to metal frame fractures, suture breaks, or fabric tears; and aneurysm anatomy.

We are working with Medtronic AVE to obtain relevant data that will help us understand how these problems affect the overall risk/benefit assessment of this product.

RECOMMENDATIONS

1. Stay Informed. Endovascular repair of AAA is a new and evolving technology, and both Ancure and AneuRx have undergone changes in design and labeling during the premarket and postmarket phases. Anticipate that there will be changes and improvements as more clinical experience accumulates with this class of devices. We recommend that you carefully follow the device manufacturer's most recent warnings, precautions, and instructions regarding patient selection and device use.

2. Make sure that all implanted patients are carefully followed, and undergo periodic follow-up imaging. Patients who are unlikely to adhere to the manufacturer's graft follow-up recommendations may be poor candidates for endovascular repair, even if they are otherwise suitable. Problems that are identified through follow-up imaging may be amenable to further endovascular repair (e.g. additional stent placement), or might require conversion to open aneurysm resection.

3. Report problems you encounter with the use of these devices, as well as adverse events, to the manufacturer and to the FDA. We will only be able to assess the risk/benefit of these devices, as well as their ultimate clinical usefulness, if we have open communication with practitioners who use them.

REPORTING ADVERSE EVENTS TO FDA

The Safe Medical Devices Act of 1990 (SMDA) requires hospitals and other user facilities to report deaths and serious injuries associated with the use of medical devices. This means that if a patient death or serious injury can possibly be attributable to an endovascular graft, you should follow the procedures established by your facility for mandatory reporting.

If the stent graft or its delivery system malfunctions, you can report this directly to the manufacturer. Alternatively, you can report directly to MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch four ways: online at http://www.accessdata.fda.gov/scripts/medwatch; by telephone at 1-800-FDA-1088; by FAX at 1-800-FDA-0178; or by mail to MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

GETTING MORE INFORMATION

If you have questions regarding this letter, please contact Janet Morgan, R.Ph., Office of Surveillance and Biometrics (HFZ-510), 1350 Piccard Drive, Rockville, Maryland, 20850, by fax at 301-594-2968, or by e-mail at phann@cdrh.fda.gov. Additionally, a voice mail message may be left at 301-594-0650 and your call will be returned as soon as possible.

All of the FDA's medical device postmarket safety notifications can be found on the World Wide Web at http://www.fda.gov/cdrh/safety.html. Postmarket safety notifications can also be obtained through e-mail on the day they are released by subscribing to our list server. You may subscribe at http://list.nih.gov/archives/dev-alert.html.

AAVS Secretary's Report

(continued from page 3)

AAVS continues to work with our sister organizations in surgery, medicine, cardiology and interventional radiology. The 4th Annual Vascular Centers Program, designed to educate members on state-of-the-art vascular centers, was held recently in Atlanta and attracted more than 600 enthusiastic participants. As we refine our outreach efforts, we anticipate a higher level of collaboration and cooperation with other organizations interested in the treatment of vascular disease. A critical review of current activities in this area resulted in the Societies' decision to discontinue support of the "Legs for Life Program," operated by the Society of Cardiovascular and Interventional Radiology.

AAVS continues to expand the Annual Meeting and will host three new debate programs in 2001. The Annual Meeting will also feature more than 80 oral presentations, 9 breakfast sessions, two postgraduate courses, and a special Endovascular Postgraduate Course. The Society continues to review the educational objectives of the annual meeting and will modify the format, as necessary, to enhance the learning experience for attendees and to keep the program attractive to vascular surgeons

The Government Relations Committee, chaired by Robert Zwolak, MD is to be commended for its tremendous efforts in conjunction with HCFA's five-year review of physician work values. The Committee appealed to HCFA to upgrade reimbursement for 94 vascular surgery procedures and is currently appealing HCFA's decision to unilaterally block payment for co-surgeons and the use of assistant surgeon modifiers. The Committee is actively building a network of physicians who serve on state or local Carrier Advisory Committees. The Council has proposed Bylaws amendments to modify the composition of the Committee to sustain the progress made this year.

The AAVS continues to talk with the International Society to improve the value of *Cardiovascular Surgery* for AAVS members. The ISCVS has been open to the AAVS' concerns that the Journal be reoriented to an all-vascular journal and have also expressed a willingness to discuss modifying the Journal for web delivery.

REMINDER

The American Association for Vascular Surgery

The North American Chapter of the International Society for Cardiovascular Surgery (NA-ISCVS) is now the American Association for Vascular Surgery (AAVS). This change was made to reflect its focus on vascular surgery and to give the Society a name that would enhance its efforts in government relations, public relations and practice issues.

Please remember to update your CV, office listings, and any other personal documents that mention the Association. The address, phone and fax numbers remain the same.

AAVS NEW MEMBERS

Eilas J. Arbid, M.D.
Worcester, Massachusetts
Yvon R. Baribeau, M.D.
Manchester, New Hampshire
Marshall E. Benjamin, M.D.
Baltimore, Maryland
Irwin M. Best, M.D.
Atlanta, Georgia
Peter M. Brown, M.D.
Kingston, Ontario, Canada
Christopher M. Ceraldi, M.D.
Oakland, California
Michael K. Deiparine, M.D.
Liberty, Missouri
Nazmi A. Elrabie, M.D.
Paterson, New Jersey
Ronald M. Fairman, M.D.
Philadelphia, Pennsylvania
Glenn R. Faust, M.D.
New Hyde Park, New York
Spencer W. Galt, M.D.
Salt Lake City, Utah
Jeffrey S. Gosin, M.D.
Somers Point, New Jersey
Homayoun A. Hashemi, M.D.
Allentown, Pennsylvania
Andrew B. Hill, M.D.
Ottawa, Ontario, Canada
John D. Hughes, M.D.
Tucson, Arizona
Karl A. Illig, M.D.
Rochester, New York
William D. Jordan, M.D.
Birmingham, Alabama
Larry W. Kraiss, M.D.
Salt Lake City, Utah
George S. Lavenson, Jr.,M.D.
Visalia, California
Raymond Wai Mun Lee, M.D.
Hilo, Hawaii
Max P. Levine, M.D.
Danville, New York
Timothy K. Liem, M.D.
Columbia, Missouri
George Louridas, M.D.
Winipeg, Manitoba, Canada
Joseph G. Magnant, M.D.
Rome, Georgia
John H. Matsuura, M.D.
Atlanta, Georgia
Gregory S. McGee, M.D.
Mobile, Alabama
James W. McNeil, M.D.
Baton Rouge, Louisiana
Takao Ohki, M.D.
New York, New York
Ferdinand M. Plecha, M.D.
Middleburg Hts., Ohio
Patrick N. Riggs, M.D.
Rochester, New York
Caron R. Rockman, M.D.
New York, New York
Lewis B. Schwartz, M.D.
Chicago, Illinois
Julianne Stoughton, M.D.
Medford, Massachusetts
Martin V. Taormina, M.D.
Gastonia, North Carolina
R. Bradley Thomason, III, M.D.
Winston-Salem, North Carolina
Henry C. Veldenz, M.D.
Jacksonville, Florida
Thomas H. Webb, M.D.
Baltimore, Maryland
Alex Westerband, M.D.
Tucson, Arizona
Robert P. Winter, M.D.
Maitland, Florida

SVS Secretary's Report

(continued from page 3)

32% and 46.3%. Other choices included competition with interventional radiology and cardiology for patients (28.4%), reimbursement (23.7%), separation from the American Board of Surgery (6.3%) and political in-fighting among the vascular leadership (2.6%).

As for governance, 63.3% of respondents believe that an independent board would be best for vascular surgery. Among respondents who are in private practice, 78.7% believe that an independent American Board of Vascular Surgery would be best. Among those in academic practice 59.8% believe that an independent board would be best. Here, the difference between the two groups is statistically significant (p=.016). If one assumes that the distribution of vascular surgeons between private and academic practices is the same in this group of respondents as in the total population of vascular surgeons, then the point estimate for the true percentage of vascular surgeons that believe that an independent ABVS would be the best governance system is 63.6%. With 95% confidence, we can say that the true percentage lies between 56.6% and 70.2%.

5. The SVS/AAVS are the recipients of a training grant from a Philadelphia organization named the Foundation for Advance Medical Education (FAME). This will be shared equally between the American College of Cardiology and the vascular societies and each will receive $300,000. The goal is to train 13 surgeons and 13 cardiologists in iliac and renal angioplasty/stenting. Drs. Kim Hodgson, Alan Lumsden and Michael Silva are working on the didactic material. Applications will be available in June.

6. Following an intensive discussion about the mailing initiated by Drs. Berguer and Hobson, the SVS Council unanimously voted on January 16, 2001 to adopt the following resolution: *Resolved that in recognition of the increasing complexity and breath of vascular disease, the SVS Council desires a fundamental and urgent change in the training paradigm for vascular surgeons that recognizes the importance of endovascular training and recommends that the vascular surgical societies and the Association of Program Directors in Vascular Surgery meet to expedite this process.*

7. At that same meeting the Council voted (6 in favor, 2 opposed) to authorize an expenditure of up to $20,000 to fund the Ad Hoc Feasibility Committee's efforts to continue its investigation of the feasibility of submitting an application to the ABMS for an American Board of Vascular Surgery and to gather all the documentation necessary for such an effort. Dr. Berguer appointed Drs. William Abbott, Robert Hobson, Thomas O'Donnell, William Pearce and James Stanley to that Committee.

SVS NEW MEMBERS

Scott S. Berman, M.D.
Tucson, Arizona
Robert A. Cambria, M.D.
Milwaukee, Wisconsin
Timothy A. M. Chuter, M.D.
San Francisco, California
David L. Dawson, M.D.
San Antonio, Texas
Hugh A. Gelabert, M.D.
Los Angeles, California
Kenneth A. Harris, M.D.
London, ON, Canada

M. Ashraf Mansour, M.D.
Maywood, Illinois
Mark A. Mattos, M.D.
Springfield, Illinois
George H. Meier, III, M.D.
Norfolk, Virginia
Robert S. Mitchell, M.D.
Stanford, California
Satish C. Muluk, M.D.
Pittsburgh, Pennsylvania
Richard F. Neville, M.D.
Washington, D.C.

Robert W. Oblath, M.D.
Encino, California
Peter J. Pappas, M.D.
Newark, New Jersey
William D. Suggs, M.D.
Bronx, New York
Timothy M. Sullivan, M.D.
Greenville, South Carolina
Peter A. Schneider, M.D.
Honolulu, Hawaii
Douglas L. Wooster, M.D.
Toronto, ON, Canada

Endovascular Mini-Fellowships

The Endovascular Committee, chaired by Gregorio Sicard, MD, has been working to enhance vascular surgeons' access to quality post-fellowship training in endoluminal techniques. The Committee has compiled a list of US endoluminal mini-fellowship program opportunities complete with program contact information. To access the mini-fellowship list please visit the Societies' website at **www.vascsurg.org.**

The Endovascular Committee will present a process for evaluating mini-fellowship programs to the AAVS and SVS Councils for decision in June. If the criteria are accepted the societies could begin evaluating mini-fellowship programs in the fall of 2001.

Society for Vascular Surgery
American Association for Vascular Surgery
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