LETTER TO THE EDITOR:

It's time for a separate residency Review Committee for vascular surgery

BY JOHN F. EIDT, MD

[Editor’s Note: At its January 2018 strategic planning retreat, the SVS Strategic Board of Directors and Executive Board discussed the merits of a Vascular Surgery residency Review Committee (RC) and have made a firm commitment to explore the process, beginning with the Association for Program Directors in Vascular Surgery (APDVS), on how best to proceed with submitting an application to the Accreditation Council for Graduate Medical Education (ACGME). SVS welcomes the input and support of all. See Letter · page 6

BY BRUCE JANCIN
FRONTLINE MEDICAL NEWS
REPORTING FROM THE AHA SCIENTIFIC SESSIONS

ANAHEIM, CALIF. – Adherence to the American Heart Association’s widely publicized “Life’s Simple 7” program addressing key modifiable cardiovascular health factors substantially reduces the risk of developing peripheral arterial disease, Parveen Garg, MD, said at the American Heart Association scientific sessions.

This is new evidence-supported information. Until this new analysis from the landmark ARIC (Atherosclerosis Risk in Communities) study, the relationship between Life’s Simple 7 and peripheral arterial disease (PAD) hadn’t been studied. It's a relationship worthy of examination, considering that more than 8 million Americans have PAD, and nearly 40% of them don’t have concomitant coronary or cerebrovascular disease, which raised the question of whether Life’s Simple 7 applied to PAD risk, noted Dr. Garg of the University of Southern California, Los Angeles.

See Simple · page 5

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PRACTICE MANAGEMENT

Surgeon pain, disability on the rise

BY KARI OAKES
FRONTLINE MEDICAL NEWS

The evidence has been accumulating for decades: Practicing surgery can exact a toll on surgeons’ physical well-being in ways that can shorten careers and contribute to professional dissatisfaction.

“Ergonomists have described the surgeon’s work environment and working conditions as equal to, if not at times harsher than, those of certain industrial workers,” wrote Sherine Epstein, MPH, and the coauthors of the systematic review and meta-analysis of studies addressing the issue. Ms. Epstein, currently a 4th-year medical student at the University of California, San Diego, and her team found a high prevalence of work-related musculoskeletal disorders and pain among surgeons and interventionists, with pooled prevalence estimates for pain among these physicians ranging from 35% to 60% of all respondents. Cervical spine disease, rotator cuff pathology, and degenerative lumbar spine disease were each reported by nearly one in five respondents in the pooled analyses, with increasing prevalence over the duration of the study period (JAMA Surg. 2017 Dec 27. doi:10.1001/jamasurg.2017.49).

The results of the study are in line with previous work that finds a high—and increasing—rate of pain and disability among at-risk physicians, who endure long work hours, awkward positioning, and few opportunities for breaks. The study also suggested a possible linkage between work-related pain and other factors, such as burnout and depression, that lead to performing vascular surgery because of musculoskeletal pain secondary to performing vascular surgery is a real issue. Our group recently presented survey results showing that 44.2% of vascular surgeons experience moderate to severe pain even before starting their operative day. During their operative day, these numbers increased to 78%. By the end of a full day doing procedures, 83% of vascular surgeons reported moderate or severe pain. The physical costs of being a vascular surgeon are real. The use of lead aprons, loupe magnification, headlights, foot pedals, and monitors only magnifies these problems.

The impact to the health care system is significant, with 6% of vascular surgeons stopping the practice of vascular surgery because of musculoskeletal pain, only exacerbating the shortage of vascular surgeons we are currently experiencing. Efforts should be made to educate vascular surgeons on ergonomic modifications to help reduce this problem. Table height, posture, monitor height, and minimizing positions of high stress during surgery are crucial to avoid chronic musculoskeletal pain (MSP) and injury. Formal micro-breaks (stretching exercises at regular intervals during long cases) are a cost-effective way to begin to combat MSP in the operating room. However, ergonomic education and careful attention to operating room and equipment setup can also be key components toward minimizing MSP.

Pain is all too common

BY KARI OAKES
FRONTLINE MEDICAL NEWS

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Pain is all too common
I am not your burnout expert

BY MALACHI G. SHEAHAN III, MD
DEPUTY MEDICAL EDITOR, VASCULAR SPECIALIST

L
ook, I am not a burnout expert. And neither are you (presumably). None of us know much, but that won’t stop the regulations from coming. Program directors are already being asked to provide “wellness plans.” Through the SVS, experts have been enlisted to help, but it is now clear that what works for others won’t necessarily work for vascular surgeons. The next step is up to us. We are the only ones with detailed knowledge of our lives. I believe we are moving closer to answers but still face a few significant hurdles. Don’t worry, there are solutions. Hear me out…

Previously, I shared three studies with you, which found that vascular surgeons had the highest rates of suicidal ideation and career dissatisfaction among surgeons while spending more hours in the hospital than any other specialty. So what has been done to address these horrific numbers? Very little. We need answers now, but most of the data are over 10 years old. Much has changed in our specialty. The endovascular revolution created an entirely new working paradigm. A busy vascular surgeon used to perform 300 cases annually; now this number approaches 1,000. More procedures mean more clerical work. Lead aprons and radiation exposure have added new ergonomic and medical concerns. Reimbursement dynamics now favor shorter, more frequent patient interactions over longer, more complex cases. We are benchmarked against old work standards while CPT bundling continuously lowers current RVU designations. EMR was supposed to make our lives better; it has done the opposite. Patient-centered health care has become a mantra, but the measures taken often backfire. Practicing medicine where the desired outcome is a high score on patient satisfaction surveys will likely lead to unnecessary tests, poor cost allocation, and low physician fulfillment. Quality of care is now measured scrupulously while the quality of our lives remains undocumented.

In the absence of organized reform, burnout appears to be increasing. A recent Mayo Clinic–AMA study found the current prevalence to be 54% among physicians. All of this has not happened overnight. I believe practicing vascular surgeons are resilient by default. The majority of us trained prior to the enforcement of duty hour restrictions. Out of high school, I enrolled in a 6-year BA/MD program (skipping 2 years of college seemed like a great idea in high school, less so when I got there). Half of my class never finished. In my intern year, six of the eight categorical residents dropped out. My odds of reaching PGY 2 were 12.5%. Fuzzy math aside, all of my stories are similar. We have proved our resilience over and over again. What is happening here is different.

Burnout is described as emotional exhaustion, low self-esteem, and depersonalization/ cynicism. It develops slowly, progressively as stressors increase. A common thread seems to be the feeling that you alone are not enough. Examine your daily life. What are your most common stressors? For me, they relate to time management, clinical documentation, and whatever fresh hell my kids’ teachers have cooked up for “school projects.”

****Scene****

Wife: Can you help Luke (kindergarten) finish his diorama? It needs to be a scale depiction of his 3 favorite scenes from Wagner’s Ring cycle. Me: Sure, I just need to complete the wind tunnel testing on Jack’s (3rd grade) carbon-neutral peanut-free alternative fuel source rocket booster.

Off stage – 7th Grade Son: The genetically modified spiders got loose again!

****End Scene****

We want to do a good job, but more hurdles are placed in our way. A recent AMA/Dartmouth Hitchcock study found that 50% of physicians’ time is spent performing data entry and other administrative work. Only 27% of time was spent on patient care. Every hour of face-to-face patient time requires 2 hours of EMR/clerical work. We are trapped in a bureaucratic prison. For years, every quality initiative was solved with a new form. To enter a simple note today, we must first “establish our relationship” with the patient, then ably click through a minefield of “warning boxes” signifying impending DVT prophylaxis catastrophes and antibiotic crimes and misdemeanors, next we scroll through a pre-populated postapocalyptic helicopter of minute-by-minute vital sign entries and lab values dating back to inception. Then, and only then, ON PAGE 11, we can meagerly type: Patient at wound care, will come back on evening rounds.

Another important component of the burnout syndrome is dehumanization. Recently I spoke with Donald Zimmerman, PhD, author of the burnout continued on page 14
When the AHA originally developed the Life’s Simple 7 concept to support the organizational goal of substantial reduction of the burden of cardiovascular disease by the year 2020, the targets were coronary heart disease (CHD) and stroke. The scope of the program was later broadened to include all cardiovascular disease, including PAD.

ARIC is a National Heart, Lung, and Blood Institute–sponsored prospective study of nearly 16,000 black or white individuals who were middle-aged at enrollment and have been followed for more than 2 decades. Dr. Garg’s analysis focused on 12,865 participants who were free of CHD, heart failure, prior stroke, and PAD at baseline, and have been followed for a median of 24 years.

The metrics for Life’s Simple 7 consist of total cholesterol, blood pressure, glucose levels, body mass index, physical activity, and adherence to a healthy diet score. Each element can be scored 2 points for ideal, 1 for intermediate, and 0 for poor. The composite Life’s Simple 7 score is rated optimal at 10-14 points, average at 5-9, and inadequate at 0-4.

During follow-up, 3.4% of ARIC participants developed PAD sufficiently severe to involve hospitalization. The incidence was 5.2 cases per 1,000 person-years for the 1,008 subjects categorized as having an inadequate Life’s Simple 7 score, 1.1/1,000 person-years for the 8,395 people in the average category, and 0.4 cases/1,000 person-years for the 3,462 in the optimal Life’s Simple 7 group.

Compared with subjects in the inadequate category, those in the average group were 56% less likely to develop PAD. Those in the optimal Life’s Simple 7 category had an 86% reduction in risk.

For each of the seven components of Life’s Simple 7 a person scored ideally in, the risk of incident PAD was reduced by 28% in a multivariate analysis fully adjusted for demographics, alcohol consumption, aspirin use, study site, left ventricular hypertrophy, and other potential confounders.

The true incidence of PAD in this study is not known, as the only indicator of PAD was hospitalization. It is possible that patients with “bad habits” were more often assessed for PAD, and diagnosed, whereas patients without “bad habits” might not have been assessed, as was frequently the case with women and cardiovascular disease a few decades ago. A measure of ABI at baseline, and at multiple time points throughout the study would have been helpful. Popliteal artery assessments, which were performed in the ARIC study, were not reported in this substudy.

More importantly, what this sub study does not assess, is the impact these lifestyle changes have once present.

The career prevalence of degenerative lumbar spine disease was estimated at 19%. The investigators’ estimate of lumbar spine disease prevalence from their own data also showed an increase, to 21%, for studies published within the past decade.

Rotator cuff pathology during the study period was estimated at 18% overall, and carpal tunnel syndrome at 9% overall; carpal tunnel syndrome also appears to be increasing in prevalence, estimated at 12% between the last decade.

Twelve of the studies met criteria for inclusion in the quantitative synthesis of musculoskeletal pain. Neck, back, and shoulder pain were all common in this group. Neck pain had a 60% estimated 12-month prevalence; shoulder pain had a 52% prevalence; and back pain was reported for about half (49%) of respondents.

Just 10 of the included studies addressed disability burden, said Ms. Epstein and her colleagues. Overall, 12% of physicians responding in this subset of studies reported that they required work modification, leave of absence, or early retirement because of work-related MSDs.

A lack of awareness of ergonomic recommendations on the part of the surgeons themselves was identified in several studies. “A few studies have found that ergonomics education during medical training appears feasible, accepted, and effective at changing behaviors and reducing symptoms,” the investigators said.

Work-related pain and disability among surgeons remains underreported and underestimated, according to both Dr. Park and the study investigators. Further research is needed, and the investigators wrote: “Ultimately, this work should be integrated with research on preventing surgeon burnout and attrition given shared risk factors.”

Micro breaks can help

What’s the solution? Dr. Park says that some fixes are low tech, and can be put in place immediately. He and his team implemented a series of brief...
Vascular Surgery RRC

Letter from page 1

partner organizations across the specialty of vascular surgery. In the following letter to the editor, John Eidt details why vascular surgeons should support the establishment of a separate Vascular Surgery residency RC within the auspices of the ACGME. — Russell Samson, MD, Medical Editor, Vascular Specialist.

It is my belief that the Accreditation Council for Graduate Medical Education (ACGME) should establish an autonomous Review Committee (RC) for vascular surgery. I believe that vascular surgery has achieved sufficient differentiation from other surgical and medical specialties to justify such an action and I believe that an independent Review Committee would have a beneficial effect on vascular surgery education.

The ACGME is an independent, not-for-profit, physician-led organization that sets the educational standards for graduate medical education in the United States. The ACGME was founded in 1981 as the restructured offspring of the Liaison Committee for Graduate Medical Education (LCGME). The LCGME, initially established in 1972 by the American Medical Association (AMA), the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC) and the Council of Medical Specialty Societies (CMSM), was somewhat dysfunctional owing to complex reporting and approval processes.

Since 1981, the ACGME has assumed the administrative responsibility for ensuring the quality of graduate medical education in the United States. In the 2016-2017 academic year, there were 130,000 residents and fellows in approximately 10,700 programs. There are currently 28 Review Committees that largely reflect the member boards of the ABMS. There are two RCs that relate to the American Board of Radiology (Radiology and Radiation Oncology). Surgery, Complex General Surgical Oncology, Hand Surgery, Pediatric Surgery, and Surgical Critical Care in addition to Vascular Surgery programs including both independent (5+2) and integrated (0+5) vascular programs.

The Surgery RC, in consultation with the Program Directors, the ABS and others, sets the standards for surgical training in the form of the Program Requirements, which describe in detail the roles of the faculty, the responsibilities of the sponsoring institution, and the composition of the educational content. The current program requirements in vascular surgery, applicable to both integrated and independent pathways, prescribe 36 months of vascular-specific training in addition to a variable amount of “surgery” experience.

For independent programs (5+2), it is expected that trainees obtain at least 12 months of vascular training during general surgery residency in addition to the 24 months of vascular training during fellowship. For integrated programs (0+5), the program requirements include 24 months of “core surgery” rotations in addition to the 36 months of vascular-specific rotations. The core rotations are designed to ensure that vascular trainees have a broad exposure to the essentials of patient care including fluid and electrolyte balance, management of shock and resuscitation, critical care, wound care, nutrition, surgical infection, and thrombosis and hemostasis.

These core surgical skills may be obtained on a variety of rotations based on the resources unique to each institution. There have been ongoing discussions with the Vascular Surgery Board regarding the need for specific case minimums, the need for required rotations and the duration and content of “core” surgery.

Applications for new programs can be submitted to the residency RC throughout the year and are reviewed by the members during three meetings annually. Until recently, ACGME policy precluded the approval of new (5+2) vascular surgery programs in institutions that did not have a General Surgery program. This policy was recently changed by the Board of Directors to give greater discretion to the RCs in determining specialty-specific needs. The RC Surgery at its September 2017 meeting determined that new applications for fellowship programs without an affiliated surgery program will be considered for accreditation. This is welcome news and will allow surgeons like Tim Sullivan, at Abbott Northwestern, to submit an application for an independent vascular program despite the absence of a surgery residency in his hospital.

While the ACGME is responsible for setting and reviewing program standards, the member Boards of the ABMS are responsible for the certification of individual physicians. The Vascular Surgery Board of the ABS sets the requirements for initial certification and maintenance of life-long certification, and develops the In-Training examination, the Qualifying and Recertification Exams (written), and the Certifying Exam (Oral). Recent discussions have focused on improving the MOC process including alternatives to the 10-year recertification exam.

The VSB functions largely autonomously within the framework of the ABS. Technically, the primary certificate in vascular surgery is awarded by the ABS (rather than the VSB) though the requirements for certification are independently determined by the VSB. The chairman of the VSB (currently Vivian Gabtan, MD) also serves as a Director of the ABS, must be currently certified in General Surgery, participate in the committee activities of the ABS and serve as an examiner for the General Surgery certifying (oral) exam.

At the present time, approximately 70% of certified vascular surgeons are also certified in Surgery, a proportion that will decrease with the influx of trainees from integrated (0+5) programs. The members of the VSB are nominated by the major national and regional vascular societies and elected by the VSB independent from the ABS. It is my opinion that the current Board structure has largely served the interests of the vascular surgery community as evidenced by the autonomy of the VSB to set the standards for vascular surgery certification free from ABS oversight. The chief drawback is that vascular surgery does not have a seat at the ABMS and relies on the ABS to represent the interests of vascular surgery in this important forum.

The American Board of Medical Specialties (ABMS) is the parent organization for 24 member boards including the American Board of Surgery, the American Board of Internal Medicine (Cardiology), and the American Board of Radiology (Interventional Radiology). The ABS offers primary certification in Surgery and Vascular Surgery and secondary certificates in surgical critical care, complex surgical oncology, pediatric surgery, hand surgery and palliative care. Vascular surgery is the only medical or surgical specialty with a primary certificate that does not have an independent RC. There is a separate Review Committee for colorectal surgery despite the fact that certification by the American Board of Colorectal Surgery requires prior certification in Surgery by the ABS, a curious anomaly arising from the fact that the Colorectal Board predat-
ed the establishment of the ABS by more than a dozen years.

So where is vascular surgery now? We have active national and regional societies, two training paradigms, textbooks, journals, a primary certificate, a national quality registry, and innovative research initiatives. We’ve come a long way in short time but I think that we need to continue to strive to improve our specialty. One important step would be the establishment of an independent RC for vascular surgery.

I believe that vascular surgeons should be responsible for determining the optimal methods for training the next generation of vascular surgeons. I should emphasize that I have no complaint with the performance of the Surgery RC. In fact, the Surgery RC has been remarkably responsive to the needs of the vascular community. The current program requirements for vascular surgery were developed in a collaborative manner with input from both General surgery and Vascular surgery and a vascular surgeon is always assigned to review new vascular surgery programs. In addition, it can be argued that cross-pollination between surgery, surgical oncology, pediatric surgery, surgical critical care, and vascular surgery may allow for the rapid adoption of best practices. But for the future of vascular surgery training, I would argue that we ought to begin a dialog with the ACGME to consider the merits (and drawbacks) of an independent Vascular Surgery Review Committee.

It seems apparent that general surgery, surgical oncology, pediatric surgery, and surgical critical care have more in common with each other than with vascular surgery. There is some evidence that surgical training is largely specialty-specific with limited transferability.

For example, I am not aware of any evidence that competence in the performance of laparoscopic cholecystectomy significantly improves the ability to perform vascular procedures. Rotations on cardiology, thoracic surgery, transplant, interventional radiology, and hematology may have more relevance to eventual vascular practice than rotations on breast, GI and burn services.

The question is who should be responsible for making these decisions: an RC composed of vascular surgeons or an RC composed predominately (>80%) of non-vascular surgeons. I think vascular surgeons are in the best position to determine the best way to train vascular surgeons just as surgical specialists in orthopedics, ENT, neurosurgery, urology, ophthalmology, plastic, and thoracic surgery determine their optimal training paradigms. The success (or demise) of the future of vascular surgery should be in the hands of those with the most skin in the game: vascular surgeons.

I think vascular surgeons are in the best position to determine the best way to train vascular surgeons.

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EDUCATION: VAM Registration, Housing Now Open

With the opening of registration and housing, the 2018 Vascular Annual Meeting officially takes a big step forward.

All scientific meetings and exhibits will be at the Hynes Convention Center. Committee meetings, the SVS Board of Directors meeting, and alumni and committee receptions will be held at the Sheraton Boston Hotel, the VAM headquarters hotel.

Attendees have several hotel options to meet a variety of needs. (See vsweb.org/VAM18 for the complete list of VAM hotels and pricing.) To receive the special VAM rates, attendees must reserve their rooms through MCI (formerly Wyndham Jade) by May 22. After that, attendees must make their own housing arrangements.

Of course, the real excitement lies in the meeting itself. “This year, it’s all about the vascular team,” said SVS President R. Clement Darling III, M.D. “There are reasons for everyone to attend – surgeons, nurses, nurse practitioners, technologists, PAs. We have special programming for PAs and the Society for Vascular Nursing has aligned its schedule with VAM.” (See story on next page.)

In addition, Dr. Darling cited:
- Topics and practical sessions for community practitioners and young surgeons, including on clinical practice guidelines, practice management, even physician burnout.
- More opportunities to interact with presenters.
- Ideas and translational research participants can take home to their practices.
- VAM on Demand. “If you miss a session, you can catch up at home,” said Dr. Darling. VAM on Demand is available at a big discount before the meeting closes. The VAM Planner and a new, mobile app will help each attendee design his or her own meeting (see story below).

Familiar favorites will be back, Dr. Darling added, including workshops, postgraduate courses, a full day of events for international members, collaborative sessions with other societies, plenty of opportunities to network and connect with friends and colleagues, and educational credits, not to mention the chance to explore a fascinating city.

“We have a great mix of old activities and some new initiatives,” said Dr. Darling. “And we’re excited for you to experience it all at VAM 2018.”

Personalize VAM Experience With VAM Planner

This year’s VAM attendees will enjoy a new schedule website and planner. VSweb.org/VAMPlanner offers a full range of options to VAM attendees, who will be able to create a personal VAM schedule filled with individual “must-attend” activities.

Website visitors can learn about sessions and faculty and can filter, by format, such details as audience, area of interest, and credits. Searching the program is an easy way to explore VAM ahead of time. A bonus – this year the online planner will sync with the mobile app.

The planner includes the full schedule, of course, plus faculty; activities for fellows, residents, and students; general VAM information; and links to the Society for Vascular Nursing and Vascular Quality Initiative programs. “Spotlight” will present interesting information about VAM and what attendees can expect.

All VAM social activities are part of the planner as well. These include not only the alumni receptions, Vascular Live programming, and industry-sponsored satellite symposia, but also the Friday evening Closing Reception in the Exhibit Hall, new this year.

To access the planner, SVS members will use their SVS log-in credentials. Non-members will need to establish an account.

Make VAM your own. Visit the VAM Planner site starting March 26.
This year’s Vascular Annual Meeting, June 20-23 in Boston, is geared to the entire vascular team: doctors, vascular nurses, PAs working in the vascular setting, technologists … everyone. In fact, VAM’s theme is “Home of the Vascular Team – Partners in Patient Care.”

So, SVS members, consider bringing your team members along. The Society for Vascular Nursing will hold its 36th Annual Conference in conjunction with VAM. The SVN meeting will be June 20-21 and the registration fee includes access to both meetings. Both meetings take place at the Hynes Convention Center in Boston.

The SVN program will focus on vascular areas, including carotid disease, venous, aneurysms, lower extremity and PAD, wound care, critical limb ischemia, and renal disease.

“VAM will include sessions on most, if not all, of these topics,” said Program Committee Chair Matt Eagleton, M.D. “We at SVS hope that after the SVN conference closes, those participants come to VAM to learn even more about vascular illnesses. Our final two days include a host of sessions, much of it relevant to vascular nurses and others on the vascular team.”

SVS created a section within the affiliate membership category late last year for physician assistants, and already has more than 135 members. The PAs will have an afternoon of programming on Thursday created by and for them. PAs submitted ideas for programming – interesting cases, quality initiatives – and also will speak on topics relevant to PAs in the vascular setting.

In addition, VAM will present a vascular team forum Friday, June 22. “Improving Metrics in Clinical Practice” is set for 1:30 to 3 p.m.

“I can’t wait to feel the energy and enthusiasm that will be part of VAM this year,” said Dr. Eagleton. “Our students and residents have always contributed interest and passion to VAM. We’ll be turning the dial up a few notches. It’s going to be great.”

Bring Your Vascular Team to VAM; Programming Scheduled for PAs
WASHINGTON UPDATE: The State of Medical Liability Reform

The SVS Washington office is working to get legislation introduced in the Senate on medical liability reform that is identical to a House bill. The House of Representatives passed House Resolution (H.R.) 1215, Protecting Access to Care Act, in June 2017. This comprehensive medical liability reform legislation is similar to laws already enacted in Texas and California. It would cap non-economic damages for pain and suffering at $250,000, create a three-year statute of limitations for filing lawsuits and allow states to keep laws that may differ from federal laws. It also would ease the cost burden shared by both patients and physicians, as a lack of federal liability reform increases health care costs and reduces access to care.

SVS participates in the Health Coalition on Liability and Access (HCLA), which supports the resolution. This coalition represents physicians and patients working to reduce medical lawsuit abuse and enacting federal legislation that eliminates inconsistent and ever-changing state liability laws. The coalition has now turned its attention to the Senate, which presently has not introduced a companion bill. Though consideration is seen as an uphill battle, the HCLA “remains committed to advancing true reform legislation.” The SVS will likely organize a grassroots effort when legislation is introduced. The SVS and coalition also support the Good Samaritan Health Professionals Act, H.R. 1876/S.781, bipartisan legislation introduced in both the House and Senate. The House bill was passed by the Energy and Commerce Committee on Feb. 14. These companion bills would eliminate the threat of medical liability lawsuits for licensed health care providers who assist victims of federally declared natural disasters.

SVS and 29 other health care organizations signed a letter supporting the legislation (see vsweb.org/Samaritan) writing that it “will ensure that an adequate supply of trained health care professionals are ready, willing and able to volunteer their services during a catastrophe and that they will not be deterred or turned away due to the threat of lawsuits.”

QUALITY: Get AAA, Other Guidelines in Several Forms

The new abdominal aortic aneurysm (AAA) guidelines are some of the most extensive ever developed by the Society for Vascular Surgery, with 112 recommendations and 774 supporting references. For convenience, the guidelines are included in the SVS IPG Mobile App and have been turned into a Pocket Guide. An educational slide set can be used as a teaching tool.

Mobile App
The free app was launched in Fall 2015 and is available at Google Play and iTunes. It features concise summaries of the latest SVS clinical practice guidelines. Each summary includes key information, an abstract and an explanation of the GRADE framework used to evaluate quality scientific evidence and strength of guideline recommendation.

Pocket Guides
SVS has partnered with Guidelines Central to create a Pocket Guide version of the AAA guidelines. It lists all recommendations, tables with helpful evaluation and risk-scoring schemes as well as treatment algorithms. Cost for the digital version is free for SVS members and $8.99 for non-members. The printed Pocket Guide is $11.95.

SVS also has Guideline Pocket Guides for three other recent guidelines: Diabetic Foot Infection, Peripheral Arterial Disease and Venous Leg Ulcers. All are free online for SVS members ($8.99 for non-members). The printed guides cost $9.95 for diabetic foot, $11.95 for PAD and $13.95 for leg ulcers.

All three cards and the Pocket Guides are available as a bundled set. The digital version is $27.99 for non-members (free to members) while the printed bundle is $37.95.

Educational Slide Set
SVS members now can access the slides that present the AAA guidelines, a useful tool to help educate vascular professionals and colleagues about state-of-the-art practices in vascular care. As with the Pocket Guides, content is available for the four most recent guidelines. The slides and online pocket guides are available at vsweb.org/Guidelines.

The SVS seeks ideas for other knowledge tools to help disseminate and implement guideline-concordant care. Send recommendations to guidelines@vascularsociety.org.

SVS VQI
Vascular Quality Initiative’s (SVS VQI) surveillance project to evaluate the safety and effectiveness of trans-carotid artery revascularization (TCAR) in comparison with carotid endarterectomy (CEA). In a TCAR procedure, carotid stenosis is treated with a stent inserted into the proximal common carotid artery via a neck incision. Flow reversal during the stent placement provides cerebral protection. Initial publications suggest that TCAR may have a lower stroke rate than CEA, potentially due to avoidance of aortic arch catheterization combined with the carotid flow reversal.

Project leaders want to obtain more data about real-world outcomes of TCAR compared with CEA. Additional information about the project can be found at vsweb.org/TCARSurveillance.

Procedures must be performed on high-surgical risk patients (asymptomatic or symptomatic) using FDA-approved or FDA-cleared devices labeled for the transcarotid approach. To qualify for Medicare coverage, data about the procedure and one-year follow-up must be submitted to the SVS VQI Carotid Artery Stenting (CAS) Registry. Surgeries must be set up to enter TCAR cases into the registry. Sites interested in participating in the project can enroll in the SVS VQI CAS Registry if they do not already participate and obtain the National Clinical Trial identifier required for billing.

For more information, contact vqi@m2s.com or call (603) 298-6717.
MATERIALS from the February webinar on the Quality Payment Program, including how surgeons can still avoid reimbursement penalties for 2017, are now available online.

The materials will also inform surgeons and their staff how to:

• Get started with 2018 reporting
• The increased requirements to avoid penalties and obtain bonus payments
• The MIPS (Merit-based Incentive Payment System) reporting requirements to maximize reimbursement based on their 2018 data.

The SVS Quality and Performance Measures Committee and the SVS Patient Safety Organization presented the webinar. It also included information on the SVS Vascular Quality Initiative (SVS VQI) and how it can help vascular surgeons meet MIPS requirements. The SVS VQI is an approved Qualified Clinical Data Registry, which provides 25 quality measures that can be used to fulfill the Quality Measures component of MIPS reporting requirements. View the materials at vsweb.org/215webinar.

FROM JVS:
Distinguish Between Diabetes Types

A review suggests physicians and surgeons pay increased attention to insulin-dependency in diabetics with chronic limb-threatening ischemia. Such diabetes is associated with poorer outcomes after first-time revascularization for the patients compared with noninsulin-dependent diabetics or nondiabetics.

The study is published in the April Journal of Vascular Surgery and is available free through May 31. Visit vsweb.org/JVS-DMvCLTI.
NEWS FROM SVS

AFFINITY PROGRAM: Is Your Income Adequately Protected?

SVS members may think their disability insurance plans have them covered. But in cases of disability or illness, their incomes as vascular surgeons, specifically, may not as secure as they believe.

The SVS has teamed up with Principal® to help members guard their incomes as vascular surgeons.

This coverage helps replace more of your income if you can’t work due to a disabling illness or injury. It supplements your existing group long-term disability insurance,” said Mark Blocker, of SVS’ Affinity Program of expanded benefits.

SVS members receive a 10 percent discount. Coverage can’t be canceled and renewal is guaranteed, at the same rate, to age 65 or 70. Other advantages include:

- Taxes. Participants are eligible to receive $17,000 in monthly benefits tax-free. Group employer-paid benefits are taxed. If that benefit is $15,000 a month, taxes likely reduce that to $9,000 a month.
- Ownership. Participants own their SVS policies; rates and discounts are guaranteed even in the case of changing practices. And there are no new medical questions or exams.
- Simplicity, with few medical/financial requirements.
- Extended coverage, with the vascular surgery specialty covered to age 65 or 70. Many group plans either do not cover a specialty or may do so for a limited time such as 24 months. After that, group plans can limit benefits to “any gainful occupation,” not the vascular surgery specialty. “This can make a big difference in benefits,” said Blocker.

Receive a quote for a comprehensive proposal, and/or policy comparisons with existing coverage, with just contact information, income and date of birth. Contact Blocker at 312-291-4472 or at Mark@nationalaffinity.net.

SPOTLIGHT ON LEADERSHIP:

Interview with Dr. Bhagwan Satiani

BY MANUEL GARCIA-TOCA, MD
CLINICAL ASSOCIATE PROFESSOR OF SURGERY, STANFORD UNIVERSITY, ON BEHALF OF THE LEADERSHIP DEVELOPMENT AND DIVERSITY COMMITTEE

Inspiring and communicating a Shared Vision; Importance of adding leadership to learning portfolio of vascular surgeons.

This is the latest column in this year’s series highlighting the evidence-based behaviors and attributes that define great leadership.

I had the privilege of interviewing Dr. Bhagwan Satiani, professor of clinical surgery in the Division of Vascular Diseases & Surgery; and Medical Director, Non-Invasive Vascular Laboratory and Director of the Faculty Leadership Institute at Weinner Medical Center at The Ohio State University College of Medicine in Columbus, and commissioner and secretary of the state of Ohio Minority Health Commission. His professional interests and accomplishments are impressive and include clinical research with more than 170 peer-reviewed publications, several book chapters, coordinating and teaching physician leadership development and business education to residents and physicians, and conducting practice management seminars for surgical residents. Most pertinent to this article, his current research focuses on faculty retention, physician work effort and compensation issues, appropriateness of utilization of diagnostic tests, and physician shortages. I talked with Dr. Satiani about his expertise regarding leadership.

Q: During your career, you have advocated in multiple publications for more diversity in membership and leadership positions in vascular societies. What can be done to inspire a shared vision on this topic?

A: I believe the efforts of many are creating a strong foundation for change, and we will continue on this positive path because the data demonstrate that diversity is simply good for business. In 2015, McKinsey completed a survey of 346 companies’ research (mostly based in the United States and the United Kingdom), noting an anemic increase in average gender representation on their executive teams of only 2 percentage points, to 14 percent, and ethnic and cultural diversity by 1 percentage point, to 13 percent. So change is slow. However, in a more recent study of more than 1,000 companies covering 12 countries, and using two measures of financial performance, a statistically significant correlation was shown between diversity of the leadership team and financial performance. In this study, companies in the top quartile for gender diversity on executive teams were 21 percent more likely to outperform on profitability and 27 percent more likely to have superior value creation. Thus, there are obvious benefits to supporting a diverse workforce, and these benefits will ultimately catalyze continued change.

In medicine and surgery, diversity is commonly oversimplified as a means to increase quotas of gender, race and sexual orientation represented in the workforce. I believe we must expand our definitions and constructs of diversity beyond physical attributes to the power that is created through synergy of new and diverse perspectives. If the members of a group of leaders sitting around a table all look alike, think alike and have similar backgrounds, it is unlikely they will be able to do much more than preserve the status quo, which in business is not a winning formula. As leaders, we need to find our voice and values and speak out when we see the homogenization of leadership.

Jim Kouzes, the famed author and speaker, says that “envisioning exciting possibilities and enlisting others in a shared view of the future is the attribute that most distinguishes leaders from non-leaders.” Our leaders have to be forward-looking and share their vision of what diversity really means for our societies. Diversity should be practiced not only in the traditional sense of people’s physical attributes but also of ideas and thought. We will be stronger for it.

Q: As you think about the future of vascular surgery, how can SVS members best position themselves to lead effectively?

A: I tell our medical students that I would pick the same specialty if I had another life to live. It is the single most innovative specialty, which attracts the brightest and therefore has a boundless future. My suggestions include: stay current with knowledge and envision how to stay ahead of the curve, involve yourself in SVS affairs to influence change, give to the political arm of SVS, take advantage of SVS offerings, stay curious to solve clinical and research problems even in private practice, and do not ever forget your families that support you every day.

Q: How can SVS best support its members to lead change in the healthcare system and in their own practices?

A: Continuing to survey membership to stay in touch with their needs. Push to get involved more on the political side. Private practitioners constitute about two-thirds of the membership. Having been one for almost 25 years, I know some issues are more pressing for that community. Leadership positions should be shared with the entire membership. If people are given a chance, most will rise to the challenge.

Leadership continued on page 13
Register for VRIC Today

The Vascular Research Initiatives Conference will be held Wednesday, May 9, in San Francisco. For the past several years, VRIC has been held the day before the American Heart Association’s Arteriosclerosis, Thrombosis and Vascular Biology (ATVB) Scientific Sessions, May 10-11. The title of this year’s AHA meetings is “Vascular Discovery: From Genes to Medicine.” Both meetings will be at the Hilton San Francisco Union Square. Visit vsweb.org/VRIC18.

“SVS | VRIC

Pain continued from page 5
breaks, taken every half hour during a procedure, that they dubbed “targeted stretching micro breaks.” These are 45- to 50-second breaks during which a series of exercise physiologist–designed brief stretches are undertaken that do not require breaking scrub.

In a study of 66 surgeons and operating room staff, Dr. Park, chair of the department of surgery at Anne Arundel Medical Center, Annapolis, Md., and his collaborators found that surgeons reported less pain and fatigue, and improved mental focus, when they took micro breaks during a procedure. When surgeons took micro breaks, operative time was no longer than when they didn’t take the breaks (Ann Surg. 2017 Feb;265[2]:340-6).

“We do this all the time in our operating room now,” said Dr. Park. “And it makes a difference in terms of pain, in terms of alertness, in terms of stamina. And it costs nothing.”

Leadership continued from page 12
Q: Which leadership skills have you found to be most critical in your day-to-day leadership success?
A: While I do not consider myself a ‘successful’ leader, I have been able to teach based on my observations of both successful and less successful leaders. I believe authenticity and integrity are ahead of all the technical and relational skills we teach. After those two, being self-aware about your own dominant style and being versatile using it, knowing the art of compromise and sharing your knowledge with others are very important. Followers are much smarter than leaders think and are able to spot fake actors.

Q: For those on the learning path of leadership, are there practical pieces of advice you can provide that may save them time and discomfort?
A: Watch those who inspire you and attach yourself to them so you can learn from them. Read as much as you can about leadership, then combine this knowledge with what you observe at work and outside. Only by learning your own strengths and weaknesses and capitalizing on your personal strengths can you lead successfully.

Connect with Vascular Specialist and follow @VascularTweets on twitter.

Pain continued from page 5
reduce aortic diseases, he said. “We hope that the highly consistent data in animal models can be translated to human studies.”

He cautioned that drug selection will be important, as major differences exist in drug properties and their effectiveness in reducing aortic diseases.

Dr. Daugherty, PhD, is a hormone system that has been known for decades to regulate blood pressure and fluid balance,” said Dr. Daugherty. His current research focuses on how angiotensin II works as a regulator of producing and propagating aortic bulges.

Working with mice, he and his colleagues have discovered that “the aorta doesn’t just bulge anywhere during infusion of angiotensin II. The bulges are localized to one region in the abdominal aorta, and also in the aortic area adjacent to the heart,” said Dr. Daugherty.

“There are biological properties of angiotensin II that we haven’t recognized fully,” he said. “We don’t know why it’s causing the pathology that is experimentally in a very localized manner.”

The researchers hope that inhibiting the actions of angiotensin III will exerted by angiotensin II. Angiotensin II is produced from a precursor called angiotensinogen through cleavage by the enzymes renin and angiotensin-converting enzyme (ACE).

Drugs that stop the synthesis or activity of the angiotensin II, such as ACE inhibitors and angiotensin receptor blockers (ARBs), are currently used to treat blood pressure and congestive heart failure, but may also be useful to treat aortic diseases as well, Dr. Daugherty said.

His current research focuses on how angiotensin II works as a regulator of producing and propagating aortic bulges.
The burnout physicians experienced was a symptom of the defective health care system and not causative of the poor care. Doctors were literally sacrificing their well-being to care for their patients.

Not surprisingly, attitudes regarding burnout vary significantly between health care executives and physicians. A New England Journal of Medicine survey of their Insights Council found that 96% of respondents agreed that burnout is a moderate or serious problem, although physicians were significantly more likely than executives to rate the problem as “serious.” Opinions on solutions varied as well, with executives more likely to support redesign of EMR, while physicians favored reduction of documentation and clerical work. Obviously the physicians’ solution would be more costly to the corporation as the executives deflected the problem back to the EMR designers. Neither group favored the use of resilience/wellness programs as a primary solution.

Of all the remedies proposed, I find resilience training to be especially egregious. Studies consistently show a 40%-50% prevalence of burnout among physicians. How can this be an individual problem? Why train doctors to endure a broken system? This type of problem solving is why burnout continues to flourish. Doctors are not suffering from a disease but rather exhibiting a symptom. To arrive at possible solutions, let’s look at the elite athlete analogy. What are you trained to do? What are your exceptional skills? For me it is clearly EMR documentation (just checking to see if any of my residents have read this far). How many of us would describe ourselves as expert at billing? Paperwork? Medication reconciliation? Discharge summaries? Should LeBron James hawk 16-ounce Miller Lites in the nosebleeds during halftime? This may sound like I am expressing a cocky attitude that these tasks are beneath us, but we now have concrete evidence that forcing physicians to perform these duties hurts patient care and literally kills us. Full stop. Physician burnout can lead to suicide in the absence of clinical depression.

While hopelessness is part and parcel of the burnout syndrome, there are now potential solutions within our grasp. Clearly a reduction in clerical duties will be a key component of any realistic plan. Our time must be proportioned. Few of us are asking to work less. Reducing patient interactions while increasing the average time of these encounters has been shown to reduce burnout without decreasing work hours. We want to do a good job. It is time to remove these barriers.

Our next steps have already been taken, and for me it represents the best example of the potential of Vascular Specialist and the SVS. Under the leadership of SVS President Clem Darling, MD, and Executive Director Ken Slaw, PhD, a task force was created to address this issue. Ably chaired by Dawn Coleman, MD, and including Sam Money, MD, from the SVS Executive Council and Past SVS President Julie Freischlag, MD, the Burnout continued on page 15

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**VASCULAR SURGERY OPPORTUNITY**

Penn State Health St. Joseph is seeking a BC/BE vascular surgeon to join an existing practice in Berks County, PA. This is an exceptional opportunity to be part of a collegial, patient-focused group with a rich history of providing great care to the community. The selected candidate will enjoy a competitive salary and comprehensive benefits, including:

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- Completion of an accredited residency program
- Board certification/eligibility in Vascular Surgery

**About Penn State Health St. Joseph**

Penn State Health St. Joseph is a two-campus health system located in Berks County, PA, with our acute care hospital in Bern Township on Route 183 and our Downtown Reading campus at 6th and Walnut Streets. We have outpatient locations and physician offices throughout Berks County and beyond.

St. Joseph physicians and staff have worked hard to earn recognition for innovation and high quality of care in various specialties, including our Heart Institute and Chest Pain Center, as well as our thriving Cancer Center which partnered with Penn State Hershey Cancer Institute in 2010. In 2015, St. Joseph became Penn State Health’s first member of the not-for-profit health enterprise.

Penn State Health is a multi-hospital health system offering exciting career opportunities in both academic and community setting across Central Pennsylvania.

For immediate consideration, please forward your CV to:
Greg Emerick, DASPR, Physician Recruiter
Email: gemerick@pennstatehealth.psu.edu
Phone: 717-531-4725

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Burnout continued from page 14 task force has collaborated with actual burnout experts Tait Shanafelt, MD, and Susan Hallbeck, PhD, to create a survey designed to identify the causes, prevalence, and potential solutions to the burnout problem in vascular surgery.

The first survey has been completed and will be issued to all SVS members this month to coincide with the SCVS annual symposium. The second, which will focus more on physical issues, will be released during the VAM in June. Look, no one hates surveys more than I do. We simply have to get this information. Each survey is designed to only take 10 minutes. Things are going to change one way or another. Let’s lead, not wait to follow. With your help this will be the last time I write this ignorantly on this crisis. Vascular surgeons are few in number but this gives us the potential to deliver the most comprehensive self-assessment any specialty has ever performed. Lend your voice to the coming change.

Finally, there are now innovations in use which have proved beneficial in mitigating burnout. A Stanford University School of Medicine program allows physicians to “bank” time spent on committees, teaching, or other administrative duties and exchange these credits for home delivery meals, cleaning services, or even work tasks such as grant applications and paper writing. While the physicians could certainly afford to pay for these assistances, the success of the program demonstrates it is the time saved in arranging the services that the doctors truly valued. Our happiness seems to excel when we spend our time performing the tasks for which we are best suited.

It is time to change. When a system reaches this point, something breaks. Let’s stop being the thing that breaks. Fill out the survey. Get involved. There is time to act before we all burn out on burnout.

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This EVAR device, which is the first to feature angulation control, is part of an investigational clinical study approved by the U.S. Food and Drug Administration (FDA). The clinical study will assess the safety and effectiveness of the device in treating infrarenal abdominal aortic aneurysms (AAA) in patients with challenging anatomy. The clinical study consists of two sub-studies, each assessing the device for a different range of patient anatomies. The implantation by Dr. Rhee is part of the short neck sub-study to assess the device in aortic neck angles of 0 to 60 degrees and aortic neck lengths of 10 mm or greater. The high neck angulation sub-study will evaluate proximal aortic neck angles of 61 to 90 degrees and aortic neck lengths of 10 mm or greater.

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