17 News from SVS

Viewing VAM: Check out more scenes from the 2018 Vascular Annual Meeting.

PAD patients at risk for high opioid use

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – National efforts have intensified to reduce opioid prescriptions because of the opioid crisis. However, little is known about the relationship between peripheral arterial disease (PAD) and high-risk opioid use, according to Nathan K. Itoga, MD, of Stanford (Calif.) University.

“As a vascular surgery resident I wanted to know how I could do my part in reducing opioid prescriptions. However, I didn’t know if vascular patients were at risk for high opioid use. The impetus for this study was the lack of studies regarding opioid use in patients with vascular disease,” said Dr. Itoga.

See Opioid page 2

Presidential address: “Changing Me to We in Vascular Care”

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – When R. Clement Darling III, MD, took to the podium at the Vascular Annual Meeting to present his presidential address, he highlighted the importance of teamwork and collaboration in training, in maintaining personal well-being, and most importantly, in providing patient care.

His talk, titled, “Looking Forward Through the Past: Changing Me to We in the Evolution of Team-Based Vascular Care,” addressed these issues through a very personal lens. To make his point, Dr. Darling outlined four key take-home concepts that he had found useful “over five decades of working in an operating room as a technologist, a student, and a surgeon,” and as chief of the division of vascular surgery at Albany (N.Y.) Medical Center.

See Presidential address page 4
FROM THE EDITOR:
I want you to do my job

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

It is never easy to replace a legend. The Vascular Specialist that Russell Samson has left behind does not require saving. There are, however, problems ahead for all vascular surgeons, and my hope is to use this forum to unite us. Vascular surgery is a small specialty in an existential crisis. There are just over 3,000 of us in the United States. Think of Vascular Specialist as your hometown newspaper. Instead of high school sports and bake sales we will cover scientific meetings, clinical trials, and relevant legislation. And maybe the occasional swap meet. Different points of view are going to be an essential part of this process. Russell Samson represented the posh, privileged world of private practice while I come from the rough and tumble streets of academia (just checking to see if he is still reading). My hope is to bring more. More Tips and Tricks, more Point/Counterpoint, more Letters to the Editor, more input from you.

How can you get involved? If you read something and have a response, send it to me. Volunteer to write up a technical tip or provide a medical debate. Have an idea for a guest editorial? Let me know, preferably before you write it. If it is good I will likely publish it. If not, well we can still be friends. Keep in mind, unlike book publishing, we work on strict deadlines. (To the three people I owe book chapters: Soon, I promise!) We will also be starting a vascular news section for brief committee updates, course registration openings, and relevant policy changes. Vascular Specialist is now open for submissions.

PAD and drug abuse

Opioid from page 1

Dr. Itoga present a study at the Vascular Annual Meeting that he and his colleagues performed to evaluate the relationship between PAD and high opioid use, and to assess whether PAD treatment impacts high opioid use.

The researchers used the 2007-2015 Truven MarketScan database, a deidentified national private insurance claims database, to identify patients with 2 ICD-9 diagnosis codes of PAD 2 months apart with at least 2 years of continuous enrollment. Critical limb ischemia (CLI) was defined as rest pain, ulcers, or gangrene. “Our primary outcome was high opioid use, defined as opioid prescriptions within a 1-year period,” according to Dr. Itoga.

Opioid prescriptions were excluded if filled within 90 days of a PAD-related procedure, as identified by CPT codes for lower-ext.
ANEURYSMS

Hospital volume is tied to the outcomes of TAAA repair

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – Contemporary data on outcomes in open thoracoabdominal aortic aneurysm (TAAA) repair are limited to reports from major aortic reference centers showing excellent outcomes, rather than broad-based, real-world observations. In order to deal with this deficiency, Virendra I. Patel, MD, and his colleagues at the Columbia University Medical Center, New York, performed a study to characterize the national experience of open TAAA repair using national outcomes data.

In the Vascular and Endovascular Surgery Society (VESS) session at the Vascular Annual Meeting, Dr. Patel discussed their results, with a primary focus on the influence of operative volume on mortality and morbidity.

He and his colleagues queried the Nationwide Inpatient Sample data from 1998 to 2011, including all patients with a diagnosis of TAAA who underwent open operative repair. Patients with a concomitant procedure code for cardiopulmonary, coronary bypass, heart valve surgery, and endovascular aortic repair were excluded, leaving 14,263 patients included in this analysis.

These patients were further stratified into tertiles based on the operative volume of the institution that performed their operation: low volume (LV, less than 3 cases/year), medium volume (MV, 3–11 cases/year), high volume (HV, greater than 11 cases/year), according to Dr. Patel.

Baseline demographics as well as perioperative outcomes were compared between the three groups and multivariable logistic regression was performed to determine predictors of operative mortality and morbidity. They also performed subgroup analyses of patients presenting for elective surgery and those presenting for urgent/emergent surgery.

The overall operative mortality was 21% for the entire cohort, with operative mortality being significantly higher at LV (26%) and MV (21%) centers compared to HV centers (15%, P less than .05). This difference was similar in both the elective (18% and 14% vs. 12%, respectively) as well as the urgent/emergent (34% and 30% vs. 19%) surgery groups.

They also found that rates of blood transfusion as well as acute renal failure were significantly lower in the HV group. Multivariable analysis revealed that, when compared to the HV group, patients operated on at LV (OR, 1.9; P less than .05) and MV (OR, 1.5; P less than .05) had at least 1.5 times the odds of in-hospital mortality.

The HV group also showed significantly lower odds of dying in the subgroup analyses of both the elective and the urgent/emergent groups. Similarly, patients operated on at LV (OR, 1.3) centers had significantly higher odds of having major morbidity when compared to HV centers.

“Our results show that national mortality for TAAA is much higher than the operative mortality quoted by national reference centers. Patients operated on at high volume centers have a significant reduction in mortality and morbidity compared to other lower volume centers. This relationship is true in the elective as well the urgent/emergent population suggesting referral to higher volume centers or centers of excellence,” Dr. Patel concluded.

Dr. Patel reported that he had no relevant disclosures.

Opioid continued from page 2

A new analysis of PAD significantly increased the incidence of high opioid use (21.3% before PAD diagnosis vs. 26.9% after diagnosis, P less than .01). This association with a new diagnosis of CLI increased high opioid use from 27.5% before CLI diagnosis to 37.7% after CLI diagnosis (P less than .01), highlighting the increased risk in this patient population.

A total of 45,028 patients (24.7%) underwent 88,229 PAD-related procedures. After exclusion of periprocedural opioid prescriptions (18% of all opioid prescriptions), the yearly percentage of high opioid users increased from 25.6% pretreatment to 29.2% post treatment, also a significant difference (P less than .01).

“Our research shows that patients with PAD are at increased risk for high opioid use, with nearly one-quarter meeting described criteria. CLI additionally increases opioid utilization, and treatment of PAD does not appear to decrease high opioid use,” he said. “In addition to heightened awareness and active opioid management, our findings warrant further investigation into causes and deterrence of high-risk opioid use.” Dr. Itoga concluded.

FROM THE VASCULAR COMMUNITY

In Memoriam

John Lockwood Ochsner, MD, (1927-2018), a world-renowned heart surgeon, will be remembered as a charismatic and skilled surgeon, a dedicated teacher, a loving father, and a role model for the hundreds of surgeons he trained.

Dr. Ochsner was born in 1927 in Madison, Wisc., but was raised in New Orleans. He received his medical degree from Tulane University. He started his surgical residency at the University of Michigan but was drafted into military service during the Korean War. He then completed his residency at Baylor University and received his cardiac training under Michael DeBakey. Dr. DeBakey was a close family friend who had studied under John’s father at Tulane and had worked in the original Ochsner Clinic. John was very close to Dr. DeBakey, who was also John’s babysitter in early life.

Dr. John, as he was known, grew up in shadow of giants, including his father, Alton, who founded the Ochsner Clinic, and Michael DeBakey who was a protégé of Alton.

As John was finishing his training with Dr. DeBakey he was asked to stay on in Houston as a member of Dr. DeBakey’s team. The Ochsner Clinic was expanding rapidly in New Orleans, however, and everyone was desirous of having John return. John initially planned to stay with Dr. DeBakey until the director of the Ochsner Clinic flew to Houston to meet with John to convince him to return to New Orleans. His argument was, “John, you will be a great surgeon wherever you practice, but there is...”

In Memoriam continued on page 4
Hospital. These formed the basis of his entire address:

1. None of us is as smart as all of us. We learn from each other which is the foundation of team-based training.
2. The key to resilience, healing and health, whether for our patients or for ourselves, is caring and supporting each other more.
3. Failure is not an end result. It is the path to success through learning.
4. Remember the past but look to the future. The best predictor of future behavior is the past, but the future we are experiencing now, is like no other!

Dr. Darling spoke from the heart about the importance of his colleagues and his parents, especially the role of his father as a pioneer in vascular surgery, and of the women in his life as role models.

He stressed how “one of the invaluable things I have learned is the value of failure, evaluating the past to avoid the same mistakes and the benefit of the TEAM in providing support and care.”

“Every day we’re asked to do the impossible and every day we get up, go to work. We do the best we can. We can make the best plans, treat the sickest patients and get a tremendous fulfillment for what we do in what we do. We do the right thing for the patient,” Dr. Darling explained, summarizing the passion that he feels for vascular surgery.

“We are always willing to do and try the impossible. We’re always willing to be the last person to call when things look bleak. It brings me great glee whenever we get called to the operating room and people look around and go, ‘oh thank God, the vascular surgeon’s here.’ Our colleagues in other specialties are often afraid of blood vessels, afraid of death, afraid of complications. We thrust ourselves every day into situations where nobody else will go,” he added.

“As vascular surgeons we face failure and roadblocks daily yet still persist where others are scared to tread. Many of you have faced far worse barriers of discrimination and unreasonable arbitrary barriers, and I am constantly humbled by your ability to overcome them,” Dr. Darling said.

“This innate ability to focus on the problem is what makes vascular surgeons great. No problem is too complex, no detail is too small.”

He pointed out that: “This innate ability to focus on the problem is what makes vascular surgeons great. No problem is too complex; no detail is too small. We do the right thing despite the odds against us. We do right by the patient.”

After telling some of his own stories of “failure,” to illustrate its importance and value, he explained, “The SVS has developed a national team of ‘captain of the ship’ to the role of team leadership, he emphasized, if they are to truly succeed in their careers and in providing optimal patient care.

“Currently, each patient coming to your service touches over 100 staff during their experience. This includes your office, vascular lab, angio suite, recovery room, hospital floor, ICU, CT scanner to name a few.” This is part of the need for the evolution from “captain” to “leader,” he added.

“If you have not had any formal training in leadership or team development, I strongly suggest you add this to your learning portfolio.” Dr. Darling counseled. “The SVS is addressing this through its Leadership and Diversity Committee, and you will see an expanding array of learning opportunities in the future.”

With regard to his own tenure as SVS President: “I am proud that, during my year as president, the SVS has invested in several new Task Forces to address critical future issues including: Alternative Payment Models for vascular surgery; a national outpatient vascular certification program; a focus on our own health, wellness, and potential ways to mitigate potential burnout; and Dr. Makaroun will be taking on the issues of vascular surgery valuation and workforce in the new Task Force on the Future of Vascular Surgery.”

He further discussed the role SVS is playing in helping to define the future of vascular surgery.

“As we work to strengthen our brand and identity, the SVS Executive Board has supported, and thanks, Amy Reed and Will Jordan for their leadership in the APDVS (Association of Program Directors of Vascular Surgery), and for taking the first step toward attaining a separate Vascular Residency Review Committee or RRC.” In addition, he described how “SVS is also working closely, and collaboratively, with the American Board of Surgery, and the Vascular Surgery Board, to complete the work that was begun a decade ago, and achieve an autonomous vascular surgery board that is an equal partner and stakeholder in the ABS.”

Dr. Darling then outlined one of his major concerns and interests: the exit path of senior vascular surgeons, and how this is often a tremendous waste of talent and expertise. “In the last decade of work when senior surgeons are trying to transition to non-clinical work, I think we throw away much of their intellectual skill and experience in dealing with vascular surgery problems,” he said. He urged that “as our senior surgeons leave clinical practice, we need to use their intellectual expertise and experience in a more productive way.”

The Society for Vascular Surgery is establishing pathways for leadership and pathways to train people in administration, he added.

Turning back to the extreme importance of teamwork, Dr. Darling addressed the future.

“We, physicians, nurses, PAs, technologists, staff, and administrators, need to work together, think together, to grow together, not only for our patients, but for our partners and our families. We are all part of the vascular team,” Dr. Darling said.

In Memoriam continued from page 3

only one hospital that has your name on the front of it!” John returned to the Ochsner Clinic in 1961, where he spent the next 57 years.

John Ochsner was revered as an innovative, energetic and talented surgeon, performing over 12,000 operations, including the first cardiac transplant in the Gulf South. He always said he was happiest in the operating room, and loved teaching young residents. He believed that “surgery is an art as much as a science. ... You have to improvise almost every case – no two cases are the same – and that’s where the fun of surgery comes in, making something new that particular moment that you’ve never seen before. ... It’s like opening up a package; it’s always a little different.”

He authored more than 300 peer-reviewed publications and gave innumerable scientific lectures around the world. He served as President of the International Society for Cardiovascular Surgery as well as the American Association for Thoracic Surgery. Over his career, he was elected president of more than 10 medical associations.

John, like his father, was active in many aspects of New Orleans life. He was an avid golfer and tennis player, and was always ready with a joke. He lived life with humor and enthusiasm, and was a member of multiple social clubs, developing lifelong friends from around the world. He was particularly thrilled when he was chosen as Rex, King of Carnival, in 1990, following in the royal footsteps of his father, who was King of Rex in 1948. Both of his grandchildren were presented as Maids of the Rex organization.

John is survived by his wife of over 64 years, Mary Lou Ochsner; a sister, Isabel Mann; two sons, Dr. John Ochsner, Jr. and Frank Ochsner, and two daughters, Jopy Ochsner and Dr. Katherine Isabel Ochsner; he has two grandchildren.

– Larry H. Hollier, MD, Professor of Surgery, Chancellor, Louisiana State University Health Science Center at New Orleans

2018 VASCULAR ANNUAL MEETING

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AORTIC DISEASE

Exploring the surgical management of aberrant subclavian artery associated with aortic arch anomalies

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – The presence of a Kommerell’s diverticulum or aortic disease increases the complexity of repair of aberrant subclavian artery (aSCA) associated with aortic arch anomalies, according to Tiziano Tallarita, MD, of the Mayo Clinic, Rochester, Minn. He and his colleagues performed a study to examine the surgical management of aSCA associated with aortic arch anomalies at their institution over a 24-year period. “This study represents one of the largest surgical series on aSCA,” according to Dr. Tallarita.

Dr. Tallarita presented their data on this rare condition at the first of a series on aSCA,” according to Dr. Tallarita. “We identified 39 consecutive patients who underwent surgery for aSCA from 1994 to 2017. Clinical presentation, surgical treatment, 30-day morbidity and mortality, and follow-up were assessed.

The median patient age was 46 years and 56% were women. Right aSCA with a left-sided arch was present in 30 patients (77%) with a Kommerell’s diverticulum in 20, and an aortic aneurysm or dissection in 14. Left aSCA was present in nine patients (23%), all of whom had a right-sided aortic arch; aortic dissection was present in six patients. Across all patients, one or more symptoms included dysphagia in 25 (65%), dyspnea in 16 (41%), chest pain in 11 (28%), and upper extremity ischemia in 7 (18%). Six of the patients (15%) required emergency surgery, two each for contained rupture and aortic dissection, and each for rapid aneurysm growth and severe respiratory distress. The aberrant artery was treated by transposition in 23 patients, carotid subclavian bypass in 10, and ascending aorta to subclavian bypass in 6.

Two patients with transposition of the left aSCA also had transposition of the vertebral artery. Primary repair of the Kommerell’s diverticulum was done in 14 patients, with the distal arch and/or proximal descending thoracic aorta being replaced in 10. TEVAR was used to exclude the Kommerell’s diverticulum in the remaining 6 patients, all of whom had a left-sided aortic arch. Nine patients did not need aortic repair.

Dr. Tallarita and colleagues found that one patient died from pulmonary embolism within 30 days of operation (2.6%). “Perioperative morbidity was 18%, with 7 patients developing one or more complications,” added Dr. Tallarita. Over a median follow-up of 22.5 months (range 0-193), two patients died (5%), neither procedure- or aortic-related. Three-year survival was 84%, and no one needed re-intervention.

“The presence of KD (Kommerell’s diverticulum) or aortic disease increased the complexity of the repair. Right-sided aortic arch was always associated with KD and frequently with aortic disease,” according to Dr. Tallarita and his colleagues. “Treatment of aSCA with and without associated aortic disease can be accomplished with low morbidity and mortality, and excellent mid-term patency,” they concluded.

PRACTICE MANAGEMENT

Wound care centers appear to benefit practice outcomes

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – Wound centers provide an opportunity for specialty services to deliver aggressive wound care before and after revascularizations or hospitalizations, and must work closely with vascular surgeons; such a program, therefore, would be expected to have a significant impact on the affiliate vascular surgical practice, according to Venita Chandra, MD, and her colleagues.

Dr. Chandra, of the Stanford (Calif.) University School of Medicine, and her colleagues reported at the Vascular Annual Meeting on a study they performed to evaluate the impact of a new wound care center opening on the practice patterns of a tertiary care vascular surgery service.

She and her colleagues assessed a prospectively maintained institutional database for patients undergoing lower-extremity revascularization, amputation, or surgical debridement for a 2-year period (2011-2013) before (BWC) and (2014-2016) after (AWC) the opening of an affiliated wound care center.

Patients with claudication, critical limb ischemia (CLI), or chronic wounds were identified. They also analyzed practice volumes, surgical indications, and operations performed in limb salvage patients in the two time periods.

Dr. Chandra discussed the results of 487 procedures identified in the BWC cohort and 1,209 procedures in the AWC cohort that met inclusion criteria. These cases comprised 20% of the total cases performed during the BWC period in the vascular practice as a whole as compared to 28% of the total vascular cases performed in the AWC period, a significant difference. Patients treated in the AWC cohort presented more commonly with diabetic foot wounds (7% vs. 13%, P = .0002).

There was no significant difference in the proportion of cohort patients undergoing revascularization (60% vs. 59%); however, there was a significant increase in surgical debridements (13% vs. 8%, P = .009) and minor amputations (24% vs. 18%, P = .036) and a significant decrease in major amputation rates in the AWC time period (7% vs. 12%; P = .006).

No differences were seen in the types of revascularization procedure performed between cohorts, although there was a trend toward increased infra-popliteal and infra-malleolar interventions in the AWC period. “According to our results, the opening of a wound center affiliated with a tertiary care vascular surgical practice was associated with an increased proportion of limb-salvage patients treated and lower major amputation rates,” Dr. Chandra and her colleagues concluded.
CAROTID DISEASE AND STROKE

Transcarotid vs. transfemoral carotid artery stenting in the SVS Vascular Quality Initiative

BY MARK S. LESNEY
MD EDGE NEWS FROM THE VASCULAR ANNUAL MEETING

BOSTON – The Safety and Efficacy Study for Reverse Flow Used during Carotid Artery Stenting Procedure (ROADSTER) trial reported the lowest stroke rate in high-risk patients compared with any prospective trial of TFCAS, according to Mahmoud B. Malas, MD, of the Johns Hopkins Hospital (Baltimore) and his colleagues. However, clinical trials have selection criteria that exclude many patients, and are highly selective of operators performing the procedures, which limit generalizability.

Dr. Malas presented a study at the Vascular Annual Meeting that compared in-hospital outcomes after TCAR and TFCAS as reported in VQI.

They analyzed data from the initial 646 patients enrolled in the SVS VQI TCAR Surveillance Project (TSP) and compared it with that of patients who underwent TFCAS between 2005 and 2017. Patients with tandem, traumatic, or dissection lesions were excluded. They used multivariable logistic regression and 1:1 coarsened exact matching (CEM) to analyze neurologic adverse events (stroke and transient ischemic attacks [TIAs]) and in-hospital mortality. Patients in the two procedures were matched on age, race, coronary artery disease, congestive heart failure, prior CABG/PCI, chronic kidney disease, diabetes, ASA class, symptomatic status, restenosis, anatomical and medical risk, emergency status, and preoperative medication use.

Compared with more than 10,000 patients undergoing TFCAS, the 638 undergoing TCAR were significantly older and had more cardiac comorbidities. In contrast, patients in the TFCAS group were more likely to be asymptomatic and to have a restenotic lesion. There was no significant change in the odds of stroke/death in TFCAS over the study period.

The rates of in-hospital TIA/stroke as well as TIA/stroke/death were significantly higher in TFCAS compared with TCAR (3.3% vs. 1.9% and 3.8% vs. 2.2%, respectively; both \( P \leq .04 \)). In both procedures, symptomatic patients had higher rates of TIA/stroke/death compared with asymptomatic patients; however, the difference was significant only in the TFCAS (3.3% vs. 2.7%, \( P \leq .001 \)). On multivariable analysis, TFCAS was associated with twice the odds of in-hospital neurologic events and TIA/stroke/death compared with TCAR, independent of symptomatic status.

“Our results show that patients undergoing TCAR had significantly higher medical comorbidities, but half the risk of in-hospital TIA/stroke/death compared to patients undergoing TFCAS. This initial evaluation of VQI TSP demonstrates the ability to rapidly monitor new devices/procedures in real-world practice,” Dr. Malas concluded.

AORTIC DISEASE

Inadequate proximal seal length predicts complications after repair of acute type B dissection

BY MARK S. LESNEY
MD EDGE NEWS FROM THE VASCULAR ANNUAL MEETING

BOSTON – There is a clear inverse relationship between the proximal seal length achieved and associated adverse outcomes after endovascular repair of acute type B aortic dissection (aTBAD), according to a study presented by Marissa Famularo, MD, at the Vascular Annual Meeting.

They analyzed data from two prospective, multicenter investigational studies of the Zenith Dissection Endovascular System in order to evaluate the effect of proximal seal length on outcomes after endo repair of an aTBAD. Their analysis included data complications continued on page 8.
Complications continued from page 7 from 51 patients in STABLE I (a feasibility study on the first-generation device including patients treated in both acute and nonacute phases) and 59 patients in STABLE II (a pivotal study including only patients presenting with aTBAD).

Patients treated for aTBAD (14 days of symptoms onset) were included if they had complete pre- and postoperative imaging to determine the actual length of proximal seal in uninvolved aorta, according to Dr. Famularo.

The length was calculated by recording the difference between the length from the left common carotid artery (LCC) to the most proximal extent of dissection and the length from the LCC to the most proximal 360° visualization of the stent-graft. Patients were divided into four groups: 20 mm; 10 mm to less than 20 mm; 0 mm to less than 10 mm; and less than 0 mm of proximal seal length. Outcomes related to proximal seal were evaluated. All imaging findings were based on core laboratory analysis.

Dr. Famularo and her colleagues found that, while the study protocol criteria required at least 20 mm length of nondissected aorta distal to the LCC to serve as the proximal seal zone, an actual proximal seal length of 20 mm was achieved in only 17.3% (19/110) of the patients. At the time of this analysis (mean follow-up of 39.6 months), the combined rate of four complications (proximal type I entry flow, retrograde dissection, transaortic growth 1 mm in the thoracic aorta, and stent-graft migration 10 mm) was lowest (15.8%) for patients with 20 mm proximal seal and increased as the seal length decreased, according to Dr. Famularo. In the two groups with 0 mm to less than 10 mm and less than 0 mm of proximal seal length, outcomes related to proximal seal were evaluated. All imaging findings were based on core laboratory analysis.

The incidence of delirium was 12% in the elective cohort. Regression analysis identified significant predictors of delirium including type of surgery: lower-limb amputation (OR 16.7), open aortic repair (OR 5.3), and cognitive variables: dementia (OR 5.6), and MoCA scores indicating moderate to severe impairment (OR 5.6), and previous delirium (OR 3.0).

Retrospective review of 434 patients identified differences between sitter needs for patients with delirium and dementia (mean = 13.6 days), delirium alone (3.9 days), or dementia alone (less than 1 day [17.7 hours]). A total of 15 patients required more than 200 hours (8.3 days), accounting for 69.7% of sitter costs for the surgical unit. Patients with underlying dementia who developed delirium accounted for 48% of the total surgical unit sitter days. Postoperative delirium is predicted by type of vascular surgery, impaired cognition (MoCA), and previous delirium. Costs and morbidity related to delirium are greatest for those with impaired cognitive burden. Preoperative MoCA screening can identify those at highest risk, allowing for patient and family education regarding postoperative delirium risk, procedure modification, and informed care,” Dr. Styra and her colleagues concluded. 

PERIOPERATIVE CARE

Preop cognitive issues and surgery type affect postop delirium

BY MARK S. LESNEY  
MDEdge News FROM THE VASCULAR ANNUAL MEETING

Boston – Postoperative delirium has a high prevalence among vascular surgery patients, increasing morbidity, mortality, and length of stay (LOS), according to Rima G. Styra, MD, and her colleagues at the University of Toronto (Canada).

Dr. Styra presented their prospective study at the Vascular Annual Meeting.

She and her colleagues preoperatively assessed 173 elective vascular surgery patients for cognitive function using the Montreal Cognitive Assessment Scale (MoCA) and the Confusion Assessment Method (CAM) for postoperative delirium, which was verified by chart and clinical review.

Demographic information, medications, and a history of substance abuse, psychiatric disorders, previous delirium, and the surgical procedure were prospectively recorded. An accompanying retrospective chart review of an additional 434 (elective and emergency) vascular surgery patients provided supplemental cost information related to sitter use and prolonged hospitalization secondary to three factors: delirium alone, dementia alone, and delirium and dementia.

Prospective screening of 173 patients (73.4% men, mean age 69.9 years), identified that 119 (68.8%) had MoCA scores indicating cognitive impairment, with 7.5% having severe impairment (dementia). Patients who underwent amputation had significantly lower MoCA scores (15.9 out of 30) compared to open and endovascular aortic surgery patients (23.6 out of 30). The normal range for MoCA is 25-30.

Open and endovascular aortic surgery patients had an MoCA of 23.6 out of 30. The normal range for MoCA is 25-30.
Resident debt burden may cloud professional future

BY GREGORY TWACHTMAN
MD EDGE NEWS
FROM THE JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS

Surgical trainees have a large, potentially unmanageable debt burden and are in need of long-term financial education to help better navigate the growing cost of medical education, according to new research.

“Surgical residents are highly leveraged financially and have minimal financial training,” Sarah E. Tevis, MD, of the University of Texas MD Anderson Cancer Center, Houston, and her colleagues wrote in a study in the Journal of the American College of Surgeons. “This places residents in a volatile financial situation as they complete their training and start accumulating debt liabilities, such as mortgages and child care, in the face of tremendous amounts of educational and other debt liabilities.”

Studies of resident debt load typically account for medical education debt, but not for other debts such as undergraduate loans, consumer debt, and mortgages. Residents’ actual debt burden may be considerably higher than has been reported.

The researchers sent surveys to all surgical residents at the University of Wisconsin, Madison, in 2015, with 105 responding (an 80% response rate). Of those responding, 38% reported having more than $200,000 in educational debt, and 42% had a moderate- or high-risk debt-to-asset ratio.

“We found that surgical residents are dangerously overleveraged, with 70% of residents found to have high debt-to-asset ratios,” Dr. Tevis and her colleagues wrote, with the addition of mortgages and vehicle debt on top of educational debt being the key factors of moving residents into the high-risk debt-to-asset category.

The debt-to-asset ratio was calculated as the sum of student loan debt + nonstudent loan debt + credit card balance + mortgage debt + vehicle debt divided by the value of home and other real estate + value of household vehicles + amount in savings + value of retirement investment. A debt-to-asset ratio of 0.5 to 0.9 was considered moderate risk, with a ratio greater than or equal to 0.9 considered high risk.

The debt-to-income ratio was calculated as the sum of student loan debt + nonstudent loan debt + credit card balance + mortgage debt + vehicle debt divided by total household income. A high-risk ratio defined as being greater than 0.4, the line at which surgical trainees might be restricted from obtaining a traditional mortgage.

Total household income included personal income, domestic partner income, military income, and any income from moonlighting, rental properties, and other sources of revenue. Assets included home and second home purchase prices when applicable, value of vehicles, amount in savings, value of retirement accounts, and value of investments. Contributors to debt included student loan, nonstudent loan, mortgage, vehicle financing, and credit card balances.

Salary data for U.S. residents, which strictly tracked U.S. inflation, were calculated over a 15-year period (2000-2015) using data from the Association of American Medical Colleges for comparison.

In examining debt-to-income, researchers found that “83% of residents have a high-risk debt-to-income ratio [greater than 0.4],” the authors wrote. “We found that the majority of residents were classified in the high financial risk exposure cohort when comprehensive total debt liabilities were considered. In this group of highly leveraged residents, over 80% of residents were dangerously unable to manage regular monthly liabilities with their current level of income.”

No statistically significant association between sex, residency year, residency program, or who manages finances and risk debt-to-asset ratios were found in this study.

The authors noted that, although this study did not look at the psychological impact of significant debt load and lack of training on how to manage finances, these factors have been shown in other studies to correlate with resident burnout and psychological stress.

Bruce A. Harms, MD, FACS, coauthor of the study said in an interview, “We are in an evolving era in surgery and in health care in general and financial resources are being stretched. We don’t know for sure that the rising educational debt and overall debt burden as residents enter their prime years will drive the next generation of physicians to certain career choices. It may even perhaps drive a given fully trained young surgeon away from a practice that is more exposed to an underserved population. Excessive financial debt–induced stress may influence a resident’s decision on what they do with their skill set but what degree is largely unknown.”

Dr. Harms added that residents may assume that when they eventually enter practice, they will have a pathway and the means to deal with educational debt. “They would be correct in that starting salaries are keeping pace with inflation. However, in many instances, they are also entering a time in their lives when they will be taking on additional debt in the form of home mortgage, family, and child care costs. I believe, in most instances, residents will focus almost totally on their residency training and many other financial considerations take a back seat and we’ll deal with our debt problem in the future’ attitude. Residents for the most part don’t have the financial means and resources to deal with debt anyway during the course of their lengthy residency training. The exception would be having a secondary income from a spouse or partner that would allow for a more robust debt-attrition strategy. Also, residents are likely not focused on or considering a strategy for the best return on investment of their time, additional expense, and career delay from their prolonged pathway to becoming a fully trained surgeon.”

The bottom line is that basic financial educational is not included in core surgical training even though most surgical residents would like some degree of financial education. That is the basic problem and shortcoming of existing residency training programs, Dr. Tevis and her colleagues wrote.

Given the financial burdens that education and other factors are placing on surgical residents, Dr. Tevis and her colleagues proposed “that formal training in the business of medicine and personal finance for surgical residents be strongly considered at the training program level or in partnership with other organizations, such as the American College of Surgeons, in an effort to improve the financial status of residents and prepare them for their careers, both personally and professionally.”

Dr. Harms noted, “It is probable that, in most cases, educational loan debt principal is not being paid down to any significant degree given the current residency salary structure. We can only hope that residents are Debt Burden continued on page 10
PAD AND CLAUDICATION

USPSTF: Insufficient evidence for ABI screening in asymptomatic adults

BY M. ALEXANDER OTTO
FRONTLINE MEDICAL NEWS
FROM JAMA

T here’s not enough evidence to recommend – or not recommend – routine ankle-brachial index (ABI) screening for peripheral artery disease (PAD) in asymptomatic adults without known cardiovascular disease (CVD) or chronic kidney disease, according to the U.S. Preventive Services Task Force.

“A substantial number of asymptomatic persons with low ABI may never develop clinical signs or symptoms of CVD or PAD but would still be subjected to the harms of testing,” including false positives, exposure to gadolinium or contrast dye with subsequent imaging, and others, the Task Force wrote in JAMA.

In short, it found “inadequate evidence to assess whether screening for and treatment of PAD in asymptomatic patients leads to clinically important benefits in either preventing the progression of PAD or preventing CVD events. ...” The current evidence is insufficient to assess the balance of benefits and harms of screening for PAD and CVD risk with the ABI in asymptomatic adults.”

The group made no recommendation, and issued an I statement, for insufficient evidence, July 10. The new work replaces the Task Force’s last visitation in 2013, which was also an “I statement.”

ABI is systolic blood pressure at the ankle divided by the systolic blood pressure in the arm while the patient is lying down. A ratio below 1 is considered abnormal.

ABI is low in perhaps about 6% of adults over 40 years old but “the natural history of screen-detected PAD, including the development of morbidity and mortality directly related to atherosclerosis in the lower limbs, is not well known. ... Large, population-based, randomized trials of screening [versus] no screening are needed to determine whether screening for PAD with the ABI improves clinical outcomes,” the task force said.

Among the many studies it reviewed were two large trials of asymptomatic women with low ABI treated with aspirin 100 mg/d for several years. Neither study showed any significant difference in CVD events, mortality, or development of intermittent claudication. Even in high-risk people – diabetes, high blood pressure, high cholesterol, current tobacco use – there was “no compelling evidence” to support routine screening, so long as they have no symptoms.

The new review is broader than the group’s 2013 effort, and includes a broader population and range of interventions. Even so, “the recommendation remains an I statement,” it said. The USPSTF is supported by the U.S. Agency for Healthcare Research and Quality.

SOURCE: Otto@mdedge.com

Insufficient evidence for ABI screening in asymptomatic adults

Debt Burden

Debt Burden continued from page 9 given some degree of good information on strategies for managing educational loan debt, which may include federally sponsored loan repayment programs such as [those offered] through NIH–sponsored research or federal loan forgiveness programs that residents may qualify for.

“In most cases, federal loan forgiveness programs require a minimum monthly payment that is calculated based upon current income. As an absolute minimum, interest payments should be made as additional interest debt will add significantly to the overall debt burden as interest will continue to accrue.”

Getting that financial training early could have significant benefits on the back end. The study authors noted that salary data from the Association of American Medical Colleges showed assistant professor salaries mirrored inflation metrics, but even better, surgeon salaries continued to exceed inflation-indexed targets and continued upward trends even through recession periods.

“Therefore, the financial pathway, built on increases in surgeon starting salaries exceeding annual inflation, presently still exists for leveraging of critical debt exposure if personal finances are optimally managed,” the authors stated.

The study did have its limitations. It did not include certain variable expenses such as utilities, food, and other shopping habits, although that may have been captured as the survey asked respondents to list other “major” sources of income and debt.

It also was limited to surgical residents at a single institution and may not be applicable to other specialties or geographic locations. It did not assess whether residents with mortgage payments were able to make educational loan payments beyond the minimum.

The investigators reported that they have no financial conflicts.

Mary McDermott, MD, is a professor of internal medicine, geriatrics, and preventive medicine at Northwestern University, Chicago, and a JAMA senior editor. Michael Criqui, MD, is a professor of family medicine and public health at the University of California, San Diego. They made their comments in an editorial. Dr. McDermott disclosed research funding from Novartis and Regeneron (JAMA. 2018 Jul 10;320(2):143-5).


Residents’ debt burden

Debt Burden

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Perioperative outcomes of revascularization for AAO

BY MARK S. LESNEY
MDEDGE NEWS
FROM THE VASCULAR ANNUAL MEETING

BOSTON – Although acute aortic occlusion (AAO) is a life-threatening event necessitating prompt revascularization to the pelvis and lower extremities because of its uncommon nature, outcomes after revascularization have not been well characterized, according to Abhisekh (Abe) Mohapatra, MD.

At the Vascular Annual Meeting, Dr. Mohapatra of the University of Pittsburgh Medical Center presented a study that he and his colleagues performed to describe the perioperative morbidity and mortality associated with revascularization and identify the patients at highest risk.

They did a retrospective chart review of patients who presented to their institution from 2006 to 2017 with acute distal aortic occlusion. Patients with a prior aortofemoral bypass were excluded, but those with aortoiliac stents were included. The primary outcome was 30-day mortality, and major complications were evaluated as secondary outcomes.

They constructed logistic regression models to identify factors associated with 30-day mortality.

“We identified 65 patients who underwent revascularization for AAO,” said Dr. Mohapatra. The median patient age was 64 years and 64.6% were men. Preoperative imaging in 44 patients showed occlusion of the inferior mesenteric artery in 36.0% and in both internal iliac arteries in 34.7%.

Treatments for revascularization included axillofemoral bypass (55.4%), aortoiliac thromboembolectomy (15.4%), aortofemoral bypass (13.9%), and aortoiliac stenting (15.4%). Overall 30-day mortality was 27.7% and was not affected by treatment modality.

Dr. Mohapatra will discuss how mortality was significantly higher in patients over the age of 60 years (40.5% vs. 10.7%) and in those presenting with lactate elevation (45.5% vs. 5.9%) or motor deficit in at least one extremity (36.6% vs. 9.5%).

“Unfortunately, despite advances over time in the treatment options available and an improved understanding of critical care medicine, and despite the fact that we are a high-volume center reporting the largest series of acute aortic occlusions to date, we have made only a modest impact on the mortality of this condition. Even with prompt revascularization, regardless of the treatment modality used, many patients inevitably suffer from complications related to the original ischemic insult,” Dr. Mohapatra concluded.

mlesney@mdedge.com

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ACR and EULAR to review new criteria for classifying vasculitis

BY SARA FREEMAN
MDEDE NEWS
REPORTING FROM THE EULAR 2018 CONGRESS

AMSTERDAM – New classification criteria for antineutrophil cytoplasmic antibody (ANCA)-associated vasculitides have been drafted and now need formal review by the American College of Rheumatology and the European League Against Rheumatism before they can be put into practice.

These draft criteria – which are based on data collected via the Diagnostis and Classification Criteria in Vasculitis (DCVAS) observational study – focus on how to classify three main types of ANCA-associated vasculitides: granulomatosis with polyangiitis (GPA), eosinophilic granulomatosis with polyangiitis (EGPA), and microscopic polyangiitis (MPA).

According to Joanna Robson, MBBS, PhD, the chair of the DCVAS steering committee, these new criteria better “reflect current practice by incorporating, but not relying on, ANCA testing and advanced imaging.”

“The old criteria were actually produced in the early 1990s and since then we’ve had further thinking about the different subtypes of systemic vasculitis,” explained Dr. Robson of the University of the West of England in Bristol. There has also been a consensus conference held at Chapel Hill, N.C., (Arthritis Rheum. 2013;65[1]:1-11) which identified MPA as a separate entity, and ANCA testing has become routine practice. Computed tomography and magnetic resonance imaging are also now used to help differentiate between the different vasculitides.

“This really has been a collaborative, multinational effort,” Dr. Robson said at the European Congress of Rheumatology. To develop the draft criteria, data collated from 135 sites in 32 countries on more than 2,000 patients were used. These had been collected as part of the ACR/EULAR–run DCVAS study, which has been coordinated at the University of Oxford, England since 2011.

Three phases were used to develop these criteria: First an expert panel reviewed all cases in the DCVAS to identify those that they felt were attributable to small-vessel vasculitis. Second, variables that might be appropriate to use in the models were examined, with more than 8,000 individual DCVAS items considered and then sifted down to 91 items and then sifted again to form a clear set of 10 or fewer items. Third, statistical analyses combined with expert review were used to develop the criteria and then validate these.

Dr. Robson reported that, of 2,871 cases identified as ANCA-associated vasculitis, 2,072 (72%) were agreed upon by the expert review panel. Of these, there were 724 cases of GPA, 291 of MPA, 226 of EGPA, and around 300 cases of other small- or medium-vessel vasculitides or polyarteritis nodosa. To develop the criteria the GPA cases were used as the “cases” and the other types of vasculitis as the comparators, Dr. Robson explained.

For GPA, MPA, and EGPA a set of items (10, 6, and 7, respectively) were derived and scored, positively or negatively, and a cutoff determined at which a classification of the particular vasculitis could be made. During discussion, Dr. Robson noted that the threshold score for a classification of EGPA (greater than or equal to 6) had been set slightly higher than for GPA or MPA (both greater than or equal to 5) “because of the clinical problem of there being very close comparators which can actually mimic EGPA.” This is where the negative scoring of some items used in these criteria are very important, she said.

The 10-item GPA criteria included three clinical (such as the presence of bloody nasal discharge upon examination) and seven investigational (such as ANCA positivity) items. These criteria were found to have a high sensitivity (92%) and specificity (94%) for identifying GPA.

“The six-item MPA criteria included one clinical item (bloody nasal discharge, which was this time attributed a negative score) and five investigational items (with ANCA testing given a higher positive score than for GPA). The specificity and sensitivity of these criteria were a respective 91% and 94%.

Finally, the seven-item EGPA criteria included three clinical items (including obstructive airways disease and nasal polyps) and four investigational items (with ANCA positivity given a negative score). These criteria had an 85% sensitivity and 99% specificity for EGPA.

Dr. Robson emphasized that all of these classification criteria were to be used only after exclusion of other possible causes of vasculitis, such as infection, malignancy, or other autoimmune diseases such as inflammatory bowel disease, and a “diagnosis of small- or medium-vessel vasculitis has been made.”

These criteria are to help classify into the subtypes of vasculitis “primarily for the purpose of clinical trials,” she said. “The next steps are review by the EULAR and ACR committee, and only on final approval will these criteria be ready to use.”

DCVAS is sponsored by the University of Oxford with funding from the European League Against Rheumatism, the American College of Rheumatology, and the Vasculitis Foundation. Dr. Robson had no relevant financial disclosures.

SVS Foundation Projects Aim to Improve Community Health

A n SVS dream of increasing awareness of and preventing vascular disease is taking root across the country.

Three projects, funded by the first SVS Foundation Community Awareness and Prevention Project Grants, will:

- Provide preventive care to those at risk for diabetic foot infections
- Educate high school students about vascular risk factors and disease so they, in turn, can educate family members
- Add vascular screening to a long-established health screening event in an area with one of the highest rates of diabetes in the country

The grants were awarded in June during the Vascular Annual Meeting. Three community-based vascular surgeons received up to $10,000 for an innovative, community-based initiative.

“It was tough to choose just three,” said former SVS Foundation Chair Dr. Ronald M. Fairman. “The three we ultimately accepted were very much aligned with our aim to promote disease prevention, reach out to the community and advance public awareness of vascular health.”

V-Health Initiative

Manish Mehta, MD, MPH, of Queensbury, N.Y., plans to empower high school students to diagnose and understand the impact of vascular risk factors and disease. This project is an outgrowth of a pilot program begun in 2016, designed to make high school students aware of how risk factors early in life impact their vascular health decades later.

The now-day-long program includes 14 high schools, numerous regional hospitals, medical practices, insurance companies and nonprofit organizations and a volunteer group of more than 150 physicians, allied professionals, teachers and patients.

Early results show promise. Nearly 400 students participated in hypertension screenings, measuring their parents’ blood pressures daily for a week; 14 percent had a pre-existing hypertension diagnosis and an additional 65 percent of parents previously undiagnosed were found to have HTN.

Dr. Mehta also wants to help increase awareness of the expertise of vascular surgeons. Vascular surgeons need to “take charge, innovate, differentiate our specialty and redefine our brand,” he said. Other specialists focus on what they do and how they do it; Dr. Mehta believes the focus should instead be on “WHY we do what we do.”

Diabetic Foot Education

Marcus Semel, MD, MPH, and Edward Maraccio, MD, both of South Shore Hospital and Brigham and Women’s Hospital near Boston, hope to reduce emergency room visits and hospitalizations for diabetic foot infections, in part by providing comprehensive diabetic preventive care for those at risk for such infections.

Dr. Semel’s program will capitalize on the interconnected nature of the health system, which includes the hospital plus a home-health visiting nurse service, a wound-healing center and a primary care practice.

With electronic records flagged, diabetic patients discharged from the hospital will receive visiting nurse services, including a comprehensive diabetic evaluation as well as education. Patients will have a foot examination, an in-home ankle-brachial index screening, hemoglobin testing and referrals where appropriate. Such referrals can include shoes, education, counseling on quitting smoking and further evaluations.

Data collected after six months of intervention will analyze emergency room visits and hospitalizations for diabetic foot infection.

Vascular Health Screening

Elizabeth L. Detschelt, MD, will expand a long-established Wellness Check held across the Excela Health service area in Pennsylvania by adding a Vascular Health Awareness and Screening event. She is director of vascular surgery for the service area in several counties in Pennsylvania. Screenings will include blood pressure, an abdominal aortic ultrasound, carotid duplex screening, an ankle-brachial index measurement and a foot check.

Two board-certified vascular surgeons will read and review all tests and offer real-time recommendations. Dietitians, diabetes educators and wound specialists will be available to all attendees, not just those present for a vascular screening.

The need is great, said Dr. Detschelt. Portions of the areas have some of the highest population of diabetes in the country. Pennsylvania itself has one of the highest rates of smoking in the country and there is a general lack of awareness and understanding in the general medical community of vascular disease and the relationship to heart disease, diabetes, obesity and vascular health.

Many Great Projects Submitted

Sometimes it was small details that the committee selecting the recipients found intriguing, said Dr. Fairman of the difficulty in selecting the three. He cited the popularity of Dr. Mehta’s existing efforts to educate teens as well as the project’s simplicity and powerful impact; the high diabetes rate in Dr. Detschelt’s area; and the intriguing concept of preventing diabetic foot infections by identifying patients discharged for another reason.

The projects are the first in the Foundation’s efforts to broaden its outreach to all SVS members, from academics and researchers who receive many of the Foundation’s grants to those in community practice, which comprise a majority of SVS members.

“The Foundation’s work is relevant to every one of our members, in all practice types,” said Dr. Fairman. “This new project expands our reach, adds visibility to our work and, as is the case with everything we do, hopefully will improve patient care.”

EDUCATION: VAM 2018 a Big Success

T he 2018 Vascular Annual Meeting featured nearly 1,800 attendees, just shy of the record; phenomenal science; a wide range of educational programming; and new session formats with overflow attendance.

Organizers consider the meeting a success and are evaluating attendee feedback to make sure next year’s meeting builds on past achievements, said Matthew Eagleton, chair of the SVS Program Committee, which oversees VAM. “We have received a lot of positive feedback,” he said.

“Some of our new initiatives were extraordinarily well-received,” he said, citing in particular the new small-group “Tips and Tricks” and “Ask an Expert” sessions. These popular courses filled quickly with overflow attendance, and the committee will consider including the sessions again and perhaps expanding them in the future.

Also receiving accolades:

- Not only the team-oriented theme (“Home of the Vascular Team – Partners in Patient Care”) but also sessions highlighting the value of the vascular team and collaboration among team members
- An afternoon of special programming for physician assistants
- The Society for Vascular Nursing’s Annual Conference, held at the same time as VAM
- Three forums, including the E. Stanley Crawford Critical Issues Forum, which explored the critical shortage of vascular surgeons, the John Homans lecture, and the Roy Greenberg lecture
- Outstanding abstracts presented in scientific sessions

Attendees also liked the breadth of programming throughout the meeting, said Dr. Eagleton.

“Of course, as happens when sessions coincide, attendance can be lower than expected in a session,” he said. “This is something we will continue to work on, to provide the most educational opportunities for the greatest number of people and to continue to emphasize the science, which has always been the mainstay of the meeting. VAM is the premier meeting for the introduction and discussion of new science and that’s something we will continue to preserve.”

In fact, organizers plan to expand the volume of abstracts by 25 to 30 percent for next year. They also will continue to look at the meeting’s structure in new ways to maintain a clear focus on the scientific sessions and to provide a variety of educational sessions across the entirety of the meeting, he said.

“Over the next couple of years, we’ll be looking at new ways of organizing the meeting to meet the needs of all attendees.”

Dr. Eagleton noted that while new initiatives...
SVS Responding to CMS Proposals
Changes Sought in 2019 Fee Schedule, Year 3 QPP Rules

The Centers for Medicare & Medicaid Services (CMS) released their proposed Calendar Year 2019 changes to both the Medicare Physician Fee Schedule and Year 3 of the Quality Payment Program on July 12. Some changes are related to specific CPT codes and their payment rates for 2019 and some are intended to reduce the administrative burden of medical billing under the CMS’ “Patients over Paperwork” initiative. CMS is also proposing to increase the requirements for physicians to avoid the penalty in Year 3 of the QPP. Comments on the proposals are due Sept. 10 and the SVS Washington office is working to offer constructive comments to impact the proposed regulations favorably for vascular surgeons. SVS will keep members apprised of the proposed changes via the SVS website and member communications. See vsweb.org/19FeeSchedule and vsweb.org/QPP19FactSheet for more information.

From JVS, JVS-VL

Smoking: Surgeons debate performing lower-extremity bypass in patients who are active smokers. A study published in September’s Journal of Vascular Surgery concludes that such patients have decreased long-term patency and overall survival, and that surgeons “should consider smoking an important risk factor.” See the article at vsweb.org/LEB-Smoking; it is open-source through Oct. 31.

Cyanoacrylate Closure: September’s JVS: Venous and Lymphatic Disorders includes a study following up earlier occlusion rates after cyanoacrylate closure of the great saphenous veins following either CAC or radiofrequency ablation. The study concludes that both treatments resulted in significant quality-of-life improvements through 24 months. See vsweb.org/CAC.

Make Time Travel a Reality with VAM on Demand

Traveling through time is a staple of science fiction books and movies, from H.G. Wells’ “The Time Machine,” to “Star Trek,” “Back to the Future” and Mark Twain’s “A Connecticut Yankee in King Arthur’s Court.”

VAM on Demand isn’t exactly traveling through time, but it’s close. This indispensable addition to the Vascular Annual Meeting lets purchasers return to sessions at VAM they attended and now want to review in more detail and watch the sessions they couldn’t attend the first time around.

VAM on Demand includes hundreds of sessions, typically with slides and audio presentations. A handful of events were videotaped. The library is $199 for VAM attendees and $499 for all others. The fee provides access for an entire year and the ability to download materials. Purchase it at vsweb.org/Recordings18.

The 2018 SVS Coding & Reimbursement Workshop

WHEN: October 19-20, 2018
WHERE: Chicago, Illinois Renaissance Hotel

Avoid costly errors! Join the experts for this intensive two-day workshop on coding and reimbursement issues that impact YOUR bottom line. Topics include not only coding essentials but also 2019 updates, the global surgical package, specifics for such procedures as hemodialysis access, wound care and aneurysm repair; and information on Medicare reimbursement regulations.

Details: vsweb.org/Coding18
NEWS FROM SVS

New SVS Foundation Bridge Grant Fills Funding Gaps

The SVS Foundation has created a new grant designed to help sustain surgeon-scientists' critical research amidst any funding gaps. Applications are due Oct. 1.

The SVS Foundation Bridge Grant is intended for mid-career vascular surgeon investigators. Applicants must have had a National Institutes of Health R01 grant or a K08 Mentored Clinical Research Grant or equivalents, and applied for an NIH R01 or equivalent but were denied funding due to a priority score below the payline.

The Bridge Grant will help sustain the recipient’s research and contribute to his or her retention as a vascular surgery investigator.

“With the funding suddenly in danger,” said Alan Dardik, MD, PhD, immediate past chair of the SVS Research Council, “this grant opportunity shows the commitment of the SVS and SVS Foundation to retaining our community of vascular surgeon-scientists.”

He added that the new grant adds an important element to those offered by the SVS Foundation. “We are trying to offer something for every step of a researcher’s career,” he said. “This fills a particular and specific need. I’m very excited about the possibilities this bridge grant creates for the future.”

New SVS Foundation Bridge Grant Fills Funding Gaps

Don’t Let Bottom Line Suffer; Register for Coding Workshop

There’s no question that medical billing coding is vitally important. Get it wrong and the bottom line suffers. It’s that simple.

Learn all about billing and coding for maximum reimbursement at the upcoming SVS Coding and Reimbursement Workshop. It, plus an optional workshop, will be held Oct. 19 and 20 at the Renaissance Hotel in downtown Chicago. This is a new location for 2018.

The courses are designed for vascular surgeons and their office staff. Topics will include the essentials, plus 2019 updates, the global surgical package and how it impacts billing and reimbursement, along with applying modifiers for streamlined reimbursement. Other topics include coding for such procedures as hemodialysis access, wound care and aneurysm repair; plus information on Medicare reimbursement legislation.

The workshop will be 1 to 5 p.m. Oct. 19 and 8 a.m. to 4:45 p.m. Oct. 20. Cost is $880 for SVS members and staff members, $955 for non-members and $250 for residents and trainees. The optional Evaluation and Management coding workshop will be from 9 a.m. to noon Oct. 19. Fee is $100, $125 and $50, depending on category. See more at vsweb.org/Coding18.

Meet the New SVS President

An interview with Michel S. Makaroun

Q. You’ve been leading the way on the issue of a future workforce shortage. Will this be a major initiative of your presidency? What other issue(s) and challenges stand out for your attention?

A. Unfortunately, the shortage in trained vascular surgeons is no longer in the future but currently upon us and has been a concern for years. There are far more advertised vascular surgery positions than we can accommodate. The shortage is only expected to get worse as nearly 40 percent of our members are over the age of 55. What complicates matters is a maldistribution of vascular surgeons. We are concentrated mostly in large urban centers and in certain parts of the country; yet vascular surgeons are necessary for most hospitals, as they enable other specialties and are required for many life- and limb-saving procedures. Some older surgical colleagues in general and thoracic surgery trained decades ago have moved on to retirement. This shortage is a huge challenge.

A new initiative for the SVS is to be able to attract more vascular surgery residents in training. There are far more advertised vascular surgery positions than we can accommodate. If we want to keep surgical and vascular surgery residents, we need to attract them to our specialty. The shortage of vascular surgery residents in training will be felt in the future.

The committee will review all the evaluations and feedback in planning for VAM 2019. “If people have specific ideas or topics they’d like to see explored, tell us,” said Dr. Eagleton. Send ideas and comments to education@vascularsociety.org, referring to VAM in the title line.

“I think we’re moving in a great trajectory for next year,” he said, thanking all who worked on the meeting. “It’s a lot of people putting in a lot of effort.”

The 2019 Vascular Annual Meeting will be June 12 to 15 at the Gaylord National Resort & Convention Center in National Harbor, Md., just outside Washington, D.C. Scientific sessions will be June 13 to 15 and exhibits will be June 13 to 14.

Don’t Let Bottom Line Suffer; Register for Coding Workshop

YOUR SVS: Apply For SVS Membership By Sept. 1

Apply by Sept. 1 to become part of the world’s premier vascular care organization.

The Society for Vascular Surgery switched to a quarterly application system this year, with deadlines on March 1, June 1, Sept. 1 and Dec. 1. This provides four chances to join the Society, which supports excellence and innovation in vascular health through education, advocacy, research and public awareness, and many perks of membership.

Visit vsweb.org/JoinSVS for more information and an application. Send questions to membership@vascularsociety.org.

VAM 2018 continued from page 13
NEWS FROM SVS

Meet the SVS Officers

Dr. Michel S. Makaroun, President, has been active in the SVS in a variety of roles since 1997 and served as secretary from 2013-2016. He is a distinguished fellow of the SVS and is professor and chair of vascular surgery and of clinical and translational science at the University of Pittsburgh and co-director of the UPMC Heart and Vascular Institute. (See his accompanying remarks.)

Dr. Kim J. Hodgson, President-Elect, has served as vice president and treasurer as well as on several committees and the SVS board of directors. He was the inaugural editor of the Vascular Educational Self-Assessment Program (VESAP) and for two more editions. He is chair of the division of vascular surgery at Southern Illinois University School of Medicine in Springfield, Ill., holds the David Sumner endowed chair in Vascular and Endovascular Surgery and has served for six years on the American Board of Surgery’s Vascular Surgery Board.

Dr. Ronald L. Dalman, Vice President, previously served three years as chair of the SVS Program Committee, which oversees the Vascular Annual Meeting, and on the SVS Board of Directors and many committees. He is the Walter C. and Elsa R. Chidester Professor of Surgery and chief of the Division of Vascular Surgery at Stanford University and serves on the ABS Vascular Surgery Board.

Outgoing President Dr. R. Clement Darling III, Chair of the SVS Foundation, has been active in SVS leadership for more than 27 years, serving on numerous SVS committees and on the board of directors and executive committee. He is president of The Vascular Group, Albany, N.Y.; director of The Institute for Vascular Health and Disease, and chief of the Division of Vascular Surgery at Albany Medical Center Hospital. He also is professor of surgery at Albany Medical College.

Dr. Samuel R. Money, treasurer, and Dr. Ali AbuRahma, secretary, continue in their respective positions.

YOUR SVS: In Memoriam and Spotlight

In Memoriam
John Feige, MD, 88, pioneering cardiac surgeon instrumental in establishing heart programs at several hospitals in Cincinnati, March 20. He was a founder of the University of Cincinnati’s heart transplant program in 1985.

John L. Ochsner, MD, 91, heart surgery pioneer who performed the first heart transplant in Louisiana and former president of the American Association for Vascular Surgery, July 6. His father was Alton Ochsner, a founding member and first president of the Society for Vascular Surgery and twice president of AAVS (pre-merger). Watch two interviews with Dr. John Ochsner at vsweb.org/HistoryProject, and read a full obituary on page 3.

Do you know of an SVS member who has passed away? Please let us know at communications@vascularsociety.org.

Spotlight
SVS Note: This month, the Society for Vascular Surgery introduces a new feature, Spotlight. We want to highlight significant honors our members receive—medical and otherwise. Know a member who has been recognized by a state or national organization? How about your partner, whose home-made cheeses are Internet best-sellers? Send information (with “Spotlight” in the subject line) to communications@vascularsociety.org.

Member is Humanitarian of the Year
The Baptist Health System in San Antonio, Texas, named Dr. Demetrios Macris its Humanitarian of the Year for his work with The Prosthetic Foundation, which helps underserved amputees obtain prosthetics at no cost. Dr. Macris founded the foundation in 2015; to date it has changed 61 lives.

Canada Honors Former SVS President
Former SVS President Dr. K. Wayne Johnston, of Toronto, Ontario, Canada, has been named a member of the Order of Canada by Julie Payette, Governor General of Canada. This is one of the country’s highest civilian honors.

Dr. Johnston was honored for his “foundational leadership as a surgeon, researcher and educator in the field of vascular surgery in Canada,” said the governor’s office. SVS president in 2007-2008, he helped launch our monthly publication, “Vascular Health and Disease,” said the governor’s office. SVS president in 2007-2008, he helped launch our monthly publication, “Vascular Health and Disease,” said the governor’s office.

New President continued from page 15 ago still provide some of these services, but are also retiring, leaving many hospitals without any vascular surgical care.

Shortages are not unique to vascular surgery, but more acute in our specialty because of an aging U.S. population as well as the diabetes epidemic. There are no easy solutions, and whatever is there will not have an immediate impact. The SVS intends to push for more training positions, attempt to develop strategies to encourage later retirement and possibly suggest mechanisms to provide vascular surgical services to smaller community hospitals.

Q. What would you like your presidency remembered for?
A. The SVS is no longer a success of one-year presidential terms, but more of a continuum of initiatives that fit into a strategic plan developed by volunteers, elected officers, representatives of different constituencies and a dedicated full-time professional staff of the Society. Many defining programs are under development to add to the existing offerings of the SVS on behalf of its members in advocacy, education, research, quality improvement and clinical practice priorities. I hope the coming year will deliver a more inclusive environment for our vascular team members, more collegial relationships with other specialties and more autonomy in decision-making for vascular surgery. We are also hoping for a signature program that will help promote quality and appropriate care for our patients.

Q. Do you anticipate changes coming to the Society? What ones?
A. The SVS is a vibrant and dynamic association that responds to our changing environment and member needs. I am excited and inspired by the hundreds of imaginative and dedicated colleagues who are working to make it stronger, more responsive and more inclusive.
NEWS FROM SVS

Viewing VAM:  
More Scenes from the 2018 Vascular Annual Meeting

Selfie Time: Immediate Past President R. Clement Darling III, center, poses for a picture with two well-wishers at a celebration marking the end of his presidential term.

A student gets personalized guidance with the tools of her trade during the always-popular Open and Endovascular Simulation Training at the Vascular Annual Meeting.

Alums of Washington University in St. Louis catch up with each other at their Alumni Reception, one of 17 held at this year’s Vascular Annual Meeting.

The Vascular Annual Meeting offers plenty of chances to learn and plenty of chances to relax and socialize as well.

Dr. Roger Greenhalgh of London receives the inaugural International Lifetime Achievement Award. At right is Dr. Enrico Ascher, chair of the International Relations Committee, which created the award this year.

Takayuki Fuji, left, of Nagoya, Japan, received the Juan C. Parodi Award while Seon-hee Heo of Seoul, South Korea, received the Thomas J. Fogarty Award. The awards are part of the Vascular Annual Meeting’s International Fast Talk Competition.

The New England Society for Vascular Surgery took home the Regional Society SVS Political Action Committee prize for participation in PAC contributions. From left are Drs. Glenn LaMuraglia, representing the regional society; Kathleen Ozsvath, chair of the SVS PAC Steering Committee, and Immediate Past President R. Clement Darling III.

Dr. Marcus Semel, right, shown with former SVS Foundation Chair Ronald M. Fairman, is one of three recipients of the SVS Foundation’s new Community Awareness and Prevention Grant. See article on the grants on page 13.

The Journal of Vascular Surgery publications honored four vascular surgeons at the Vascular Annual Meeting. Robert B. Patterson, MD, (left) received the JVS “Best Reviewer Award” while Fedor Lurie, MD, PhD, (right) received the same award from JVS: Venous and Lymphatic Disorders. Honors for the two publications’ “Most Highly Cited Article Award” went to Michael S. Conte, MD, (center) and his co-authors for JVS, and Thomas Michael Proebstle, MD, (not pictured) and his co-authors for JVS:VL.
The top three winners of the annual Poster Competition are (front row): Jesse Columbo, for his poster on Aortic Disease 2, center; Aleem Mirzan, Aortic Disease 1, left; and Katherine McMackin, PAD 2 and Education Training/Credentialing. In the back row, from left, are: President-elect Kim Hodson, MD; SVS Program Chair Dr. Matthew Eagleton; finalist James Iannuzzi, moderator Venita Chandra, MD; and finalists Anahita Dua, Frank Davis, Fabrizio Mascielli, Francesco Squizzato, Annalise Panthofer; and James Wall. Finalists all received $300 for reaching the final round. The top three finishers also received prizes of $1,500 (first place), $1,000 (second) and $500 (third).

Kaspar M. Trocha, MD, (left) received the SVS Foundation Resident Research Award and presented his research during the meeting on “Pre-Operative Protein-Restriction Attenuates Vein Graft Disease Via Induction of Endothelial Cystathionine gamma-lyase.” Samantha D. Minc, MD, and Bjoern D. Suckow, MD, MS, received the SVS Foundation Clinical Research Seed Grant. Dr. Minc’s project is “A Mixed-Methods Approach to Understanding Diabetes and PAD-Related Amputations in a Rural Population” and Dr. Suckow’s is “Development of a Critical Limb Ischemia Quality of Life Outcome Measure.”

Dr. Ronald Fairman, immediate past chair of the SVS Foundation, was honored for his leadership, guidance and mentorship.
Through the looking glass

BY LAURA MARIE DRUDI, MD
RESIDENT MEDICAL EDITOR

July 1st is a transition for many in postgraduate medical education, with fourth-year medical students becoming residents, and residents continuing to pursue and grow in their residency training. I stand at a turning point as a minted senior resident now looking through a new lens.

My responsibilities have shifted from what I would describe as scut work to developing medical and surgical plans for patients and making sure they are carried through. I have gone from being a junior under the umbrella and care of senior residents who came before me to the safety umbrella for those working under me. I have gone from wanting to go to every single case as a junior to making sure my team is reaching their technical objectives and that cases are divided fairly amongst team members. I have undergone a maturation in how I see, interact with, and resolve conflict with patients or healthcare providers. The transformation is hard to pin point when it exactly happened but maybe it has been evolving over the course of training unknown to me.

Sitting at my desk on our vascular surgery floor, and hearing my junior’s pager go off for the fourth time in a span of 20 minutes, I just stare into the distance of the not so far past, struggling to make it through the day as a junior resident and attempting not to throw my pager at the wall, or out the window or maybe just have the guts to take the battery out of the pager and pretend it died. The days were long and not easy in the slightest and even as a newly minted senior resident, I almost lost sight of that and the incredible work juniors across disciplines do on a daily basis and some struggling in silence.

As I look through the looking glass, I hope to not lose sight of the struggles, trials, and tribulations those that are following in my footsteps are experiencing. Sometimes a simple gesture as expressing gratitude can go far in a line of work plagued with environmental and occupational pressures that lead to chronic fatigue and burnout. Changing the optics of how we look through the looking glass can lead to a healthy, functional, and efficient team for the benefit of optimal patient care and safety and overall, our well-being.

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