



Society for Clinical Vascular Surgery

NEWSLETTER

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Fall 2003

President's Message - Investing In The Future of Our Specialty



Kim J. Hodgson, M.D.

It is a sad fact of life that many vascular surgeons will be afflicted by the very diseases that have served as the focus of our careers. Who will be there for us in our time of need? Will our care be managed by cardiologists or radiologists with a limited understanding of our problem and all of the therapeutic options? Will we be well served by caregivers unable to deliver the full range of treatment options and, therefore, biased in their treatment plan decisions? Or will vascular surgery revitalize itself and redefine the role of the vascular surgeon in the comprehensive management of vascular diseases, and the training paradigm required to prepare for it?

For our specialty to survive the challenges of today we must retrain our existing vascular surgery workforce to empower the practicing vascular surgeon to participate in the full spectrum of vascular disease diagnosis and management, both endovascular and surgical. And to insure our vitality into tomorrow we must draw upon the talents of our best and brightest, our most vigorous and passionate - those vascular surgeons anxious to play a role in redefining our specialty and leading us into a prosperous future. These leaders of tomorrow will come from our fellows of today. The 2004 SCVS Annual Meeting is packed with changes designed to educate and inspire our vascular fellows and to welcome them and involve them in the SCVS annual meeting. We hope that we may be stimulated by their fresh look at our old problems and, in

turn, they can learn from the good judgment we've developed over many years of practice.

To encourage further involvement of vascular fellows, I am delighted to announce that W. L. Gore and Associates, Inc., a longtime major supporter of physician education and the SCVS, will align the time and venue of their annual Vascular Surgery Fellows meeting to immediately precede the 2004 SCVS annual meeting in Palm Springs. This will give more than 100 vascular fellows the opportunity to stay and avail themselves of the scientific, educational, business, and social offerings of our annual meeting.

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32nd Annual Meeting - Marriott Rancho Las Palmas Resort & Spa, Rancho Mirage, California

ABOUT THE RESORT.....

Marriott's Rancho Las Palmas Resort & Spa is located in Rancho Mirage, California in the heart of the Coachella Valley, just minutes from nearby Palm Springs, Indian Wells, and other desert communities. Majestic mountain ranges provide a dramatic backdrop to the spectacular property. Nestled amid 240 acres of lushly landscaped grounds and lakes, this award-winning world-class resort blends the picturesque charm of Early California hacienda and mission architecture and the open spaces and exotic flora of the desert. Spanish accents abound from the red-tiled roofs, wood beamed trusses, ornate ironwork and colorful ceramic floor tiles to the eclectic flavors of the distinctive regional cuisine.

A virtual playground for adults and kids alike, the resort abounds in outdoor recreation facilities including three swimming pools, Tortuga Island - a recreation complex with 100' water slide, hydrotherapy pool, water jets and kids play area, a 25-court Tennis Center and Pro Shop (three red clay/22 hard surface and eight lighted), a 27-hole Ted Robinson-designed championship golf course. Nearby, guests can enjoy the River across the street - a shopping, dining and entertainment center, the Bob Hope Cultural Center, Palm Springs Aerial Tram, The Living Desert Reserve, El Paseo Shopping (the Rodeo Drive of the desert), hot air balloon rides, horseback riding and off-road jeep tours.

The 20,000-square-foot Spa Las Palmas is complete with whirlpools, relaxation lounges, Finnish saunas, private men's and women's locker rooms with showers, massage and treatment rooms, body and beauty amenities, heated Spa Pool with underwater music, state-of-the-art fully-equipped Fitness Center, and Spa Boutique.



BE THERE - March 10-13, 2004

31st ANNUAL SYMPOSIUM ON VASCULAR SURGERY
of the Society for Clinical Vascular Surgery
March 15-19, 2003
InterContinental Miami, Miami, Florida

Hypogastric Artery Bypass To Preserve Pelvic Circulation: Improved Outcome Following Endovascular Abdominal Aortic Aneurysm Repair

Frank R. Arko, MD, W. Anthony Lee, MD, Bradley B. Hill, MD, Cornelius Olcott, IV MD, Thomas J. Fogarty, MD, Christopher K. Zarins, MD

Hypogastric artery bypass to preserve pelvic circulation is safe and significantly decreases the risk of buttock claudication. Preservation of pelvic circulation results in a three fold improvement in the ambulatory status of patients with common iliac artery aneurysms compared with coil embolization.

Does Transrenal Fixation Of Aortic Endografts Impair Renal Function?

Neal S. Cayne, MD, Soo J. Rhee, MD, Frank J. Veith, MD, Evan C. Lipsitz, MD, Takao Ohki, MD, Nicholas J. Gargiulo, III, MD, Manish Mehta, MD, William D. Suggs, MD, Reese A. Wain, MD, Patrick J. Lamparello, MD, Carlos Timaran, MD

There is a slight rise in serum creatinine and decrease in creatinine clearance following aortic endografting. However, there was no significant difference in these changes between patients with transrenal fixation (TFX) and infrarenal fixation (IFX). Although TFX may produce a higher incidence of small renal infarcts, these do not impair renal function. Thus, TFX can be performed safely with no greater change in renal function than that observed after IFX.

WINNER OF THE SAMUELS AWARD

Successful Management Of Type I Endoleaks Following Endovascular Aortic Aneurysm Repair Using N-Butyl Cyanoacrylate Adhesive

Thomas S. Maldonado, MD, Caron R. Rockman, MD, Robert Rosen, MD, Patrick J. Lamparello, MD, Danielle R. Bajakian, MD, Nick Lange, MD, Mark A. Adelman, MD, Glenn R. Jacobowitz, MD, Paul Gagne, MD, Thomas S. Riles, MD

Use of N-butyl 2-cyanoacrylate (NBCA) occlusion suggests that it may offer an effective and durable method of treatment for certain type I endoleaks following endovascular aortic aneurysm repair. Results are comparable to other endovascular treatment modalities utilized for type I leaks. Additionally, NBCA may provide an alternative endovascular treatment for proximal type I endoleaks in which extender cuffs are not an option for anatomical reasons.

Does Hostile Neck Anatomy Preclude Successful Endovascular Aortic Aneurysm Repair (EVAR)?

Ellen D. Dillavou, MD, Satish C. Muluk, MD, Robert Y. Rhee, MD, Edith Y. Tzeng, MD, Jonathan D. Woody, MD, Ravyash Gupta, MD, Michel S. Makaroun, MD

Non-supported endografts with active fixation can yield excellent results in treating many patients with hostile neck anatomy. Nonetheless, an unsuitable neck remains the most frequent cause for exclusion of a patient with AAA from EVAR.

Accuracy Of Cine Magnetic Resonance Angiography In Quantifying Aneurysm Pulsatility Associated With Endoleak

Peter L. Faries, MD, Gautam Agarwal, MD, Robert Lookstein, MD, Hadley Cadot, MD, Nicholas J. Morrissey, MD, Neal S. Cayne, MD, Alfio Carroccio, MD, Sharief Ellozy, MD, Michael E. Minor, MD, Jeff Goldman, MD, Larry Hollier, MD, Michael Marin, MD

Persistent aneurysm perfusion (endoleak) has been associated with pulsatility of abdominal aortic aneurysms (AAA) after endovascular repair. However, the resultant pulsatile change in AAA diameter may be difficult to quantify and therefore its significance is unknown. Cine MRA may be used to accurately quantify these small changes in AAA wall motion. The extent of change in diameter corresponds to type of endoleak, with type I endoleak generating greater pulsatile change in diameter than type II-collateral or no endoleak. Cine MRA may provide a non-invasive means of assessing the success of endovascular treatment of AAA.

Quality Of Life Following Ruptured Abdominal Aortic Aneurysm Repair

Clifford J. Buckley, MD, Marvin Atkins, MD, Mark Mettauer, MD, Shirley Lee, MSN, R.N., Danny Little, MD, M. Kuo, F. Arko, MD

Majority of RAAA survivors experience a satisfactory quality of life that compares well with age-matched general population mean scores. Loss of independent living status was the dominant factor influencing patient dissatisfaction.

Challenges Of Endovascular Graft Repair Of Thoracic Aortic Aneurysms (TAA): A Successful Future Demands New Technology

Sharif H. Ellozy, MD, Alfio Carroccio, MD, Michael E. Minor, MD, Kristina S. Chae, B.A., David Spielvogel, MD, Nicholas Morrissey, MD, Victoria J. Teodorescu, MD, Larry H. Hollier, MD, Michael L. Marin, MD

Endovascular stent graft repair has great potential in the therapy of thoracic aortic aneurysms. This study analyzed a single center's experience using "first generation" commercially produced thoracic stent grafts to treat descending thoracic aortic aneurysms. Three significant advancements are required to fulfill the potential of this important treatment modality: 1) a stent graft with a durable proximal and distal fixation device; 2) enhanced engineering to accommodate high thoracic aortic fatigue forces; and 3) a mechanism to adapt to aortic arch and visceral segment branches to allow for treatment of lesions which extend to or include these vessels.

Endoleaks After Stent-Graft Repair Of Thoracic Aortic Aneurysms

Frank J. Criado, MD, Nancy S. Clark, MD, Gregory S. Domer, MD

Endoleaks occurring after stent-graft repair of thoracic aortic aneurysms differ from those seen after treatment of abdominal aneurysms, with very low or zero incidence of type 2 branch flow endoleaks. More aggressive use of detailed angiography during the initial implant procedures might have prevented some of the observed attachment-site leaks, minimizing need for secondary procedures. Prompt angiography and repair is justified for a CT-detected endoleak after endovascular repair of TAA.

The Presence And Evolution Of Abdominal Aortic Aneurysms In Patients With Thoracic Aortic Dissection

Jacqueline J. Lee, B.S., Justin Dimick, MD, David M. Williams, MD, Peter K. Henke, MD, G. Michael Deeb, MD, James C. Stanley, MD, Gilbert R. Upchurch, MD

This study documented that patients with thoracic aortic dissections are at relatively high risk to harbor or develop an AAA. The high occurrence rate of AAAs observed in this experience supports the tenet that abdominal CTs or ultrasonography should be mandatory in the follow-up of patients with known thoracic aortic dissections.

Robot-Assisted Laparoscopic Aortic Reconstruction For Occlusive Disease: A Case Report

Lois A. Killewich, MD, Lori L. Pounds, MD, Guillermo Gomez, MD

The robotic system facilitated creation of the aortic anastomosis and shortened aortic clamp time over that achieved with laparoscopic techniques.

Superior Mesenteric Artery (SMA) Angioplasty And Stenting Via A Retrograde SMA Approach In A Patient With Necrotic Bowel

Ross Milner, MD, Edward Y. Woo, MD, Jeffrey P. Carpenter, MD

Traditional surgical revascularization of the mesentery necessitates suprarenal aortic cross-clamping or exposure of the aortic graft to provide bypass inflow. In the setting of gross contamination, combined open-endovascular approach to mesenteric revascularization via retrograde SMA access permits a decrease in the overall surgical trauma while achieving revascularization for these critically ill patients.

(continued on next page)

Tuberculous Aneurysm of the Supraceliac Aorta - Case Report and Review

Thomas L. Forbes, MD, Robert G. Nie, MD, D. Kirk Lawlor, MD, Kenneth A. Harris, MD

Major vascular complications are rare following systemic infections with Mycobacterium tuberculosis (T13). Prosthetic reconstruction of the affected aorta results in this case resulted in a favorable outcome. Anti-tuberculous medications are required.

Successful Limb Reperfusion Using Prolonged Intravascular Shunting in a Case of an Unstable Trauma Patient

Matthew M. Nalbandian, MD, Thomas Maldonado, MD, James Cushman, MD, Glenn R. Jacobowitz, MD, Patrick J. Lamparello, MD, Thomas S. Riles, MD

This case demonstrated the effectiveness of prolonged (>6hours) use of an intravascular shunt as part of damage control surgery for peripheral arterial and venous injuries. In a patient who would otherwise undergo an amputation for their injury, the risk of shunt thrombosis, or infection, may not be a contraindication for placement.

Endovascular External to Internal Iliac Artery Bypass to Preserve Pelvic Blood Flow

Manish Mehta, MD, R. Clement Darling, III MD, Gary P. Siskin, MD, Kyran Dowling, MD, Paul B. Kreienberg, MD, Benjamin B. Chang, MD, Sean P. Roddy, MD, Kathleen J. Oszvath, MD, Philip S. K. Paty, MD, Dhiraj M. Shah, MD

Endovascular external to internal iliac bypass is feasible and safe. This technique can facilitate pelvic blood flow in patients with ruptured AAAs undergoing EVAR with an aorto-uni-iliac stent graft and a femoral-femoral bypass, and in patients with extensive aortoiliac aneurysms extending up to iliac bifurcation bilaterally.

Treatment of Severe Carotid Stenosis With Angioplasty - Stenting (CAS) On Patients Deemed "Inoperable"

Frank J. Criado, MD, Nancy S. Clark, MD, Gregory S. Domer, MD

CAS emerges as an appealing treatment alternative for patients deemed to be anatomical high-risk candidates for endarterectomy, especially those who may be truly "inoperable". The intervention can be performed safely, and would seem to produce acceptable mid-term results. Longterm clinical efficacy remains unknown.

A Model For Predicting Occult Carotid Artery Stenosis: Screening is Justified in a Selected Population

Caron R. Rockman, MD, Glenn R. Jacobowitz, MD, Paul Gagne, MD, Mark A. Adelman, MD, Patrick J. Lamparello, MD, Ronnie Landis, MD, Thomas S. Riles, MD

The incidence of carotid stenosis increases with the presence of identifiable demographic risk factors (smoking, hypertension, cardiac disease, or hypercholesterolemia) in a selected population. In the presence of two or more defined risk factors there is a significant increase in the prevalence of occult carotid stenosis. Assuming the diagnosis and treatment of carotid stenosis are fundamental to stroke prevention, screening for carotid artery disease is justified in this group of patients.

Safety And Durability of Redo Carotid Operation (RCO): A 10-Year Experience

Keshav Pandurangi, MD, Alexander D. Shepard, MD, Timothy J. Nypaver, MD, Daniel J. Reddy, MD, Jae-Sung Cho, MD

This study confirms that RCO for recurrent carotid stenosis can be performed safely with excellent protection from stroke and long-term durability. This data provide a standard against which the results of carotid stenting can be compared.

Are We Under Treating Carotid Stenosis Diagnosed By Ultrasound Alone

L. Richard Sprouse II MD, George H. Meier, III MD, Christopher Lesar, MD, Robert G. Gayle, MD, F. Noel Parent, MD, Richard J. DeMasi, MD, Michael J. Marcinczyk, MD

The clinical management of carotid disease is primarily based on the results of national trials (i.e.- NASCET and ACAS) that used the distal internal carotid artery diameter as a reference. However, the commonly accepted non-invasive criteria of carotid stenosis were derived from the correlation of ultrasound velocity measurements with angiographic diameter reduction at the carotid bulb. The difference in these two methods may lead to errors when the results of non-invasive studies are used to guide therapy based on standards derived from the national carotid trials. Bulb diameter reduction measured by modern grayscale imaging correlates strongly with diameter reduction determined by velocity criteria, and can independently predict the grade of carotid disease. With this in mind, the accuracy of grayscale imaging can also be extended to the measurement carotid stenosis based on distal diameter reductions as performed by arteriogram in ACAS and NASCET. By grayscale criteria, many patients appropriate for surgical treatment were not offered treatment secondary to the velocity criteria commonly used in non-invasive ultrasound diagnosis. Modern grayscale imaging provides a non-invasive method to determine appropriate patients for intervention and should be added as a routine to carotid ultrasound interrogation.

Trends In The Management Of Coronarysubclavian Steal Syndrome

Alex Westerband, MD, Julio A. Rodriguez, MD, Venkatesh G. Ramaiah, MD, Edward B. Diethrich, MD

The optimal management of patients presenting with a proximal subclavian artery stenosis (SAS) prior to or following coronary artery bypass grafting (CABG) has not been well established. SAS may lead to flow reversal through a patent left internal mammary artery (LIMA) graft with resulting myocardial ischemia (coronary-subclavian steal). PTA and stenting for SAS appear to provide both immediate treatment of and effective protection from coronary-subclavian steal when the LIMA is used as a coronary bypass graft.

MRA vs. Duplex Arteriography for Patients Undergoing Lower Extremity Revascularization: Which Is The Best Replacement for Contrast Arteriography?

Enrico Ascher, MD, Anil Hingorani, MD, Richard Schutzer, MD, Sreedhar Kallakuri, MD, Alex Hou, MD, William Yorkovich, RPA, Theresa Jacob, Ph.D., Sergio Salles-Cunha, Ph.D., Natalia Markevich, MD

Based upon these data in this series, MRA does not yet seem to be able to obtain adequate data, at least for this highly selected population. When severe calcification is present, duplex arteriography is inadequate.

(continued on next page)

The SCVS Administrative Office Has Moved!

Our new contact information:

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E-mail addresses remain the same. Please make a note and pass this along to any personnel who may have reason to contact the office.

Comparison of Tibial Artery Reconstruction Using Popliteal or Tibial Vessels As Inflow. Analysis Of 719 Procedures

John A. Adeniyi, MD, R. Clement Darling, III MD, Sean P. Roddy, MD, Manish Mehta, MD, MPH, Kathleen J. Ozsvath, MD, Paul B. Kreienberg, MD, Benjamin B. Chang, MD, Dhiraj M. Shah, MD, Philip S. K. Paty, MD

The results of this study demonstrate that the use of popliteal and tibial arteries as inflow sources in the absence of any significant proximal disease carries satisfactory results. Use of a tibial artery inflow is an acceptable option especially in those patients with limited autogenous conduit.

Endovascular Assisted In Situ Bypass Grafting: A Simplified Technique For Coil Side Branch Occlusion

Sean D. O'Donnell, MD, David L. Gillespie, MD, James M. Goff, MD, Mary V. Parker, MD, Norman R. Rich, MD

Side branch occlusion during in situ bypass can be easily performed without the use of a specialized angioscope using fluoroscopic techniques only. Early patency is excellent but further follow-up will be necessary. This simplified technique may reduce the cost of coil embolization of the greater saphenous vein side branches during in situ bypass grafting considerably and make an endovascular assisted in situ technique more widely applicable.

Tissue (Muscle) Oxygen Saturation (StO₂): A New Measure Of Symptomatic Lower Extremity Arterial Disease (PAD)

Anthony J. Comerota, MD, Richard C. Thom, B.A., Patrick Kelley, B.A., Michael Jaff, D.O.

Near-infrared spectroscopy provides a non-invasive method of measuring tissue oxygenation and has been used to monitor extremity compartment syndrome. Muscle O₂ saturation (StO₂) is potentially useful in assessing patients with PAD. StO₂ is a new and potentially useful technique to evaluate patients with PAD. It may offer additional insight into the pathophysiology of exercise-induced muscle ischemia and its recovery. StO₂ offers a different and perhaps more appropriate endpoint for diagnosis and treatment of patients with PAD.

Balloon Angioplasty is an Effective Treatment of Failing Infrainguinal Bypasses With Autologous Vein

Gregory A. Carlson, MD, Jamal J. Hoballah, MD, Mario Martinasevic, MD, William J. Sharp, MD, John D. Corson, M.B.ChB

Balloon angioplasty of failing infrainguinal vein bypasses can be successfully performed with a low rate of morbidity/mortality. Acceptable long-term patency can be achieved. This procedure should be considered as a viable option for failing infrainguinal vein bypasses.

Intravascular Ultrasound Identifies an Unusual Cause for Blue Toe Syndrome

Marvin Atkins, MD, Clifford J. Buckley, MD, T. Christian Pratt, MD, Shirley D. Lee, MSN, R.N.

Intravascular ultrasound can visualize vascular lesions not detected by angiography. IVUS can be extremely useful in identifying vascular pathology including the source for emboli in the peripheral arterial system when standard evaluation techniques are non-diagnostic.

Blunt Injury To The Thoracic Aorta In Multitrauma Patients: Should Endovascular Therapy Become The Gold Standard?

Matthew R. Uzjeblo, MD, Luis A. Sanchez, MD, Brian G. Rubin, MD, Eric T. Choi, MD, Patrick J. Geraghty, MD, Gregorio A. Sicard, MD

Acute injuries of the thoracic aorta appear to be an excellent indication for the use of endovascular devices. In general, these patients are at high risk of complications from surgical repair due to their associated injuries and comorbidities. At this time, long-term experience with endovascular devices and wider availability are needed before making endovascular repair the gold standard.

Endovascular Management Of Occluded Axillo-Femoral Bypass Graft Stump Syndrome

Enrico Ascher, MD, Anil Hingorani, MD, Richard Schutzer, MD, Sreedhar Kallakuri, MD, Alex Hou, MD, William Yorkovich, RPA, Theresa Jacob, Ph.D., Sergio Salles-Cunha, Ph.D., Natalia Markervich, MD

Upper extremity embolism is a rare complication following occlusion of AXFEM by pass grafts. Post embolectomy angiograms should be carefully reviewed to identify the Stump which may be a source of recurrent upper extremity emboli. Endovascular approach to obliterate the Stump of occluded AXFEM by pass graft is an effective alternative to treat this rare condition.

Use Of A Retrievable Suprarenal Inferior Vena Cava Filter

Raymond J. Holmes, MD, Larry A. Scher, MD, Jason J. Naidich, MD, Craig R. Greben, MD, Burton L. Rochelson, MD

Retrievable inferior vena cava filters may be useful in patients with short term needs for protection against pulmonary embolism. Preliminary data has been published suggesting the feasibility and safety of retrieval of Gunther Tulip™ filters up to two weeks after implantation.

Management Of Primary Aortoiliac-Enteric Fistulae

D. Kirk Lawlor, MD, Thomas Forbes, MD, Guy Derose, MD

Treatment of patients with vascular-enteric fistulae is a difficult problem, often associated with delayed diagnosis and high morbidity and mortality rates. Successful surgical management can be achieved with primary closure of the intestinal tract and an in situ vascular graft or extra-anatomic bypass.

Simultaneous IVC Filter Placement And Gastric Bypass In Super-Obese Patients Prevents Pulmonary Embolism

Nicholas J. Gargiulo, III, MD, William D. Suggs, MD, Evan C. Lipsitz, MD, Frank J. Veith, MD, Takao Ohki, MD, Neal S. Cayne, MD, Reese A. Wain, MD, Taylor Reed, P.A., Harrie Kurvers, MD, Carlos Timaran, MD Amy Goodwin, P.A., Elliot Goodman, MD

Simultaneous IVC filter placement and gastric bypass in patients with a BMI > 55 reduces the incidence of PE from 17% to 0%. This can be performed safely with minimal additional operating room time and morbidity.

Development And Maintenance of Hemodialysis Access In Patients With Prior Failed Synthetic Grafts: Impact of Mesenteric Vein Bioprosthetic Graft

Howard E. Katzman, MD, Jeffrey H. Lawson, MD, Marc H. Glickman, MD, A. Frederick Schild, MD, Roy M. Fujitani, MD

The MVB provided the patient superior secondary graft patency over both their own prior failed synthetic graft and the ePTFE control group with significant reduction in the incidence of thrombosis, infection, and interventions. These results suggest that the MVB offers a means of extending vascular access to the challenging patient population.

The Lifesite Hemodialysis Access System in Patients With Limited Access

Sunil S. Rayan, MD, Elliot L. Chaikof, MD, Thomas T. Terramani, MD, Thomas F. Dodson, MD, Victor J. Weiss, MD

Despite the potential advantages of a fully implantable access device, within 8 months the Lifesite system failed due to infection or thrombosis in approximately half of all patients.

Salvaging Prosthetic Hemodialysis Grafts With Stents: Fore Arm vs. Upper Arm Lesions

Stephen Kolakowski, MD, Matthew J. Dougherty, MD, Keith D. Calligaro, MD

Stent deployment can salvage thrombosed dialysis grafts. However sustained patency is infrequent with this strategy, with better results for upper arm grafts compared with forearm grafts. As surgical revision of the latter is usually straightforward, stenting should be reserved high axillary grafts and other situations where surgical repair is difficult or hazardous.

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Endovascular Treatment Of Celiac And Mesenteric Artery Stenoses: Indications And Outcomes

Melhem J. Sharafuddin, MD, Craig H. Olson, MD, Shiliang Sun, MD, Timothy F. Kresowik, MD, John D. Corson, M.B.ChB.

Endovascular therapy of celiac and mesenteric arterial occlusive disease has a high technical success rate, low complication rate and good durability.

Divergent Outcomes After Percutaneous Therapy For Symptomatic Renal Artery Stenosis

Nayan Sivamurthy, MD, Scott Surowiec, MD, Jeffrey Rhodes, MD, David Lee, MD, Richard M. Green, MD, David L. Waldman, MD, Mark G. Davies, MD

Percutaneous endovascular intervention for clinically symptomatic atherosclerotic renal artery stenosis is technically successful and safe. There are excellent patency and low restenosis rates. There is immediate clinical benefit for most patients but divergent longterm functional outcomes in the long term. Endovascular interventions enhance the care of the hypertensive patient but do not preserve long term renal function in the patient with chronic renal impairment.

Renal Preservation Following Renal Artery Angioplasty

Laura A. Gruneiro, MD, Robert B. McLafferty, MD, Juan Ayerdi, MD, Jose R. Parra, MD, Maurice M. Solis, MD, Kim J. Hodgson, MD

Percutaneous transluminal angioplasty (PTA) of renal artery stenosis (RAS) is being performed with increasing frequency and for more liberal indications. PTA of RAS achieves acceptable patency. Stabilization or improvement in renal function is seen in the majority of patients. However, patients with pre-existing renal insufficiency are less likely to benefit following PTA.

Can Duplex Ultrasound Replace Computed Tomographic Scan For Surveillance Following Endovascular Abdominal Aortic Aneurysm Repair (EVAR)?

Kathleen G. Raman, MD, MPH, Nita Missig-Carroll, R.N., Tracey Richardson, RVT, Michel S. Makaroun, MD

US demonstrates high specificity and Negative Predictive Value (NPV) in detecting endoleaks after EVAR. However, it is less sensitive than CT in detecting endoleaks and should not be used exclusively early in the post-operative course. It may provide some value in the follow-up of stable patients, as there is a high degree of correlation in measuring AAA diameter between US and CT over time.

Same Evening Discharge After Carotid Endarterectomy: Our Initial Experience

Maureen K. Sheehan, MD, William H. Baker, MD, Fred N. Litooey, MD, Howard P. Greisler, MD,

Same evening discharge is safe and feasible in select patients. Currently nearly one third of our patients are safely discharged 8 hours after CEA but up to 76% of patients could have been safely discharged the same evening. With appropriate scheduling, patient education, and increasing physician awareness, the majority of patients can be discharged home after CEA.

Intraoperative Duplex Ultrasound Of Visceral Revascularizations: Optimizing Technical Success And Outcome

Gustavo S. Oderich, MD, Jean M. Panneton, MD, Thanila A. Macedo, MD, Kenneth J. Cherry, Jr MD, Audra A. Noel, MD, Robert A. Lee, MD, Thomas C. Bower, MD, Peter Glowiczki, MD

This study supports the routine use of intraoperative ultrasound of visceral revascularizations to optimize technical success and outcome. Patients with normal examinations, either on initial ultrasound or following immediate revision, can expect excellent results. Major defects are associated with graft/vessel-related complications and warrant immediate operative revision.

WELCOME NEW MEMBERS

ACTIVE MEMBERS

Cameron M. Akbari, M.D.

Washington, DC

Christopher G. Carsten, III, M.D.

Greenville, South Carolina

Alan Dardik, M.D.

New Haven, Connecticut

A. David Drezner, M.D.

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Matthew M. Nalbandian, M.D.

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Jeffrey M. Rhodes, M.D.

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Layne Yonehiro, M.D.

Pensacola, Florida

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Stony Brook, New York

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Brooklyn, New York

Venkat R. Kalapatapu, M.D.

Easton, Pennsylvania

Sunil S. Rayan, M.D.

Atlanta, Georgia

Maureen K. Sheehan, M.D.

Maywood, Illinois

Larry R. Sprouse, II, M.D.

Norfolk, Virginia

Membership information is available on the SCVS website (scvs.vascularweb.org) and by contacting the SCVS Administrative Office, (978) 927-8330.

Highlights from the 2003 Annual Meeting

More than 200 physicians and guests attended the 31st Annual Symposium held from March 5-9, 2003 in Miami, Florida. Traditionally, one of the most exciting forums for the exchange of ideas and experience in vascular surgery, this year's meeting attracted participants from as far away as Italy and Brazil.

The Program Committee, chaired by Dr. Michel S. Makaroun, assembled an outstanding variety of state-of-the-art papers and incorporated breakfast sessions, how-to videos, poster presentations, symposia, and postgraduate courses to enhance the educational experience.

Thirty papers were presented in sessions divided into aneurysm, thoracic, carotid, lower extremity, venous access, and mesenteric/renal and other. (A complete review of all papers begins on page 2.)

Thirty-five posters were presented and covered such topics as "Screening for Significant Vascular Disease: A Study of 14,365 Patients"; "Combined Axillary and Interscalene Block – A Preferred Technique for Creation of Upper Extremity Arteriovenous Fistulae"; and "Gender Related Differences in Results Following endovascular Aortic Aneurysm Repair."

Additional Highlights included:

- ♦ The **Distinguished Visiting Professor** was **Frank J. Veith, MD**, who presented a timely talk on "**Where is Vascular Surgery Coming From and Where is it Going? A Call to Arms for Every Vascular Surgeon.**"
- ♦ The **Hume Memorial Lecture** was presented by **Robert W. Hobson, II, M.D.** on "**Clinical Trial Methodology and Carotid Occlusive Disease.**" (Complete review on right.)
- ♦ The **Peter B. Samuels Award** was presented to **Thomas Maldonado, M.D.** for his paper entitled, "**Successful Management of Type-I Endoleaks Following Endovascular Aortic Aneurysm Repair Using N-Butyl Cyanoacrylate Adhesive.**"
- ♦ The **Allastair Karmody Poster Presentation Awards** were given to: Joseph Lombardi, M.D. (1st Place); Stephanie Elkhouri, M.D.; Douglas Wilhite, M.D.; and Cecillia Lorenzo.
- ♦ The **Presidential Address**, by Enrico Ascher, M.D., focused on "**The Modern Vascular Specialist: A Surgeon, An Interventionist and a Clinician.**"
- ♦ Postgraduate Course – "**Expanded Noninvasive Testing: Does Your Lab Need to Add These?**", moderated by Drs. J. Dennis Baker and Anil Hingorani.
- ♦ Postgraduate Course – "**Angio / AV Access**", moderated by Drs. Michael Silva and R. Clement Darling, III.

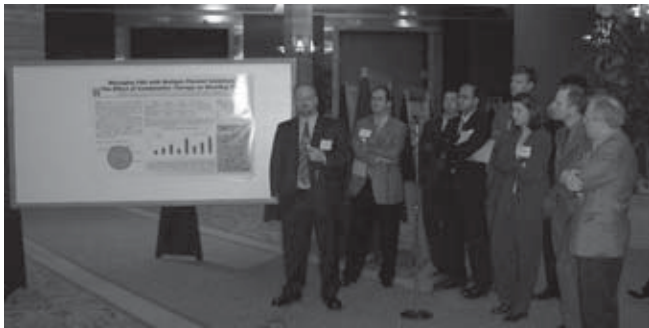
New features this year:

- ♦ **International Symposium** – Four international experts from Brazil, Italy and the Netherlands presented the state of vascular surgery in their respective countries.
- ♦ Symposia on "**Vascular Medicine for Vascular Surgeons**", moderated by Drs. Peter Lawrence and Enrico Ascher; "**Venous Disease**" moderated by Drs. Thomas Bower and Matthew Dougherty; "**Surgical Treatment of Peripheral Vascular Disease is Obsolete – The Great Debate**", during which two experts debated the pro and con of four vascular conditions; "**How to Build Your Vascular Practice and Income**," which was divided into two separate topics - "**Efficiency in Practice - How to Get More out of What You're Doing**" and "**Expanding a Vascular Surgery Practice.**"
- ♦ Symposia on "**Peripheral Limb Salvage**" and "**Aortic Surgery**" incorporated "how to" videos into the presentation.
- ♦ Issues Session – Consensus Conference – "**The Role of Open Surgery in the Era of Endovascular AAA Repair (EVAR)**" which examined the continued importance of open surgical techniques in aneurysm management.
- ♦ Two breakfast sessions featuring interesting and unusual vascular cases included such fascinating presentations as "**Superior Mesenteric Artery (SMA) Anigoplasty and Stenting via a Retrograde SMA Approach in a Patient with Necrotic Bowel**" and "**Intravascular Ultrasound Identifies an Unusual Cause for Blue Toe Syndrome.**"

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You can now view this issue of the SCVS Newsletter, plus up-to-date meeting information and Society activities on line at: scvs.vascularweb.org

Photo Highlights from Miami...



President's Message

(continued from page one)

In addition, to give them a sample of the training modalities of the future and to test their endovascular skills, Cordis-J&J will be bringing several endovascular training simulators to the meeting - the same type they plan to use in their much anticipated training program to teach carotid angioplasty & stenting to those who did not acquire these skills in their fellowship. Advances in computer processing power have made realistic endovascular case simulation possible, incorporating both tactile and visual feedback as well as psychometric performance analysis. These endovascular simulators are showing promise to be the long-awaited solution to the endovascular training dilemma faced by so many practicing vascular surgeons today, and the likely future pathway to carotid stenting and other evolving endovascular technologies. This is a great opportunity to see the future of endovascular training firsthand.

The Program Committee has met and selected the abstracts to be presented during the plenary sessions of the annual meeting. With over 160 abstract submissions to choose from, the quality, originality, and diversity of the 31 selected for oral presentation is nothing short of outstanding. As in previous years there will be an opportunity for other exceptional abstracts to be presented as posters and compete for awards during the ever-popular Poster Session reception and competition.

Our Distinguished Guest Lecturers this year will be two endovascular role models. Drs. Thomas Fogarty and Richard Green will share words of wisdom on the changing face of vascular surgery and how to grow with our evolving specialty rather than be left behind. The International Lunch program will highlight evolving technologies in use or trial outside of the United States (on their way to us soon) such as carotid angioplasty and branched vessel endografting. On the clinical side we will once again offer a number of focused symposia on bread-and-butter issues for practicing vascular surgeons, including symposia on venous disorders, AV access procedures, vascular lab testing, and endovascular therapy. And to provide updates on other important clinical issues and insight into future products, there will be a number of industry-sponsored evening programs where more informal discussion of relevant clinical issues can occur in the congenial atmosphere of food and drink.

I recently visited the Rancho Las Palmas Marriott and know that you'll be as impressed as I was with the resort facility itself and the myriad of nearby recreational and entertainment opportunities. With a full-service spa, outstanding golf, tennis, and swimming on-site, and alpine hiking, shopping, sightseeing, and hot air ballooning nearby, Palm Springs has something for everyone. To insure a "guilt-free" opportunity to partake in these activities, Friday afternoon has been left open, to encourage family activities and recreational outings. The meeting will culminate with our annual Gala Reception and Dinner on Saturday evening, a time to catch up with old friends and meet new colleagues and their families.

Your Executive Council has been working overtime to insure that this year's meeting exceeds the high standards you've come to expect of the SCVS. The anticipated influx of fresh faces and minds in the form of our vascular fellows promises to invigorate discussion and debate over the issues of our times. And with scientific and practical programming geared towards the needs of the practicing vascular surgeon, and delivered in the family-friendly environment of Palm Springs, this year's meeting promises to be the best ever. We hope to see you and your families there.

Review of Hume Lecture - Robert Hobson, M.D.

"Clinical Trial Methodology and Carotid Occlusive Disease"

This was an excellent review of current literature and state of carotid artery stenting. It reviewed methodologies including randomized clinical trials versus case studies. Randomization is important to allow assessment of confounders, disease severity, and risk factors. These make the patient assignment difficult and can cause skewing of data. To control for confounders, matching cohort studies may be a better methodology; it allows adjustments for confounders and cross sectional analysis with multi-variant analysis adjustment for difference in confounders. You must know, however, what all of the confounders are in this methodology. For instance, homocysteine and arteriosclerotic heart disease - the relationship was not known ten years ago, therefore, it is hard to measure all of the confounders. The degree that the disease is present may be influenced by the severity of the confounders; therefore, you cannot predict the known and unknown confounders. This is why randomized clinical trials have been so important. Randomization allows adjustment and elimination of confounders in management of disease; therefore you do not need to know all of the confounders if you can provide adequate trial size.

Outcome and CREST study design, data, and endpoints were reviewed. There was no clustering of serious adverse events at any one center. Credentialing is key in the even distribution of serious adverse events. There was no difference in the specialists performing the procedure. Contributions from all participants were acknowledged. In the discussion, the use of completion studies after carotid endarterectomies seemed to help with improved surgical results. There were 2% unsuspected problems found in the common carotid artery. This can improve results and decrease the unexpected technical errors with carotid endarterectomy. This should be a requirement for the surgical arm. For surgical participation, it comes down to the results of the last 50 cases. Subset analysis and re-stenosis data may be very helpful.

The other discussion point was how surgeons should get trained to do carotid artery stenting. The credentialing phase is very problematic. Co-venturing with other specialists may be helpful. This may require inter-departmental participation. You must have good catheter based skills if you are going to do this. Similarities will be helpful in training and especially if you can use your co-venture material from the cardiac cath lab. You need to enter trials as co-venture efforts with other participants. The use of protection devices must be used and, currently, cardiology is the only group of physicians who have Food and Drug Administration (FDA) approved devices. PercuSurge is the only available device. We must apply for angio suite privileges and catheter lab privileges. Technical help and catheters are available. Anesthesiology coverage is needed and can also be important. The stroke rates appear to be comparable with and without the use of protection devices; however, there is no data and no studies available. We need to add additional cases to use the protection devices to verify the results. The device adds approximately a one thousand dollar cost to the procedure.

There was quite a controversial and interesting discussion. It was an excellent review of the current status of carotid artery stenting. Thank you, Dr. Hobson. *Review by Joann Lohr, M.D.*



Signed Consent Form Does NOT Constitute Informed Consent

Before any patient is brought into the operating room, the circulating nurse is instructed to make certain that an operative permit or consent form is signed. In fact in some institutions, a patient may not be brought to the preoperative holding area unless the “consent form” is signed. However, a signed consent form must never be equated with obtaining informed consent. In 1914, Justice Cardozo in *Schloendorff v. Society of New York Hospital* ruled, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Though the courts have subsequently argued the boundaries of this theory, the obligation of “full disclosure” by the physician to the patient regarding the patient’s diagnosis and treatment remains uncontested.

While most physicians agree that patients should be “fully informed” they have no idea what legally constitutes informed consent. At a minimum, informed consent includes discussing with the patient his diagnosis, the physician’s treatment plan, as well as the risks and benefits of the proposed treatment plan. In addition, the physician must discuss alternative treatment plans as well as the prognosis of the disease with and without the various treatment alternatives. Whereas this seems self-evident to most physicians, the difficulty arises in determining exactly how detailed the discussion should be in each category. For example, should a patient who is to undergo a carotid endarterectomy be told that he/she could die as a result of the procedure? Should every patient who is to undergo a carotid endarterectomy be offered carotid angioplasty and stenting as a treatment alternative? Most courts have suggested that all reasonable risks and alternatives must be discussed. However this too is subject to significant controversy.

Over the years, the courts have given some guidelines to the medical community as to what needs to be included in a discussion of informed consent. The courts have suggested that all risks that potentially might affect a patient’s decision to proceed or not proceed with a planned treatment must be discussed. However, the courts have also emphasized that the physician does not have to read the patient’s mind as to what is important to the patient. A patient will not be permitted to claim after undergoing a resection of an abdominal aortic aneurysm that had he known he would have numbness in his incision postoperatively, he would not have undergone the procedure. It must also be remembered, that the informed consent standard is not predicated on what other physicians in the area consider informed consent but rather what is reasonable under the circumstances. However the courts have also stressed that the standard should be a national medical standard and not what the lay court or jury felt should be discussed.

Obtaining informed consent is a non-delegable duty. This means that informed consent must be obtained by the attending surgeon. A nurse, physician assistant, or surgical resident cannot obtain informed

consent for the operating surgeon. In truth one partner cannot obtain consent for another partner.

Finally, since we have many young vascular surgeons beginning in practice, let me issue a word of caution regarding quoting “literature results” to your patients. In *Johnson v. Kokemoor*, a patient was referred to a neurosurgeon for treatment of an enlarging basilar artery aneurysm. Following the procedure the patient was rendered an incomplete quadriplegic. The patient was also noted to have visual and speech disturbances.

At trial, plaintiff introduced evidence that the defendant overstated his experience with this type of aneurysm surgery. When asked about his experience, the defendant stated he performed the surgery “several” times. When he was asked what several meant, “the defendant said “dozens” and “lots of times”.

However, the defendant had only performed thirty aneurysm surgeries during his residency and all involved the anterior circulation. Plaintiff’s expert testified that anterior circulation aneurysm surgery is much less complex than posterior circulation aneurysm surgery. In addition the defendant had operated on only nine aneurysms following his residency of which only two were in the basilar circulation and neither was a large bifurcation aneurysm like the plaintiffs. The plaintiff further stated that the surgeon underestimated the morbidity of the procedure quoting percentages that if applicable at all would only apply to surgeons with extensive experience. Finally, the plaintiff introduced evidence that “patients with basilar artery aneurysms should be referred to tertiary care centers-such as the Mayo Clinic, only 90 miles away.” After an extensive analysis, the court ruled that the defendant’s lack of experience could be admitted into evidence. The court further concluded “a reasonable person in the plaintiff’s position would have considered such information material in making an intelligent and informed decision about the surgery.”

The courts have suggested that all risks that potentially might affect a patient’s decision to proceed or not proceed with a planned treatment must be discussed. However, the courts have also emphasized that the physician does not have to read the patient’s mind as to what is important to the patient.

Highlights of the SCVS ANNUAL BUSINESS MEETING

March 8, 2003, Miami, Florida

Report of the President

Dr. Ascher recognized Dr. Herbert Dardik, who has for over 20 years contributed his time and talents to build the SCVS into the tremendously successful society that it is today. Dr. Dardik served as President in 1984-85, Secretary/Treasurer from 1986 to 1993, and has been the Editor of the SCVS Newsletter since its inception. Dr. Ascher presented Dr. Dardik with a gift of appreciation from the SCVS.



Discussion by the Executive Committee on the SVS/AAVS merger resulted in the following consensus, which Dr. Peter Lawrence, as the SCVS Representative to the AAVS will take to the AAVS:

the SCVS encourages a more democratic council; the SCVS wants a seat on the new council; if democracy and representation occur, the SCVS supports merger; and the SCVS supports the name being the "Society for Vascular Surgery".

Regarding the American Board of Vascular Surgery and the denial of specialty certification to vascular surgery by the American Board of Medical Specialties, the Executive Committee has voted that the incoming SCVS President will send a letter to the ABMS suggesting that the process for ABVS application review was flawed in that the ABMS, ABS, and LCSB chose representatives from vascular surgery whose personal opinions did not reflect the majority opinion of vascular surgery and the vascular surgery societies' position advocating an independently identified specialty.

Report of the Secretary

Dr. Calligaro reported that the SCVS has 643 Active, 22 Honorary, 1 Inactive, 232 Senior, 1 Foreign Corresponding, and 88 Candidate Members for a total of 987 members. After elections, the SCVS Membership will be over 1,000 members.

Drs. Frank J. Veith and Robert W. Hobson, II have been voted Honorary Members of the SCVS.

The Executive Committee has engaged in the following activities over the past year:

- ♦ The SCVS joined Vascularweb to establish a web presence. The website can be located at scvs.vascularweb.org. The SCVS offers online dues renewal and is exploring electronic abstract submission and meeting registration for future meetings.
- ♦ The SCVS will not only post future newsletters online but will also once again mail paper copies to the membership.

- ♦ The Executive Committee voted to create an Advisory Committee to increase SCVS' visibility with public and private entities. The Advisory Committee will be comprised of the 5 immediate past Presidents and 5 SCVS members. The Advisory Committee will poll the membership to determine issues of great importance to the practicing clinician and determine the appropriate modality to give the SCVS membership a voice. For example, if the issue involves government reimbursement, the Advisory Committee would present the SCVS membership position on this matter to the AAVS/SVS Political Action Committee for consideration. Dr. Brown will work with management to develop the infrastructure.
- ♦ Dr. Anton Sidawy was appointed to serve as the SCVS Representative to the Vascular Disease Foundation for a term of one year.

Report of the Treasurer

Dr. O. William Brown reported on the First Quarter for Fiscal Year October 1, 2002 to September 30, 2003. As of December 31, 2002, the SCVS enjoys a comfortable financial position. The Executive Committee worked diligently to realize savings and will continue to do so. The Executive Committee revitalized fundraising efforts in support of the annual meeting, resulting in a total of \$120,500 in industry support.

Report of the Recorder

Dr. Alan Lumsden reported the SCVS received 182 Abstracts (42 more than last year) for review. Of the 182, 30 were selected for oral presentation and 35 for poster presentation. In addition, 10 abstracts were accepted for the Breakfast Sessions. He also stated that effective immediately, the *Journal of Vascular Surgery* requires online manuscript submission. The SCVS will continue to request one paper or disc copy at the time of presentation, but actual submission to *JVS* must adhere to the new online submission requirements. This should streamline the manuscript submission process.

Reports of Committees

Constitution and Bylaws Committee

Dr. Matthew Dougherty, Chair of the Constitution and Bylaws Committee, reported that the Bylaws Committee worked with Drs. Ricotta, Hodgson, and Sidawy to review and present proposed amendments to the Bylaws, which were subsequently approved by the SCVS membership.

Program Committee

Dr. Michel Makaroun reported that 136 member physicians, 94 guest physicians, and 7 allied health professionals for a total of 237 attendees participated in the outstanding annual meeting program this year. In addition to the exceptional science presented, Dr. Robert Hobson was the Hume Memorial Lecturer and Dr. Silva was the Distinguished Visiting Lecturer. New this year was the "How to Build Your Vascular Practice and Income" session, chaired by Dr. Money,

(continued on next page)

HIGHLIGHTS FROM THE ANNUAL BUSINESS MEETING

(continued from previous page)

created in response to the membership's request for non-clinical practical business information.

The AAVS' "Best of the Nationals" session at the Joint Vascular Societies meeting in June will include the best oral presentation given at this meeting and the presenter will go on to present his or her work at the SVS/AAVS meeting in June. The winner will be chosen at the conclusion of this meeting.

Dr. Lawrence reported that the Postgraduate Course was outstanding and it created added membership value. He thanked the Committee on Postgraduate Education - Bruce Brenner, Larry Hollier, and Enrico Ascher - for their work on this year's course entitled, "Expanded Noninvasive Testing: Does Your Lab Need to Add These?" and "Angio / AV Access".

Dr. Ricotta asked that the meeting venue and format be reviewed as this program, albeit excellent, was very long. It was suggested that the SCVS return to its previous format that allowed for some free time. Dr. Ascher asked that the membership direct all comments about the meeting format and venue to Dr. Hodgson and to Dr. Makaroun.

Election of New Officers

On behalf of the Nominating Committee, Dr. Ascher presented the proposed slate of Officers for election to serve for 2003-2004, subsequently approved.

President	Kim J. Hodgson, M.D.
President-Elect	Peter F. Lawrence, M.D.
Vice- President	Anton Sidawy, M.D.
Secretary	Keith D. Calligaro, M.D.
Treasurer	O. William Brown, M.D.
Recorder	Alan B. Lumsden, M.D.
Member-at-Large	Samuel R. Money, M.D.
Member-at-Large	Kenneth J. Cherry Jr., MD
Member-at Large	Michel S. Makaroun, M.D.

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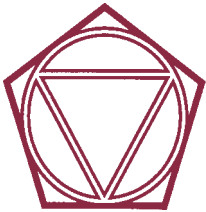
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