The Hidden Battle of the Sexes Affecting Your Practice

A man and a woman walk into your exam room. It sounds like the start of a joke, but gender—and racial—differences are no laughing matter when it comes to vascular disease diagnosis and treatment.

“There’s this perception that every patient that walks into a procedure room is the same,” said Maureen Kohi, MD. “But we’re not all interchangeable to older white men.”

Dr. Kohi will be one of the speakers at today’s Gender and Racial Disparities in Peripheral Interventions and Procedures session. The session has been designed to make practitioners think about how men, women and people of various ethnicities differ in terms of vascular disease presentation, treatments and outcomes.

NCVH chairman Craig Walker, MD, has described the female demographic as underdiagnosed and horribly mistreated. Often, a woman presenting with PAD or CLI symptoms is told that osteoporosis or arthritis are causing her pain. Dr. Walker said. And a woman is five times more likely to end up in a nursing home than a man, most commonly due to outliving her spouse.

Charisse Ward, MD, and Dr. Kohi share Dr. Walker’s passion for raising awareness about these differences, and commended him for adding this session to the NCVH agenda.

“My biggest stance is that in all of medicine, women are treated as if we are 70 kg men, and that’s a big issue and problem,” said Dr. Kohi. “The pathology and workups of why women have vascular disease may be the same as men, but we know there are additional conditions that affect only women. This impact how a woman presents.

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CLI Summit Takes a Deep Dive Into Treating a Deadly and Costly Disease

Just from the numbers alone, CLI is a growing healthcare crisis. During Thursday’s 14th Annual Critical Limb Ischemia Summit, Mary Yost, MBA, said CLI interventions account for the majority of PAD costs, at $134 billion to $248 billion.

Yost said in 2015, it was estimated that between 2 million and 3.4 million Americans suffered from CLI, but only 700,000 to 800,000 were treated. By 2030, the number of people with CLI is predicted to increase to 4.7 million, based on rising age levels alone. If skyrocketing diabetes diagnoses are also taken into account, CLI numbers could be higher.

Treatment costs increase with disease severity, Yost said. Only 54 percent of hospital admissions are due to primary CLI—the rest are the result of diabetes, sepsis, post-procedure complications and other factors. The readmission rate at 30 days is almost 27 percent, compared to 12 percent for ischemic stroke, she said.

CLI patients are currently treated for preventable risk factors like diabetes and smoking, which increases the risk of amputation or death eightfold, Yost said. In fact,

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NCVH Changes Outlook, Saves Limbs

Every healthcare professional has one patient who has left a lasting mark—someone they will never forget.

NCVH Chairman Craig Walker, MD, has spoken about a patient who said he had purchased a gun and was planning to take his own life if there couldn’t be some resolution to his severe leg pain due to ischemia. Dr. Walker did treat him, and he lived 12 additional years.

For Claude Minor, MD, that patient is a 16-year-old girl. In 2003, he performed a bilateral above-the-knee amputation on her, due to complications from renal failure. Shortly after the surgery, depression set in, and she died six months later. Dr. Minor, a father of five, said this case still gets him choked up.

He told himself at that time, “There had to be a better way.” Shortly afterwards, he came across a flyer for a vascular conference in New Orleans, and thought he’d check it out. “I walked into NCVH and here was Dr. Walker talking about limb salvage, balloons and stents,” he said.

After hearing Dr. Walker discuss how endovascular procedures could be an option for nonsurgical candidates, Dr. Minor walked up to the NCVH chairman and said: “I have to learn how to do this.”

Dr. Minor then spent the better part of the next two years under the tutelage of Dr. Walker. Dr. Minor estimates he worked on hundreds of cases with Dr. Walker before returning to Monroe, La., to begin offering his community this alternative to amputation.

It may not be surprising to hear that Dr. Minor’s new skills were not well-received by other healthcare professionals in his hometown, who still saw amputation as the only option.

“I was criticized by other surgeons and radiologists,” he said. “I was told this wasn’t the way to do it. It [endovascular procedures] is now the standard of care.”

Prior to attending his first NCVH, Dr. Minor said he performed anywhere from four to 12 amputations a month. His patient population had high rates of diabetes and renal failure.

“I came to NCVH doing amputations, and I left doing limb salvage.”
- Dr. Claude Minor

Dr. Clark Walker of NCVH Chairman Dr. Craig Walker and Dr. Claude Minor

He hopes that by speaking about the impact of amputations in this way, it may cause a surgeon to hesitate before performing a major amputation.

Another challenge Dr. Minor has faced is when a patient has already had one amputation and is looking at losing the other limb due to disease progression, which sometimes happens in less than six months. That would make everyday tasks such as using the restroom or rolling over in bed nearly impossible to do without assistance.

“With one limb is so important,” he said. “It’s so worthwhile to save that other limb. You’ll go to any means necessary.”

Dr. Minor hasn’t missed an NCVH since 2003, and this year, he brought his entire cath lab team with him.

“NCVH is always a great learning experience,” he said. “This is an ever-changing field.”

Why are you at NCVH?

“NCVH is a multidisciplinary educational platform focused on the development of a collaborative care vascular network. As podiatrists, we are entrusted with the care of patients with PAD and must serve as the gatekeeper of this dreaded disease. Recognizing the risk factors, clinical science, diagnostic options and innovative treatments are all imperative to saving limbs and saving lives.”

Frank Turisi, DPM

Dr. Eric Dippel comments on a live case transmission from Italy.

Friday, June 1, 2018

CLII

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Dr. Walker said this allows a doctor to assess plaque morphology and vessel sizing, determine the location and extent of calcium, and provide more detail about lesion morphology and geometry. IVUS also requires less use of fluoroscopy and angiography, which reduces radiation exposure.

But despite these advantages, “we are underutilizing a wonderful tool,” Dr. Walker said.

Specific Treatment Strategies

Barry Bertolet, MD, opened the afternoon session with a presentation on the role of antegrade femoral access in CLI interventions.

Antegrade femoral access allows for better wire manipulation and device interaction with the lesion, Dr. Bertolet said. It also encourages superior push of devices, which avoids prolapse into the aorta from contralateral access; better reach of devices to tibials; use of devices too large for pedal access; and less contrast use.
If you’re not already in the CTO field, now’s a great time to enter, said Owen Mogabgab, MD, as he kicked off the Thursday session. Similarities in the Treatment of Critical Limb Ischemia (CLI) and Coronary Chronic Total Occlusions (CTOs): Lessons We Can Learn From Each Other.

Treating coronary CTOs allows physicians to administer to patients and not the anatomy, Dr. Mogabgab said. Often, CTO patients suffer from symptoms for months to years, not days to weeks.

“We can offer therapy to patients who are told they have no other options, much like a patient who’s told they need an amputation,” he said.

Benefits to patients include a reduction in angina, increase in LV function, fewer future consequences of ACS, fewer arrhythmias/ICD shocks, and less need for CABG and nitrates. For providers, Dr. Mogabgab said treating CTOs improves operator skills and boosts PCI volumes.

Dr. Mogabgab said there are two randomized, controlled clinical trials evaluating CTOs.

The DECISION-CTO trial involved 834 patients. There was a 91.1 percent success rate, but the trial showed no benefit of CTO over medical therapy. However, Dr. Mogabgab said 77 percent of patients in the OMT group had multivessel disease and got PCI for all of the non-occlusive vessels. The trial was shut down early for lack of enrollment, and has yet to be published more than a year later—perhaps because of these issues, he said.

The EUROCTO trial included 396 patients, with an 86 percent success rate. Dr. Mogabgab said this trial showed across-the-board significant improvement in angina and quality of life after 12 months, with similar MACE rates. The study was published in the European Heart Journal this month.

“It’s going to be hard to ignore the results of this randomized trial,” Dr. Mogabgab said.

Jack Casas, MD, said CTO requires operator and staff training, along with new equipment and tools. This can be challenging and expensive, but “clearly we need something different from vein graft bypass, which has been around for seven decades—but five-year patency has been unchanged, at 30 to 50 percent, over the

**Why are you at NCVH?**

“I am at NCVH, along with my cath lab team, because NCVH has a message that needs to be spread. Patients still undergo amputation without knowing about limb salvage. Surgeons think it’s a quick fix, but they don’t understand the impact on the family unit, as this person now needs to be cared for 24 hours a day.”

_Claude Minor, MD_
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Go West: Salt Lake City Joins NCVH Regional Family

Sachal Khan, MD, first attended NCVH as a cardiovascular fellow, knowledge of PAD or CLL. He now points to limb salvages as one of his passions, and will serve as co-chairman of the inaugural NCVH Salt Lake City regional conference, scheduled for next February.

He sees NCVH’s educational offerings to Salt Lake City because it is one of the country’s fastest growing cities, with a rising population of older Americans and greater incidence of diabetes.

“The PAD market is underserved in Utah, with the number of amputations performed each year growing,” said Dr. Khan. “We need to bring NCVH’s multidisciplinary approach to Utah, so that we can brainstorm, educate and learn from each other.”

He feels that the minds of the healthcare community need to change. The conference program will focus on PAD awareness and the importance of limb salvage programs, along with discussion of venous disease and structural heart disease.

“The endovascular revolution has not happened in Salt Lake City,” he said. “We can change the paradigms in the community.”

The primary focus of the Salt Lake City regional will be awareness and emphasize the teamwork aspect of PAD patient care.

“We need to show how amputation impacts lives and puts a huge financial burden on our healthcare system,” said Dr. Khan. “By preventing amputation, we can improve quality of life and lessen healthcare costs.”

Log pain from PAD can be debilitating. Dr. Khan’s efforts to improve their children’s lives play a large role in his patients.

“I have noticed that my limb patients are more appreciative than my heart patients,” he said.

Dr. Khan hopes attendees will join him at NCVH for the medical education, then stay to enjoy Utah’s great outdoors. Don’t forget to pack your skis!

CTOs Continued from page 4

past two decades,” he said.

Treatment of CTOs requires patience, knowledge of many devices, expertise in the devices one uses and, with healthcare in 2018, fiscal responsibility for sustaining a solvent vent program. If your lab loses money, you will lose your lab,” Dr. Casas added.

Wires, Catheters and Imaging

Srinivas Iyengar, MD, said coronary CTO training has been growing, and there are now centers of excellence devoted to the treatment of coronary CTOs. Multiple wires have been developed to facilitate crossing and in conjunction with wires, catheters have been developed to assist and support wire crossing.

Think of these catheters like an offensive line in football, and the wire like the running back, Dr. Iyengar said. Without the line to block for the back, the back can’t advance. Catheters do the same job for wires, he said.

Dr. Iyengar said the catheters that work best for PAD are .014 inch and .018 inch. “Avoid bulky .035 inch systems if possible,” he said. Other considerations include hydrophilic function, pushability, tip angulation and support.

Alvaro Alonso, MD, discussed the role of imaging in CTOs. In the past, he said, anatomy dictated whether to attempt revascularization. But now, anatomy determines the strategy for successful intervention. Imaging is key in identifying the difference.

In addition, “adjunctive imaging can be helpful in CTO revascularization procedures beyond identification of the total occlusion,” Dr. Alonso said. Key benefits include predicting the clinical benefit of revascularization, procedural planning, intraprocedural guidance and long-term follow-up.

Protected PCI and Algorithms

James McCabe, MD, tackled the topic of protected PCI. “It’s the wild west, and the field is wide open,” he said.

Support devices are tools to facilitate comprehensive PCI but are not an end in themselves, Dr. McCabe said. He also noted that “probably no single trigger mandates PCI support. Rather, an aggregation of concerning hemodynamic, patient substrate and anatomic features must be considered.”

Eric Armstrong, MD, discussed whether progressive algorithms used to treat coronary CTOs can be applied to CLI interventions. His conclusion: Combining antegrade and retrograde crossing strategies can dramatically increase procedural success rates. Anatomical, flow morphology, calcification and occlusion length may help determine the optimal crossing strategy.

“The key is to switch strategies and utilize all possible crossing approaches,” he said.

New Product Showcase

HyperMed Imaging

HyperMed’s new product called HyperView™ is a smaller, faster, easier to use device for applications including wound care, amputation, vascular surgery, and reconstructive surgery. HyperView™ is intended for use by physicians and healthcare professionals as a non-invasive tissue oxygenation measurement system that reports an approximate value of oxygen saturation (O2Sat), oxyhemoglobin level (Oxy), and deoxyhemoglobin level (De- oxy). The superficial tissue oxygenation system displays two-dimensional, color-coded images of tissue oxygenation of the scanned surface. Diagnostic images and data can be exported to a PC through the provided docking station.
Disparities
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with vascular disease, as well as the treatments and outcomes.”
Dr. Ward said there are similar challenges in regard to other types of cardiovascular disease.
“Prior to efforts to increase education and awareness, we didn’t know how coronary artery disease impacted women differently,” she said. “Programs like NCVH serve to educate the public about the true prevalence of disease in each community, along with the individual and socioeconomic impacts in women and ethnic minorities. More research needs to be done on this issue, along with determining what the barriers to care are.”

Lack of Clinical Trial Participation
Another issue cited by both Dr. Ward and Dr. Kohi is the disproportionate number of Caucasian men included in clinical trials.
“Women and ethnic minorities are wholly underrepresented in clinical trials, so we really don’t know how unrepresented groups respond to device therapies and currently accepted treatments,” said Dr. Ward.
Dr. Kohi said there’s been a mandate from the FDA that clinical trials be more inclusive of minority groups. “We have great data for older white men, but we can’t do subgroup analysis because that data is not as robust,” she said. “We can’t assume, based on outcomes, that they are applicable to a wide group of patients.”

The Patient Benefits
Some of the key takeaways from today’s session are that women present with PAD at a later stage than men, and are often sicker and older. “We need to look at the outcomes and understand why they aren’t the same,” said Dr. Kohi. “Does it require different devices? Do some drugs work better in women than in men?”
Understanding that sex and ethnicity have an impact on disease presentation and outcomes is critical.
“You’ll be a better doctor if you think that way, and you’ll continue to improve and learn how these differences affect patients and their outcomes,” said Dr. Kohi. “We want to perform procedures that help patients. We need to feel better about doing something to help the patient appropriately.”
NCVH attendees can play a role in building awareness about what’s needed, both in terms of education of the healthcare community and the role that industry can play in moving things forward.
“I am hoping that attendees are made aware of the alarming discrepancies in the diagnosis and treatment of peripheral vascular disease, see the opportunities to understand why the disparities exist, and identify the potential to close this gap and play a transformative role in the way healthcare is delivered in America,” said Dr. Ward.

NCVH Expands into the Deep South

NCVH’s fall calendar of regional meetings has expanded, with the addition of NCVH Meridian on October 27 at the MSU Riley Center. Co-chaired by Wes Bennett, MD, and Craig Walker, MD, the conference hopes to have an impact on the greater regional healthcare community that treats peripheral vascular disease.
“We believe strongly in the mission of NCVH and the quality of the education the symposiums provide,” said Dr. Bennett. “Mississippi has a very high prevalence of PVD and our intention is to use this platform to educate our medical community on options for treatment that provide great outcomes and lower amputations.”
Topics to be covered on the day-long agenda include coronary artery disease, PVD, and rhythm management, along with an update on the current healthcare industry.
“Our hope is that the community leaves aware of the best options to care for their patients and how those options are offered right here in Mississippi so their patients do not need to travel,” said Dr. Bennett.

While the conference is being held in Meridian, Dr. Bennett hopes to draw primary care providers, hospital staff, administrators and nurse practitioners from throughout the region, including Jackson, Miss., Starkville, Columbia, and Tuscaloosa.
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