Wednesday Highlights

8:00 AM - 6:00 PM
General Session
Crescent City Ballroom

9:00 AM - 7:30 PM
Exhibit Hall Open
Roosevelt Ballroom

8:00 AM - 11:30 AM
RCIS Review Course
Chambers I and III

10:00 AM - 3:10 PM
Podiatry and Wound Care Session
Blue Room

10:00 AM - 3:20 PM
Healthcare Professionals Forum
Waldorf Astoria Ballroom

6:00 PM - 7:30 PM
Exhibitor Reception
(All Invited)

Enter to Win!
Don’t miss our daily gift card drawings. To enter today’s drawings, visit five exhibit booths and collect five different business cards from exhibitors in the 100 aisle. Write your name and badge number on the back of the card holders and place in the drawing box. Drawings will be held at 6:30 p.m. in the exhibit hall. Must be present to win.

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NCVH sets an attendance record for its Fellows Course.

What’s on the Horizon?

WEDNESDAY | MAY 30

Work Continues on Lower Amputation Rates and PAD/CLI Awareness

NCVH brings healthcare professionals from around the world to New Orleans every year for a week of medical education focused on PAD, CLI, and vascular and venous diseases. But the organization’s reach doesn’t end here. Regional and international conferences, training programs, and yesterday’s Fellows course support the organization’s goal of increasing awareness about these deadly diseases.

“We feel we’re impacting changes in patient care,” said Craig Walker, MD, NCVH chairman. “There is more understanding and greater awareness about how to treat these diseases. We’ve reached the point where we can treat all these patients in advanced-care centers, and as a result lower amputation rates.”

Tuesday’s agenda included record attendance at the NCVH Fellows Course and an expanded Business of Peripheral Interventions course, which featured a keynote presentation by Congressman Garrett Graves.

“We think this keynote is important because PVD is not given the attention it deserves in medicine,” said Dr. Walker. “It’s widely unrecognized as a major issue, but has higher costs compared to coronary disease. And it’s just not among people who cannot afford care. It’s a lack of knowledge across the board.”

However, he’s encouraged by the potential that office-based labs offer for PAD and CLI patients.

“Office-based labs allow us to treat patients at approximately one-third of the cost of traditional hospital,” said Dr. Walker. “There are also higher rates of patient satisfaction at office-based labs.”

Another new avenue discussed during the business course was the benefits of telemedicine, which creates opportunities for healthcare professionals to lend expertise to patients who may not otherwise have access to specialized care.

A hallmark of the NCVH Annual Conference continues to be the live cases.

“You will see world experts doing difficult cases,” said Dr. Walker. “The audience is exposed to the thought process of the operator, giving them the confidence that this is something that can be performed with training.”

Today’s general sessions will focus on the great ves-

Today’s Live Case Schedule

8:40 – 9:00 a.m.
Thomas Zeller, MD
Universitäts-Herzzentrum
Freiburg - Bad Krozingen
Bad Krozingen, Germany

9:00 – 9:20 a.m.
Marco Manzi, MD
Mariano Palena, MD
Policlínico Abano Terme
Abano Terme, Italy

10:40 – 11:00 a.m.
Marco Manzi, MD
Mariano Palena, MD
Policlínico Abano Terme
Abano Terme, Italy

11:00 – 11:20 a.m.
Thomas Zeller, MD
Universitäts-Herzzentrum
Freiburg - Bad Krozingen
Bad Krozingen, Germany

1:30 – 2:10 p.m.
Tom Davis, MD
St. John Hospital
Detroit, MI

2:10 – 2:30 p.m.
Thomas Shimshak, MD
Florida Hospital Heartland
Medical Center
Sebring, FL

4:30 – 4:50 p.m.
Thomas Shimshak, MD
Florida Hospital Heartland
Medical Center
Sebring, FL

4:50 – 5:10 p.m.
Tom Davis, MD
St. John Hospital
Detroit, MI

Fellows Course Sets Attendance Record

Craig Walker, MD, welcomed a record 138 Fellows to NCVH’s 8th Annual Fellows Course, Complex Strategies for Peripheral Interventions, on Tuesday, May 29.

“How can I tell you how excited I am!” he asked. “You’re the ones who will shape the future of what we do. You are the future of PAD.”

Dr. Walker spoke about how NCVH’s education initiatives are working to reduce the trend to “cut off the leg first, think second” when treating PAD patients. “That’s still the case in some places, but it’s changing. Amputation rates are falling – our message is starting to resonate that we can improve patient care.”

He also pointed to advances in technology that are improving treatment outcomes, noting that “lesions we couldn’t have even dreamed of crossing are now commonplace.”

Continued on page 6
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Peripheral Interventions: Essential for Every Patient and Hospital

Programs to treat PAD and venous disease are often not front of mind among hospital administrators. In fact, most hospitals view PAD and venous diseases as secondary, tertiary or even quaternary issues, said NCVH Chairman Craig Walker, MD.

But the reality is that PAD and venous disease screening and other early detection measures are essential to every community, hospital, interventional lab and patient, Dr. Walker said during the opening remarks for Tuesday’s day-long “The Business of Peripheral Interventions” course.

“There is a great opportunity to save lives, save limbs, improve quality of life, lessen overall healthcare expenditures and have a successful business model,” he said.

The morning session included a variety of presentations emphasizing the importance of peripheral interventions.

Can a Complete Peripheral Vascular Program Improve a Community’s Health?

Dr. Walker cited the PARTNER trial, which showed that a minimum of 29 percent of patients over age 70, or ages 50 to 69 with diabetes or who were smokers, had PAD as defined by ankle-brachial index.

“It’s very apparent these people are not going to diagnose themselves,” he said, noting that only about 12.5 percent had typical PAD symptoms.

As the ABI falls, so does survival. Dr. Walker pointed out that a person with an index of less than 0.8 who is asymptomatic has a worse five-year prognosis than a woman with breast cancer.

Dr. Walker noted that PAD and CLI affect many parts of the body, “but you may get 100 treatments in the legs because we haven’t created a best-case diagnosis.”

“For some reason, it is considered conservative treatment to chop someone’s leg off and aggressive treatment to even do an angiorrhaphy,” he said. “The problem is our definitions are upside down, backwords, they’re stupid. We need to inject some common damn sense.”

Dr. Walker believes no one should have an amputation without a team evaluation that includes a nurse coordinator, interventionalists, open surgical revascularization specialists, infectious disease personnel, podiatrists, diabetologists, wound-healing experts, and dialysis and smoking cessation professionals.

Continued on page 8

Congressman Says U.S. Healthcare System Provides ‘Persevering Incentives’ for Innovation and Outcomes

Healthcare has more government regulation than any other sector in our economy. And yet costs are rising and innovation and outcomes are not being rewarded, said Louisiana Congressman Garret Graves during Tuesday morning’s keynote address.

“We’ve seen healthcare premiums in Louisiana increase 140 percent since Obamacare was enacted,” said Graves, a Republican who represents the south-central

Continued on page 10

Indications for Use
The INACT™ Adelence™ PTA Catheter is indicated for percutaneous transluminal angioplasty, after appropriate vascular preparation, of the femoral, iliac, or subclavian arteries or lesions involving the common, external, or internal iliac arteries with lesions up to 360 mm in superficial femoral or popliteal arteries with reference diameters of 4-7 mm.

Contraindications
The INACT™ Adelence™ DCBs are contraindicated for:
- Coronary arteries, renal arteries, and supra-aortic/torso/brachiocephalic arteries
- Patients who cannot receive recommended antiplatelet and/or anticoagulant therapy
- Patients judged to have a lesion that presents complete intima of an angioplasty balloon or proper placement of the delivery system
- Patients with known allergies or sensitivities to paclitaxel

Warnings
- Do not use the product if the inner coating is damaged or removed.
- Do not use air or any gaseous medium to inflate the balloon. Use only the recommended inflation medium (equivalent part contrast medium and saline solutions).
- Do not use the balloon for more than a 1 (one) inflation of the INACT™ Adelence™ DCB.
- Do not exceed the recommended burst pressure (BRP). If the BRP is 4 atm (60.935 PSI) is based on the results of in vitro testing, use of pressures greater than BRP may result in a ruptured balloon with possible intimal damage and dissection.
- The safety and effectiveness of using multiple INACT™ Adelence™ DCBs with a total drug dosage exceeding 1.64 mg/patient in a patient who has not already been clinically evaluated in the INACT™ TRIA Trial.

Precautions
- This product should only be used by physicians trained in percutaneous transluminal angioplasty (PTA).
- The product is customized for single patient use only. Do not reuse, reprocess, or resterilize this product.
- Reste, reprocessing, or resterilization may compromise the structural integrity of the device and/or create a risk of contamination of the device, which could result in patient injury, illness, or death.
- Assess risk and benefits before treating patients with a history of severe reaction to contrast agents.
- The safety and effectiveness of the INACT™ Adelence™ DCB used in conjunction with other drug-coated stents or drug-coated balloons in the same procedure or following treatment failure has not been evaluated.
- The patient’s exposure to the drug coating is directly related to the number of balloons used.

For the Instructions to Use (IFU) for details regarding the use of multiple balloons and paclitaxel coated balloon.

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Vessel preparation using only pre-dilatation was studied in the clinical study. Other methods of vessel preparation, such as atherectomy, have not been studied clinically with INACT™ Adelence DCB.

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Refer to the Physician’s Desk Reference for more information on the potential adverse effects observed with paclitaxel. There may be other potential adverse effects that are unforeseen at this time.

Please reference appropriate product Instructions for Use for a detailed list of indications, warnings, precautions and potential adverse effects. This content is available electronically at www.manulns. medtronic.com.

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2 Based on clinical data for drug-coated balloons indicated to treat LSA lesions (D 180 mm) compared to Lutone™ IFU BW13187/4003/0 and Silhouette™ IFU PUD 1966-B. Silhouette is not indicated to treat lesions longer than 180 mm. Definitions of patency may vary for different studies.
3 Primary patency is defined as freedom from core laboratory–assessed restenosis (duplex ultrasound and/or clinically driven target lesion revascularization through 12 months post-device or at the clinical events committee blinded to the assigned treatment). Patency per Kaplan-Meier estimates at 12 months (95% CI).

Medtronic Further, Together.
Embolization was once considered to be the property of interventional radiologists. It has been used to treat cancer, stop hemorrhage and redirect flow – and recently made the news, courtesy of First Lady Melania Trump.

But in recent years, embolization’s applications have expanded, making it an timely topic for today’s afternoon session.

“We wanted to appeal to a broader audience that seeks information on embolization,” said Robert Beasley, MD. “This session will speak to all specialties.”

Adding the topic supports NCVH’s mission to provide better patient care.

“We want our attendees to have a basic understanding of what embolization is and many of the common ways it can be used,” said Timothy Yates, MD. “We want our viewers to think of ways they can grow their practice and offer their patients more options. If this engenders new treatment strategies across specialties, well, even better. We also want to serve as a resource to attendees, not only now but going forward as colleagues. Vascular surgeons, interventional cardiologists and interventional radiologists should grow together as vascular specialists—not isolate practices.”

Embolization also has crossover applications for arterial disease.

“As an example, patients with fibromuscular dysplasia (FMD) can develop visceral aneurysms, particularly in the arteries of the kidney,” said Bret Wiechmann, MD. “A few patients from my own practice come to mind, where we successfully treated their hypertension due to FMD, but they were also noted to have a renal artery aneurysm which required coil embolization.”

Dr. Yates echoed those sentiments.

“We have all heard that “there is more than one way to skin a cat.” He said. “This holds true here as well. A surgeon may ligate a vessel for hemo-stasis, while a radiologist might embolize it. Considering both options and being adept at both enriches the specialist’s practice, but also may spawn the next generation of therapy that may be superior to our current tools. I would much rather be at the dinner table, than being what is for dinner. We need to enhance one another for our patients’ benefit.”

Another potential embolization application is AAA repair.

“Having a basic knowledge of embolization can be extremely beneficial in any practice,” said Nicholas Petruzzi, MD. “Endovascular embolization plays a role in AAA repair, where basic coil embolization can prevent or treat endoleaks for AAA. It can also treat benign, symptomatic uterine fibroids with particles. And there are even more advanced embolization techniques such as treating malignant liver tumors with radioactive microspheres.”

A discussion about embolization requires one to think differently, however.

“The benefit of this session is to really open the eyes of attendees as to what embolotherapy can provide to patients,” said Dr. Wiechmann. “So much of what we tend to focus on in the vascular world is ‘opening up’ blood vessels that may be obstructed. Gaining knowledge about how to intentionally ‘block’ vessels to improve patients’ lives can be equally as important.”

Jos van den Berg, MD, said there can be times during an endovascular procedure that could require the embolization of side vessels.

“It’s important to have these skills for troubleshooting,” he said. “If you have a complication during a procedure and can handle them yourself, it’s better and faster.”

Yet more and more today, patients seek minimally invasive alternatives, and embolization falls into that category.

“It is important that patients are offered alternatives to classic surgical options, which include highly effective, minimally invasive embolization techniques,” said George Vatackencherry, MD. “We hope attendees learn more about the role of embolization in various disease processes throughout the human body for both emergent and elective conditions.”

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**Why are you at NCVH?**

“As an interventional cardiologist and vascular specialist, this is my passion. I have a lot of patients that suffer from PAD. Learning new treatments and learning new device technology is the way I impact my patients and the way I impact the medical community I am a part of.”

— Charlisse Ward, MD
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Embolization Added to Fellows Program

As NCVH’s Fellows Course grows in size, so does the scope of material covered during the day-long program. In addition to new topics, attendees rotated through nine hands-on stations, learning from faculty about procedure techniques and working with devices.

Carlos Mena, MD, chairman of the Fellows Course along with Robert Beasley, MD and Craig Walker, MD, attributed the record attendance this year in part to NCVH’s focus on building one of the country’s strongest fellow programs.

“Fellows are the future,” said Dr. Mena. “Investing in them and preparing them to deal with the challenges ahead is key for the adequate management of patients with PAD.”

While some of the core competencies remain the same, such as focuses on wire technology and devices, embolization is a new topic integrated into the course agenda.

“We wanted to make the NCVH Fellows Course more accessible to all the fellows in all the specialties and disciplines around the country that will eventually perform procedures related to PAV and treat patients with CLI,” said Dr. Beasley.

One of the reasons for adding new topics this year was to educate more specialties about these dangerous and deadly diseases. The majority of attendees at past fellows courses have represented the field of interventional cardiology. Adding new topics such as embolization creates opportunities for greater outreach among interventional radiology and vascular surgery fellows.

In some of their fellowship programs, they get very limited exposure to PAD and techniques, and treatment and devices,” said Dr. Beasley. “We provide a strong overall representation, with a heavy emphasis on PAD and CLI.”

Presentations during yesterday’s program covered both basic and advanced embolization techniques, as well as aneurysm repair—another new topic. Venous disease, while not new to the agenda, was also covered in greater depth.

“Venous disease has been overlooked, but it is so prevalent in the United States. We’re not seeing how severe it is,” Dr. Beasley said. “New procedures and techniques are being developed to treat venous occlusion, varicose veins, severe venous ulcers through endovascular procedures.”

Feedback from past attendees has showed that the NCVH Fellows Course is having an impact on patient care.

“We open their eyes,” said Dr. Walker. “Fellows have said they were completely enlightened as to what could happen, said they’ve often never seen many of the procedures that are performed during our live case sessions.”

Fellows
Continued from page 1

Must Look for PAD

Dr. Walker said one of the biggest obstacles for treating PAD and PVD is that many patients are asymptomatic, and therefore go undiagnosed. Diminished foot pulses may be the only signs of advanced disease.

“We’re missing an opportunity to start preventive care that can stop them from dying from a heart attack or stroke, or preventing progression to ischemia,” he said. “This is a massive healthcare problem, and one that we can leave a mark on.”

Dr. Walker implored the attendees to look for PAD, because otherwise they won’t find it. But he also warned that it’s not just about the lower extremities. “You must treat the whole patient,” he said, using the example of how an interventional procedure relieved a patient’s impotence, among other things — and that’s what resonated the most with this individual.

“I ask you, as young physicians, to keep an open mind,” Dr. Walker said. “Don’t accept any truism as absolute.”

Why are You Attending the NCVH 2018 Fellows Course?

“I have seen first-hand the devastating effects that vascular disease can have on patients and their families. I am attending the NCVH Fellows course to improve my skills and knowledge to better care for patients.”

Matthew Czar Taon, MD
Los Angeles, Calif.

“NCVH is one of the leading international meetings in cardiovascular surgery. It will propose new concepts and discuss the latest technology. I want to obtain more information and gain more experience.”

Binshen Zha, MD
Anhui, China

“As an incoming interventional cardiology fellow I am interested in peripheral vascular disease and I was looking for an opportunity to get a little bit of a head start in an important aspect of the field. General fellowship allowed for good exposure to the outpatient management of PAD but our time in the cath lab was appropriately focused on coronary basics. I saw this course as an opportunity to enhance my knowledge of the medical/noninvasive management of PAD while also gaining important insights into the technical aspects of peripheral interventions.”

Joseph J. Ingrassia, MD
Hartford, Conn.

“I am attending the NCVH 2018 fellows course to equip myself with skills necessary for complete Cardio-Vascular care by learning from leaders in the field.”

Ramprakash Davaud MD

“The NCVH fellow’s course is a fantastic opportunity to meet and network with other like-minded, up and coming health care providers, who are interested in devoting a significant portion of their careers to the care of patients with peripheral vascular disease. It’s a good venue to obtain hands-on training, meet stellar clinicians and ask questions in a laid back and comfortable setting.”

Pedro Calderon, MD
Royal Oak, Mich.

“I’m attending the NCVH fellows course and conference because I want to make sure that I have the knowledge I need to be able to provide quality, evidence-based care to my patients as I begin practicing on my own this year. When I became a doctor and, specifically, an interventional radiologist, I committed to be a life-long learner. Part of my job is staying on top of the newest developments in my constantly evolving field. Attending meetings and courses is one way I hope to fulfill that responsibility.”

Michael H. Secrist, MD
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NCVH Chairman
Craig M. Walker, MD

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Overall, he said, “We’re getting people by the time their foot is unsalvageable. We have to get to these patients earlier. PAD can be the key to diagnosing and treating other cardiovascular diseases. Sick legs are rarely attached to healthy people.”

Economic Cost of Peripheral Artery Disease, Critical Limb Ischemia and Venous Disease: How Big is the Market?

Mary Yost, MBA, The Sage Group, cited figures from her group showing that PAD affects more people than cardiovascular disease, stroke and all cancer diagnoses combined. PAD also accounts for $223 billion to $414 billion per year in inpatient and outpatient costs. But diabetes, CVD and all cancer treatments total only $88 billion.

Yost also noted that Medicare and Medicaid pay 80 percent of these PAD expenses. “These are our tax dollars at work here, and they’re not working very well,” she said.

Yost also pointed out that since 2003, CLI patients have become sicker. Only 54 percent of hospital admissions are due to primary CLI; the rest are due to diseases like hypertension and diabetes.

“Venous disease is the most common chronic disease, but it’s underestimated, undiagnosed and undertreated,” she said.

Which Patients Should Have Peripheral Vascular Screening and Why So Many Patients are Missed: The Lost Opportunity

“There are only about 50 to 80 physicians nationwide who are passionate about PAD. General practitioners must be engaged in prognosis and treatment of this disease,” said Osama Ibrahim, MD, North Memorial Health Care.

PAD has similar characteristics to cancer—it’s progressive, asymptomatic, usually identified too late, and has significant morbidity and mortality, he said. It’s also extremely prevalent, with numbers on the rise. But PAD doesn’t have the same screening procedures as cancer.

“Every practitioner knows about earlobe bruises, colonscopy and mammograms, but you ask them an ABI and they say what is that?” Dr. Ibrahim said. And yet, ABI is a very fast, inexpensive and effective test—equivalent to an electrocardiogram for cardiovascular disease—and it’s in the guidelines.

Dr. Ibrahim discussed North Memorial Heart and Vascular Institute’s free PAD screening program, which focuses on diabetics and smokers. He said doctors convinced administrators to pay for the program by doing a pilot study showing that 40 percent of patients had positive PAD screenings.

The program has screened 1,000 patients over the past two years. Thirty percent had PAD, and most had unrecognized symptoms for years and were misdiagnosed. All patients received risk-factor modification and were placed in U.S. surveillance programs. The majority also enrolled in supervised exercise programs. Dr. Ibrahim said.

The Cost Analysis of Amputation vs. Revascularization and the Impact of Treating Critical Limb Ischemia Patients: Benefits to Hospital

Larry Diaz-Sandoval, MD, Metro Health Hospital, discussed how to justify lengthy, complex and costly CLI procedures to hospital administration.

He said a Markov probabilistic model was used to simulate five-year survival of 100,000 hypothetical patients with diabetes, and found that primary prevention was at least 90 percent likely to provide cost savings.

Dr. Diaz-Sandoval also noted that PAD patients average 2.7 procedures per year, with a 13.2 percent profit margin. They create downstream revenue through cardiac and parietal workups, AAA screening, venous workups, AV fistula programs, recurrent interventions, wound care and follow-up programs. In addition, “satisfied patients are more likely to refer their friends and family to your facility,” he said.

“The elephant in the room” is physicians’ rejection of approaches and technologies due to a lack of awareness and understanding. Dr. Diaz-Sandoval said. Competition versus collaboration can also hinder an interdisciplinary team approach.

An Overview of CMS and the New FDA Changes

Ken Waksman, MD, MedStar Heart & Vascular Institute, said in 2009, the prevailing perception in the U.S. was that healthcare regulation was unpredictable, inefficient and expensive. Lengthy approval times were also jeopardizing America’s leadership in medical device innovation.

But since then, the perception has changed. For instance, he said, Early Feasibility Studies (EFS) are giving device manufacturers an incentive to start studies in the U.S. instead of overseas. During the first series of EFS in 2015-17, Dr. Waksman said more than 50 companies participated. There were more than 120 early feasible investigative device exemptions, which is over 50 percent higher than in the past.

“In the past nine years, novel device approval increased fourfold,” he noted. “By Dec. 31, 2020, more than 30 percent of manufacturers of novel technologies for the U.S. market intend to bring their devices to the U.S. first or in parallel with other major markets.”

Dr. Waksman said the FDA vision has also changed, including looking more at benefit-risk relations as opposed to solely concentrating on safety.

“The FDA feels our pain,” he said. But the problem is that the FDA and CMS have separate authorities under statute.

“It’s up to the government to make the cuts as it sees fit,” Dr. Waksman said. “I think the FDA has transformed to a dynamic regulatory organization, with more devices approved in a timely fashion. But if we don’t change the laws and the regulations, the FDA are just civil servants.”

The Role of Telemedicine in 2018 and Beyond

David Konur, FACHE, Cardiovascular Institute of the South, said last year, 52 percent of Kaiser Permanente’s patient transactions were conducted online. When one of the nation’s largest healthcare systems embraces virtual medicine and telemedicine to this extent, it’s because the delivery system actually works, he said.

“But in cardiology, we haven’t done a very good job of adopting this technology,” Konur said. Challenges include lack of reimbursement, physician’s prior poor experiences with low-tech virtual medicine, and a lack of standardized telemedicine platforms.

Konur said his facility’s virtual care center touches one patient every minute, every day. He cited case studies showing that telemedicine is particularly effective for engaging with rural hospitals, easing the burden of subspecialists traveling to low-volume sites, collaborating with leading subspecialists and providing international coverage.

The Cardiovascular Coalition: Navigating the Changing Reimbursement Landscape

Janet Does, BS, American Vascular, said the Cardiovascular Coalition was formed in response to the 2014 PPS proposed cuts, which would have slashed office-based labs’ (OBL) key codes by 50 percent. But as the result of advocacy efforts, the PPS final rule significantly mitigated the cuts.

Does said since the coalition was formed, there has been more positive media about PAD interventions, reinstatement of PAD Awareness Month, an increase in comment letters to about 40,000 months of regulatory agencies, collaboration with several CMS subcommittees and key members of Congress, participation in legislation regarding amputations, and an impact on future reimbursement rates.

Currently, the Coalition has eight companies and represents 149 of the estimated 600 national OBLs doing PAD.

“Our voice needs to be heard proactively rather than reactively in July of every year for new fee schedules which become effective in January,” she said. “Together, we can save one leg at a time.”

My Personal Experience with Limb Salvage

Fred Goad Jr. of Nashville, Tennessee, said he visited his doctor after a wound on his foot wasn’t healing. He was a regular exerciser in good health and had no symptoms of PAD, but the hair wasn’t growing on his lower legs.

Goad said he tried a variety of treatments, including Pilates, acupuncture and being placed in a hyperbaric chamber every day for 40 days. None of them were effective.

Finally, a doctor did a vascular CT scan and found his legs were totally occluded. Goad said he had a seven-hour surgery at the Cleveland Clinic, but the doctor was unable to get blood flowing to Goad’s feet. The doctor recommended that both of Goad’s legs be amputated.

Another doctor recommended that Goad call Dr. Walker. “He seemed like he really understood peripheral artery disease better than any other doctor did. He prevented amputation and saved my quality of life,” Goad said.
New Healthcare Professionals’ Forum Starts Today

The NC VH agenda has frequently included programming geared towards allied health professionals treating PAD and CLI patients. Some courses have focused on nursing, while others targeted technologists.

As planning began for this year’s NC VH, the program committee decided to revamp these courses, and created the NC VH Healthcare Professionals Forum.

Comprising four sessions over the next two days, the forum will provide a comprehensive look at developments in the diagnosis and treatment of cardiovascular disease.

“Just like the frequent changes and advances in medicine, this program needs to stay current and remain open-minded to change,” said Valerie Harris, a member of the course’s program committee. “We felt that there is always room to grow and improve. The hope is that we have created a program that invites new audience members and provides well-balanced topics.”

The revamping also involved taking the focus beyond CLI and limb salvage to include all aspects of cardiovascular disease, said David Slavut, MD, who has served as program chairman since 2012.

Harris explained that the program committee wanted to create coursework that complemented the NC VH general session.

“We hope to provide quality topics in a more intimate setting that produces discussions, questions and networking opportunities for healthcare professionals,” she said.

The session was renamed to include all allied health professionals and recognizes the critical role they play in patient care.

“We wanted to create a unified message to the participants, so everyone leaves with the same educational foundation,” said program committee member Ryan Hebert. “Attendees will be able to take a role in further developing their programs by having unified key takeaways.”

Today’s sessions will include a discussion of the latest advances in PAD, venous care and pharmacology over the past year, as well as risk management. Tomorrow, the focus will move to the cath lab, and then onto special topics such as advanced heart failure.

“Time and attention is often spent on making sure that the topics are applicable to the day-to-day responsibilities of our audience members,” said Harris. “We strive to bring in what is current and what affects daily practices. Ultimately the goal is that those who attend this session have learned something new, but more importantly feel that what they learned can be used when caring for their patients.”

Hebert said the cath lab component, which used to be a stand-alone program, will focus on both patient care and the business of that care.

“We wanted to create a more robust format that will provide a guide for facing today’s challenges in patient care,” he said. “We’ll also look at finding a balance for improved patient outcomes while also having a positive financial impact on the hospital.”

A popular component of previous NC VH nursing courses—live case viewing streamed in from the general session—remained on this year’s agenda. These discussions, Dr. Slavut said, are less focused on the technical aspects of the procedures and more on the nuances related to caring for patients before and after a procedure.

“The live cases provide real scenarios about how to apply the scientific quality into real-world practice,” said program committee member Denise Brousard. “The audience is more focused on the aspects that related to the nursing and cath lab challenges of the procedures. It’s a great learning opportunity for the audience.”

Planning this revamped program has been in the works since last year’s conference, and the committee is excited about the unveiling.

“We hope that our excitement about the changes to this session is felt by the audience,” said Harris.

“Learning is the key to success and providing quality patient care. If someone walks away and says, ‘Wow, I learned something today,’ I believe we succeeded.”
Graves
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portion of the state. “We’re paying more and we’re getting less.”
Graves said voters showed in 2016 that they want to see government transformation, and that has occurred. President Trump has repealed 24 existing regulations for every new one enacted, and has also lowered tax rates to create more corporate competitiveness.

But third-party providers dis- centrize the innovation that results in better healthcare interventions, Graves said. In any other industry in our economy, if you develop a better widget, “you are absolutely going to score,” he said. That’s not the case with healthcare.

In fact, Graves believes the current U.S. healthcare system actually provides perverse incentives, and CMS is part of this problem.

“We have to move in the direction where we’ve moved in every other sector of the economy since this president has come in: deregulation,” he said. “This means incentivizing the right types of outcomes and paying doctors for better outcomes.”

This doesn’t have to be a partisan fight, Graves noted. “Who doesn’t want better outcomes, more innovation, lower costs and lifesaving remedies?”

Graves said two recent Congressional bills are a step in the right direction. The 21st Century Cures Act addresses the time and cost of FDA approval for drugs and medical devices. The Right to Try bill, which was passed last week by the House and is on its way to the Senate, is designed to provide more flexibility for terminal patients to try non-approved drugs.

Also, recent President Trump’s announcement on drug costs means there will be more activity toward negotiations with pharmaceutical companies, Graves said.

“Congress is working to shift the healthcare paradigm, but things aren’t working as quickly as we would like,” he told the audience. “If you have more systemic solutions, I would love to get your thoughts.”

Why are you at NCVH?
“NCVH addresses all of the aspects of vascular disease. We need conferences like this that provide a global overview.”
– Jos van den Berg, MD

NCVH
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New Product Showcase
HyperMed Imaging
Booth #109

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. The HyperView™ is intended for use by physicians and healthcare professionals as a noninvasive tissue oxygenation measurement system that provides an approximate value of oxygen level (O2Sat), oxyhemoglobin level (Oxy), and deoxyhemoglobin level (DeOxy) in superficial tissue. The HyperView 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.

Explore Expanded Treatment Options with Devices from Reflow Medical
Refow Medical, Inc.’s flagship devices, the Reflow SpeX™ and Wingman™ Catheters, are being featured at this year’s NCVH Annual Conference in separate presentations by S. Jay Mathews, MD, on Thursday and Friday. Based in San Clemente, CA, Reflow is dedicated to empowering physicians with easy-to-use and cost-effective technologies for treating peripheral and coronary vasculature.

The Wingman Crossing Catheter is an over-the-wire catheter with a unique, extendable radiopaque tip that the physician controls to engage with the lesion. A push-and-twist motion makes it possible to penetrate into the cap with the tip and advance the wire into the CTO.

“We’re continually looking for ways to help physicians prevent the need for bypass surgery or amputation,” says Isa Rick, CEO of Reflow Medical.

Dr. Mathews will present “The Wingman Device for Crossing Totally Occluded Vessels” at 2:46 pm on Friday, June 1, highlighting case studies of successful procedures.

The Reflow SpeX is the shapeable support catheter that lets a physician shape it to a preferred angle that’s maintained during the procedure. In the “Utilization of the SpeX Catheters” on Thursday, May 31, at 5:12 pm, Dr. Mathews will share case studies demonstrating how this ingenious device promotes better and more predictable access to the vasculature.

“Our devices are compatible with the guidewire and technique chosen by the physician,” Rick continues.

“The needs of the physician are what drive us – that’s why we’re always looking for clinical feedback. Together, we are designing and developing new devices that help improve and save lives.”

For more information, visit www.reflowmedical.com or contact Isa Rick directly, irick@reflowmedical.com.
Meet the Titans of Peripheral Interventions

NCVH wrapped up Tuesday with “Meet the Titans of Peripheral Interventions,” a networking event designed to connect Fellows and conference attendees with leaders in healthcare innovation.
LUTONIX® 035 DCB had the highest reported freedom from TLR rate at 2 years among real world patients in two separately-conducted registry studies.¹

In.Pact Global Study

83.3%
FREEDOM FROM CD-TLR
At 24 Months²

Lutonix Global SFA Real-World Registry

90.3%
FREEDOM FROM TLR
At 24 Months³