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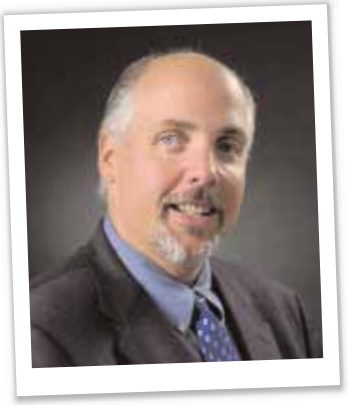
The past president of the SVMB shares his insight on board certification, turf battles, and future vascular disease therapies.



The American Board of Vascular Medicine has recently been very active in establishing criteria and testing strategies for board certification in vascular medicine. What are some of the details of the progress that has been made so far, and what can we expect in the near future? This is the most exciting initiative in which I have professionally been involved, and we have made a lot of headway. After we formed the American Board of Vascular Medicine as a free-standing, not-for-profit corporation, we interviewed and hired a very experienced professional testing company called ACT (Iowa City, Iowa), probably best known for the ACT exam, which is a college entrance exam parallel to the SAT. We've put together a battery of subject-matter experts who have created the exam questions, which are now in the process of being statistically validated, after which the examinations will be prepared.

We are going to offer two exams. One is a general vascular medicine exam for physicians who clinically evaluate and manage patients with vascular disease. The other, the endovascular exam, is designed specifically to provide a nonspecialty-specific board certification in endovascular medicine. The endovascular exam is designed for interventionists with some background in internal medicine. For example, an interventional cardiologist who has completed internal medicine can sit for the endovascular exam. A radiologist who has completed internal medicine, of which there are plenty, can take the exam. Vascular surgeons with some prior training in internal medicine will also be eligible. The goal is to expand the group of physicians who care for patients with vascular disease.

The exam is going to be offered during the week of September 12, 2005. It will be administered by computer so that people can take it locally near their home; they don't have to come to a central place to take it. Information about the exam is available at www.vascularboard.org. The Web site also has all the information on who can sit for the exam. You can actually download the application and file it on the Web site.

As a vascular medicine specialist, you must have a good view of the various turf wars that exist between the medical specialties. What developments have helped to quell some of these battles, and which have stoked the flames? Does any good come from this? I actually do think good comes from this. Virtually all specialists involved in managing patients with vascular disease understand that the volume of patients with this disease is growing faster than the number of physicians who can care for them. The turf battles are going to become moot as we try to figure out how to treat the increasing patient population. I think that a lot of our efforts are now merging to deal with device approval, clinical trials, and also reimbursement. We have been able to come together to work toward getting new technologies and effective treatments to the patients that need them the most, and we have been somewhat successful in making it possible for people to get reimbursed. I think that is the good that has come out of it.

Carotid stenting is what has stoked the flames. There has been tremendous effort to reach a combined, multisocietal opinion on reimbursement, and it has only been partially successful. The areas that are still very hotly contested include reimbursement for the high-risk asymptomatic patient, and the severity of carotid stenosis that ought to be treated with a carotid stent. These are not areas upon which all of the specialists have agreed, so CMS is unfortunately receiving a bit of a mixed message.

It is interesting that carotid artery stenting appears to have also been a catalyst for cooperation. What kind of cooperation can we expect among the specialties? You know, I would hate for people to have the impression that the reason we've rallied is because we are just interested in getting money. But the truth of the matter is that, without reimbursement, many patients who would be appro-

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priate candidates for these therapies would not be able to receive them. It is not the doctors' fee that is the biggest portion—it is the hospital cost combined with that of the device. Those are things that doctors do not earn a penny for. Yet, those are the areas that if we don't get coverage, patients will either have to pay for the services themselves (which most of them cannot afford) or they will have to go without therapy. I think it is appropriate that reimbursement has been the coalescing factor because we are trying to provide what we all believe to be important new technological advances to patients who really need them.

One current area of disagreement between specialties is certification requirements for CAS. What do you think are the ideal standards one must reach before performing this procedure? Should they vary at all according to specialty? The easy answer is yes. If a doctor has gone through a neurointerventional fellowship, and he has been performing intercranial procedures for a long time, he knows how to do cerebral arteriography as well as anybody, and they shouldn't have to be held to the same requirements as a physician who has never performed a cerebral arteriogram before. Ideally, requirements could be tailored to specialties and allow individual hospitals to make those decisions. Unfortunately, it is hard to do that, which is why specialties have tried to work together. I was one of the authors on a recent carotid consensus article (SCAI/SVMB/SVS Clinical Competence Statement) that has been published in several journals (*Catheterization and Cardiovascular Interventions*; *Journal of the American College of Cardiology*; *Vascular Medicine*). The SCAI/SVMB/SVS document includes all the specialties, other than interventional radiology and neuroradiology. I think the reason is that the interventional radiology and neuroradiology groups generally believe that more cases are required than what this document suggests. Until we can come to some middle ground on this issue, I don't see a quick solution.

Does the idea of establishing a multidisciplinary approach to carotid artery stenting seem like the best approach to you? It seems like a good idea on paper. And I do like the idea, at least early in a group's experience, of having a neurologist analyze and evaluate these patients, before and after intervention. The problem is that in practice, it's very hard to get a cardiologist, a surgeon, and an interventional radiologist all around the table for a case. Both scheduling and politics can make this difficult. It's just not a practical solution in most institutions. The best solution is probably the concept that, early on in an experience, there is evaluation of patients by at least a neurologist who is independent to the case, and the interventionist to whom the case was referred, and see if there is agreement on a treatment strategy.

What insights would you offer an up-and-coming vascular medicine specialist regarding diagnostic strategies? I would actually strongly recommend anybody coming up in this field to take the time to learn axial cross-sectional imaging, just like how we were trained in ultrasound-based imaging. I think duplex ultrasound and physiologic tests will always be around, mainly due to cost, safety, and accuracy. The future is in CT angiography and MR angiography, however, and I think that the vascular medicine physician should undergo formal training in how to perform and interpret those tests, just like we did back when we learned how to do ultrasound.

What is on the horizon for medical endovascular therapies for vascular disease? From the medical side, I have to tell you the outlook isn't that exciting. There are some angiogenesis trials that are starting or ongoing that hold some promise, although there is always concern about the safety of angiogenesis. There are a couple of pharmacologic trials of some muscle enzyme agents and nitric oxide types of metabolites that are coming down the road. There is also a very novel therapy using *ex vivo* modification of blood through oxidation and impacts on cellular apoptosis, but the data are pending on many of these therapies. From an endovascular side, it is continuing to explode, and what we need now is not only more cool devices, but a lot more data. There is a lot of interest in things like cryoplasty. The FoxHollow SilverHawk atherectomy catheter is getting a lot of press. Cook has received approval to begin enrollment in its SFA drug-eluting stent trial, which is scheduled to start soon. I know that there are a number of other devices that are in the pipeline for FDA approval to begin trials in the periphery. The drug-eluting stent (DES) area continues to struggle in peripheral arterial disease, and we'll have to see how that plays out. Of course, for DESs in renal artery disease, the only data we had was the GREAT trial from Cordis in Europe, which was promising but not as impactful as it has been in coronary artery disease. ■