

# Anthony C. Venbrux, MD

An eminent radiologist discusses the impact of treating Vice President Cheney, and the current state of DVT treatment.



**What is unique about your method of practice at The George Washington University?** I feel very fortunate to be in a metropolitan area and at a hospital that provides me with an opportunity to offer my patients a broad range of medical services. There is extraordinary receptivity by the medical staff to new ideas and treatment options offered by the Interventional Radiology Division. Health care as practiced at The George Washington University Medical Center is multidisciplinary and interactive. The dialogue and shared expertise by teams of multiple specialists provides a unique working environment that affords me great professional satisfaction.

**What is the focus of your research at The George Washington University?** My primary research interests include management of venous thromboembolic disease using aggressive pharmacomechanical treatment of deep venous thrombosis (DVT) and pulmonary emboli (PE), such as Power-Pulse Spray. Evaluation of recanalization techniques and outcomes for treatment of long-term chronic venous occlusive disease is also an area of ongoing clinical research. Other areas of research include evaluating the role of optional vena cava filters in clinical practice and clinical outcomes for venous and arterial embolotherapy procedures.

**What are the special concerns for DVT patients?** Patients with DVT have several significant concerns. In my opinion, they often receive incomplete therapy. Although anticoagulation is recognized as the primary treatment for DVT, patients with significant DVT and clinical signs and symptoms of swelling, pain, or a

venous thromboembolic event are often neglected in terms of follow-up. Thus, health care providers who treat patients with DVT must take responsibility for management and follow-up.

The second major concern that I have for patients with DVT is the failure to recognize a hypercoagulable state or an anatomic abnormality. In my own practice, I have seen several patients who have had recurrent episodes of DVT treated with anticoagulation alone. Some of these patients have never had a hematologic work-up, or an evaluation for a possible structural abnormality causing recurrent DVTs, such as iliac compression syndrome.

**How will endovascular therapies continue to impact the treatment of DVT during the next 5 years?**

Recognizing the limitations of anticoagulation therapy alone, combination therapies utilizing pharmacologic, mechanical, or combined therapies (ie, use of lytic agents combined with mechanical clot removal) will most likely become a major part of the endovascular treatment regimen for DVT/PE in the next 5 years. In addition, heightened physician and patient awareness of the signs and symptoms of acute DVT, steps to take to prevent DVT, and the need to look for causes of recurrent DVT are necessary. Noninvasive imaging (MR, CT, ultrasound) will certainly help us in our evaluation and endovascular management.

**What are the current controversies regarding IVC filter use?** Current controversies include the more widespread use of optional (ie, removable) vena cava filters. This is especially true in young patients and in patients for whom immobility (eg, secondary to trauma) poses a significant risk for DVT/PE.

**What is your position with regard to the controversy?**

In my opinion, the threshold for the use of IVC filters has been lowered. I currently use optional filters to protect a patient from potential PE when aggressively treating iliofemoral DVT with Power-Pulse Spray techniques. At our practice at The George Washington University, we have had episodes in which significant thrombus has been trapped in the optional (removable) vena cava filter during pharmacomechanical treatment of large iliofemoral or IVC clot burdens.

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**You recently coperformed stent graft placement in popliteal artery aneurysms in Vice President Cheney. Please comment on the impact of that procedure and the associated coverage this has had.** The coverage has been substantial and recognized for its multidisciplinary team approach. The team included interventional radiologists Barry T. Katzen, MD, and myself; vascular surgeons Joseph M. Giordano, MD, and Peter Gloviczki, MD; interventional cardiologist Jonathan S. Reiner, MD; and internal medicine specialist Ryan G. Bosch, MD. There is greater public awareness of endovascular treatment options for management of vascular disease (ie, aneurysms) beyond the abdominal and thoracic aorta. Although somewhat controversial, it has been generally supported by those medical specialists who treat vascular disease.

**What is your view on the future of endovascular procedures as a whole?** Endovascular procedures as a whole will continue to expand as they provide options for patients. There is generally a rapid recovery time and a potential for fewer complications due to the minimally invasive nature of such image-guided procedures.

In certain areas, whether the durability and outcomes of specific endovascular devices will be comparable to open or more traditional surgical approaches remains to be

seen. In specific endovascular procedures, for example, long-term studies with evaluation of clinical outcomes and impact on quality of life are needed.

**Where will the endovascular specialist of the future originate?** The endovascular specialist of the future will undoubtedly come from a number of subspecialties including interventional radiology, interventional neuroradiology, vascular surgery, neurosurgery, interventional cardiology, vascular medicine, and in certain instances, possibly nephrology, and pulmonary medicine.

**What challenges will endovascular specialists face in 2006?** Endovascular specialists will continue to be faced with the problem of treating patients with techniques and devices that do not have specific, labeled indications, yet are part of "standard of medical care," such as off-label use, and the issues associated with the regulatory environment. Hospital reimbursement—or lack of reimbursement—for state-of-the-art devices and procedures continues to be an important issue for minimally invasive therapies. On the educational front, consistent training of interventionists across medical specialties to reach a uniform level of competence affects all endovascular specialists. The lack of uniformity in training complicates hospital credentialing and the setting of national practice standards. ■

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