

Iliac Artery Interventions

Iliac artery interventions are often our best cases. We can consistently achieve excellent angiographic and hemodynamic results, and our patients experience gratifying clinical benefit. I most enjoy those patients I have seen over the years with "hip arthritis" who are found to have a diminished/absent femoral pulse and are cured of their arthritis by iliac artery stenting. What could be better than that? These are also some of the most durable endovascular procedures we perform. In selected cases, the long-term patency of iliac stenting can rival that of aorto-bifemoral bypass surgery. So, after 25 years of iliac artery angioplasty, is there anything more to learn? After reading this issue of *Endovascular Today*, I think you will agree with me that there are still a lot of important questions that remain unanswered.

If we see a patient with appropriate symptoms and a diminished femoral pulse, should we proceed directly to angiography or should noninvasive testing be performed first? If so, what is the best test? Michael R. Jaff, DO, will address some of these issues with a state-of-the-art review of clinical evaluation and diagnosis of iliac artery disease. Once the patient is in the endovascular suite and iliac disease is documented, should we stent everything or is a strategy of provisional stenting more appropriate? Gary Ansel, MD, and John Rundback, MD, will revisit this controversy and debate the merits of each approach.

The most authoritative document we have with regard to patient selection and the appropriateness of a given therapy for PAD is the TransAtlantic Inter-Society Consensus (TASC). Is this document still current, and should we follow its recommendations with regard to more diffuse disease and long occlusions (TASC C and TASC D)? Dierk Scheinert, MD, will make the case that in the modern era, endovascular procedures are safe and

effective for even the most complex iliac artery disease. David Stone, MD, and Richard Cambria, MD, counter with the surgical viewpoint and remind us of the important role that surgery continues to play. They provide an excellent review of the different surgical options, including the use of hybrid procedures (combining open surgical and endovascular techniques).

The role of endovascular stent grafts for iliac aneurysmal disease is expanding. Iliac aneurysms now can be excluded with a variety of commercially available covered stents,

including a balloon-expandable PTFE-covered stent that can be delivered through a 7-F sheath. Zvonimir Krajcer, MD, provides a summary of the latest techniques for percutaneous treatment of iliac aneurysmal disease and discusses the role of the Viabahn covered stent (W. L. Gore & Associates, Flagstaff, AZ) and Wallgraft (Boston Scientific Corporation, Natick, MA) for this application.

At the end of the day, it is nice to be appropriately compensated for our effort and expertise. At times, I am still confused by the complexities associated with billing

for endovascular procedures. Roseanne Wholey provides us with a nice overview of CPT coding and reimbursement for iliac artery interventions.

Lastly, we should never forget that although complications after iliac angioplasty and stenting are infrequent, these complications can sometimes be devastating. M. Habeeb Ahmed, MD, reminds us of some of these potential complications and the need to have all of the ancillary equipment available to be able to bail out from difficult situations.

As you can see, there is still plenty to talk about regarding iliac artery angioplasty and stenting. I hope you find this issue of *Endovascular Today* enjoyable and informative. ■



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