

TASC II 2007: What Has Changed?

An interview with TASC II Co-Chair Lars Norgren, MD, PhD, FRCS, regarding the recently updated and published recommendations.

Endovascular Today: How was the Trans-Atlantic Inter-Society Consensus (TASC) committee first formed, and who comprises it?

Dr. Norgren: The “original” TASC recommendations, which were published in 2000, included Working Group members from 14 societies composed of vascular surgery, interventional radiology, angiology, and cardiology, as well as experts in health economy and epidemiology.

Endovascular Today: Were there changes in the committee’s makeup between its landmark publications in 2000 and 2007?

Dr. Norgren: TASC II included Working Group members from 16 societies, now not only from North America and Europe, but also from Japan, Australia, and South Africa. Further, podiatry experts and experts of evidence-based medicine were included.

Endovascular Today: What are the most significant differences between the recommendations presented in TASC 2000 and those in TASC II 2007? Which lesion types were affected most, and why?

Dr. Norgren: In principle, diabetes and its vascular complications were more extensively discussed in TASC II. There is great focus on prevention. In addition, concerning treatment, the TASC classification of lesions has been kept as such, but modified to reflect increased evidence for endovascular treatment of more extensive lesions.

Endovascular Today: When developing the recommendations, what factors were considered?

Dr. Norgren: At this occasion, the level of evidence was considered to grade recommendations. Those levels have been graded “A” when randomized controlled trials are available, “B” when other well-performed studies exist, and “C” for other evidence, such as consensus or expert statements.

“... the TASC classification of lesions has been kept as such, but modified to reflect increased evidence for endovascular treatment of more extensive lesions.”

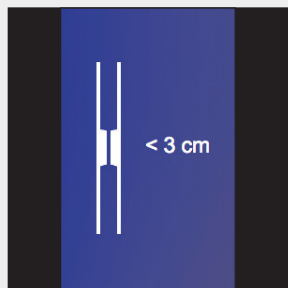
Endovascular Today: What developments led to the new recommendations?

Dr. Norgren: Little has been shown regarding the treatment of peripheral arterial disease, especially critical limb ischemia, while there is a technical development that justifies more endovascular treatment than was the case with the original TASC guidelines. Great emphasis has been put on diabetes, which has clearly increased as a risk factor and is now at the same level as smoking. Clear recommendations have now been given to perform ankle-brachial indices in some categories of subjects, such as all patients older than 70 years, with or without risk factors.

Endovascular Today: What do these changes indicate regarding the trends we are seeing in modern vascular care?

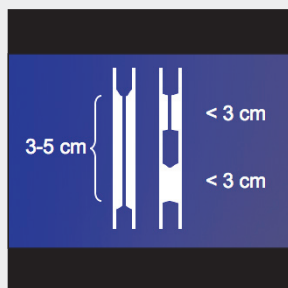
PREFERRED OPTIONS FOR TREATING FEMOROPOPLITEAL LESIONS

TASC 2000

**TASC TYPE A**

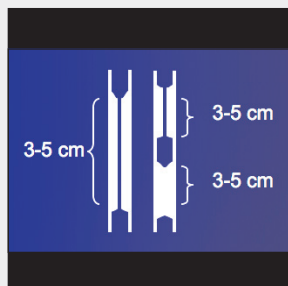
- Single stenosis <3 cm in length, not at the origin of the superficial femoral artery (SFA) or the distal popliteal artery

Endovascular therapy is the treatment of choice.

**TASC TYPE B**

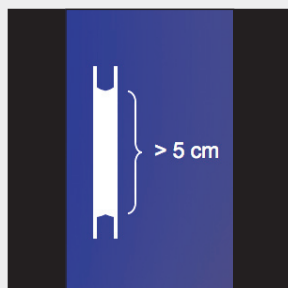
- Single stenoses or occlusions 3 cm to 5 cm long not involving the distal popliteal artery
- Heavily calcified stenoses up to 3 cm in length
- Multiple stenoses or occlusions, each <3 cm
- Single or multiple lesions in the absence of continuous tibial runoff to improve inflow for distal surgical bypass

Endovascular therapy is more often used, but there is insufficient evidence to make a firm recommendation.

**TASC TYPE C**

- Single stenoses or occlusions longer than 5 cm
- Multiple stenoses or occlusions, each 3 cm to 5 cm, with or without heavy calcification

Surgical treatment is more often used, but there is insufficient evidence to make a firm recommendation.

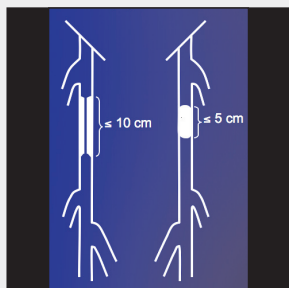
**TASC TYPE D**

- Complete common femoral artery or SFA occlusions, or complete popliteal artery and proximal trifurcation vessels occlusion

Surgery is the treatment of choice.

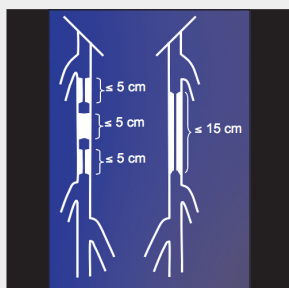
TASC. Management of peripheral arterial disease (PAD). Trans-Atlantic Inter-Society Consensus (TASC). J Vasc Surg. 2000;(1 part 2):S1-S287.

TASC II 2007

Endovascular
TODAY**TASC TYPE A**

- Single stenosis ≤ 10 cm in length
- Single occlusion ≤ 5 cm in length

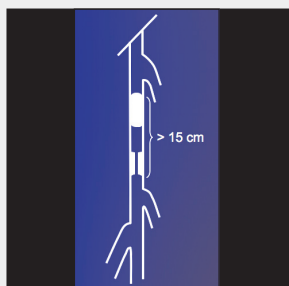
Endovascular therapy is the treatment of choice.

**TASC TYPE B**

- Multiple lesions each ≤ 5 cm (stenoses or occlusions)
- Single stenosis or occlusion ≤ 15 cm not involving the infrageniculate popliteal artery
- Single or multiple lesions in the absence of a continuous tibial vessel to improve inflow for a distal bypass
- Heavily calcified occlusion ≤ 5 cm long
- Single popliteal stenosis

Endovascular therapy is the preferred treatment.

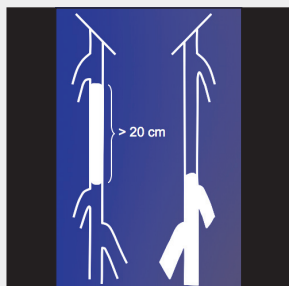
Patient's comorbidities, fully informed patient preference, and the local operator long-term success rates must be considered when making treatment recommendations.

**TASC TYPE C**

- Multiple stenoses or occlusions totaling > 15 cm in length, with or without heavy calcification
- Recurrent stenoses or occlusions that need treatment after two endovascular interventions

Surgery is the preferred treatment for good risk patients.

Patient's comorbidities, fully informed patient preference, and the local operator long-term success rates must be considered when making treatment recommendations.

**TASC TYPE D**

- Chronic total occlusion of the common femoral artery or SFA > 20 cm in length involving the popliteal artery
- Chronic total occlusion of popliteal artery and proximal trifurcation vessels

Surgery is the treatment of choice.

Norgren L, Hiatt WR, Dormandy JA, et al. Inter-Society Consensus for the Management of Peripheral Arterial Disease (TASC II). Eur J Vasc Endovasc Surg 2007;33(Suppl 1):S58-S59.

COVER STORY

Dr. Norgren: We are seeing an increasing population requiring prevention and also treatment and more focus on endovascular treatment.

Endovascular Today: What feedback have you received on the latest publication, and how does it compare to that received after the original publication?

Dr. Norgren: It has to be recognized that the most important aim of TASC II has been to abbreviate the document and to disseminate it into primary health care for earlier and more appropriate patient referral. This phase has just started, but specialists all over the world have shown great appreciation. It is far too early to make any comparison to the original document, which was an extremely well-received guideline that is referred to in most publications on peripheral arterial disease.

Endovascular Today: Can you make any predictions on how the field will change by the time the next TASC recommendations are published?

Dr. Norgren: Just a few months have passed since we finished TASC II, therefore little, if any, new information is available. One area in which almost nothing has happened is the treatment of critical limb ischemia. A sincere hope would be to find that angiogenetic treatment would benefit these patients. Many trials are ongoing, but so far they have yielded limited results. ■

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