Steve Elias, MD

Director and Founder of the Annual Fellows Course in Venous Disease shares his thoughts on the growing venous intervention arena in terms of physician education and how to integrate this specialty into your practice.

In recent years, venous interventions have gained increased attention among the vascular community, with greater focus on educational symposia for a variety of specialties. To what do you attribute this growing interest?

We have seen what I have described as "the three waves of venous education." The first wave involved those of us who were already treating venous disease using traditional procedures and some less-invasive procedures such as SEPS (subfascial endoscopic perforator surgery) and sclerotherapy. This began in the mid to late 1990s. First-wave venous specialists were involved with the development of many minimally invasive vein surgery (MIVS) procedures. We taught ourselves and we taught each other. We went through the global learning curve. We also experienced the growth and acceptance of MIVS procedures from the perspective of physicians, patients, industry, and insurance companies. As procedures proved to be safe, durable, and efficacious, the second wave began to take notice.

The second wave consisted of physicians from various specialties who were already in practice and, for many reasons, found treating vein disease interesting and satisfying. These physicians were usually in practice for 15 to 20 years or more. The interest grew because of personal satisfaction, better technology, lifestyle advantages, and/or monetary compensation. However, their interest was held by the fact that vein care was now fun. Procedures did not involve ripping, cutting, or pulling—they became more elegant and less invasive. Most patients were happy patients, and happy patients also make your job more satisfying. This positive feedback is where I believe the real staying power of vein treatment comes from.

Educational symposia and courses are now reaching out and training the third wave: physicians who recently went into practice or who are in training programs now. We are seeing practitioners develop interest in venous disease much closer to the time that they have completed residency or fellowship training. Of course, the ultimate early interest begins during training. It was to address this need that I founded the Fellows Course in Vein Disease 5 years ago. The earlier we excite physicians about vein disease, the better trained they will be, and better results for patients will follow. Currently, educational symposia need to address the training of our successors (third wave) to ensure the future of vein care not only from a patient care perspective but from a venous research aspect also.

Tell us about the progress that is being made in venous disease education and some of the initiatives that are planned for the coming year.

In response to the changing needs of current vein specialists and new (third wave) specialists, those of us involved with venous education have made almost all courses/symposia more interactive and have incorporated more live cases. The American Venous Forum Fellows Course in Venous Disease has live ultrasound cases and discussions and many case presentations with a good faculty-to-fellow ratio. In addition, we will be incorporating simulator training for the December 2011 course being held at UCLA.

The American College of Phlebology Annual Meeting and Advanced Sclerotherapy Course have hands-on sessions and special interest sessions so that physicians can have many practical questions answered. Nonsocietal courses such as the International Vein Congress (directed by Jose Almeida, MD) and the New York Venous Symposium (co-chaired by Tony Gasparis, MD, and Nicos Labropoulos, PhD) have new initiatives for next year that build on the interactive hands-on model that they had in 2011. In 2012, I think it will be hard to find a mostly didactic, passive learning course. We are trying to make learning more interesting for attendees and make teaching more fun for the faculty.

Finally, the most exciting change I hope to accomplish in 2012 for venous education is the use of simulators and simulation models for venous education. Simulation feels like the real thing and has the advantage of learning many techniques without concern for patient safety and radiation exposure to physicians. This is one of the main directions I see venous education taking. Simulator venous training will debut at the Fellows Course in December 2011. As with all advances in venous disease, it is best accomplished with the cooperation of the triumvirate of physicians, venous societies, and industry.

To what degree do you think having more devices designed specifically for use in venous occlusive disease will improve patient care, such as dedicated venous stents, for instance?

Just as physicians have become more focused, technology and industry have as well. Big veins are now hot topics, whether the problem is acute or chronic. Physicians and

(Continued on page 81)

(Continued from page 82)
industry need to better understand that just because arteries and veins both carry blood, the similarity ends there. They have different mechanisms to move blood, respond to insults and trauma, and clot, and they also respond to treatment differently. The more specific that devices, technologies, and techniques are, the better results we will see. Recently, there have been (and will be) very important developments in our understanding of deep vein thrombosis (DVT). These developments are occurring within all phases of the disease, including prevention, acute DVT, and chronic DVT. It is now a treatable disease at all stages, and new technologies, such as dedicated venous stents, will translate into a better quality of life for patients.

What is the ideal setting for performing varicose vein interventions?

The word *ideal* is relative. The simple answer is wherever the physician and patient are most comfortable. Almost all varicose vein procedures can be done using local or tumescent anesthesia, perhaps with some oral sedation. The push has always been to do these procedures in some type of office setting. Part of the reason may be for patient and physician convenience, but a large part is due to reimbursement, which is currently better when the procedures are performed in the office. The operative word is *currently.* We should not be so naïve as to think that reimbursement will remain at current levels. It never does, and of course, it has decreased already. Once physicians start chasing the money, they give up control to those who have the money: insurers. There will come a point when profit margin is so narrow that other plans will need to be made. Physicians should think ahead and consider starting new alliances that allow them to share in the whole pie for any procedure. Reimbursement is going global. It is no coincidence that the last few years have seen more physicians employed in some way by hospitals than there are in private practice. Thinking about the future before it becomes the present is always advantageous.

What advice do you have for vascular specialists who wish to add venous components to their current practice?

This is a question that always comes up at the various meetings. I tell practitioners that veins can be divided into small, medium, and large sizes. Small veins are reticular, spider, and some small varicose veins. Medium veins are the great saphenous vein, small saphenous vein, larger varicose veins, and perforating veins. Large veins are deep veins, iliac veins, inferior vena cava, uterine/pelvic veins, and upper extremity veins. Considering these three sizes, I think physicians new to vein care should start by understanding and learning how to treat medium veins. This gives you the biggest bang for your buck. Then they can decide where they want to go next: small or large. This depends on their interests, technical skills, hospital association, and patient population. It is my bias that vein specialists should know how to treat all three sizes. If they do not, then they should know to whom they can send patients with problems in veins that they cannot treat.

At Columbia University and Medical Center, Division of Vascular Surgery Vein Programs, we have various physicians treating venous disease with different areas of expertise so that all aspects of venous disease can be managed. This does not mean that everyone manages all aspects, but with the team approach, we can help almost any patient with venous disease. If possible, this center of excellence concept benefits both patients and physicians.

One of the greatest challenges we face in venous education is that vein specialists come from varied training backgrounds. Skill sets are different, and the knowledge base is different. Even with the Fellows Course in Venous Disease, we have trained vascular fellows, interventional radiology fellows, vascular medicine fellows, dermatology fellows, etc. They may not all wind up treating small, medium, and large veins, but it is our goal that they know when to investigate, what techniques are available, and who is available to help if they will not be treating the problem themselves.

The challenge we face with any venous educational venue is for us to be inclusive of all specialties and not exclusive. Most of the meetings such as the International Vein Congress, New York Venous Symposium, American Venous Forum, and American College of Phlebology understand this, and they are to be commended because some of them did not appreciate this in the beginning of MIVS in the early 2000s. Industry has been a very supportive partner in venous education by being inclusive but also understanding that physician education is key to good patient outcomes. Venous education couldn't exist in its present state without industry. Now we all try to educate trainee physicians about the global aspect of care for venous disease and let physicians know it is okay if they do not personally treat small, medium, and large veins. However, they do need to educate themselves about all three types of veins because in the end, it is about the right physician treating the right patient with the best technology in the best setting for the best results. Vein specialists need to know it all even if they are not doing it all. Those of us in venous education need to keep this in mind and make sure trainees, industry, and patients understand this goal. ■

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