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The outgoing president of the American Venous Forum discusses its goals, as well as the areas of venous disease treatment that need the most attention.

How is the American Venous Forum (AVF) working to increase medical education and foster research in venous disease?

The mission of the AVF is to promote venous and lymphatic health through innovative research, patient and physician education, and advocacy. Our premier education programs are presented at our annual meeting, where cutting-edge research from around the world is presented. We also have three fellows courses and one advanced, hands-on attendings course. The fellows course, which was originally developed by Steve Elias, MD, is directed toward vascular fellows as well as interventional radiology fellows. Primarily, this course is intended to fill educational gaps in venous- and lymphatic-related topics that Accreditation Council for Graduate Medical Education (ACGME) training programs in vascular surgery and interventional radiology may not cover thoroughly during the trainee's residency. It is a 2-day course in which participants will attend lectures on venous disease and lymphatic disease and also get hands-on experience with multiple devices. The curriculum and lectures are standardized, and it has been extraordinarily well received in the past 3 to 5 years by the residents and the Association of Program Directors in Vascular Surgery. In addition to a thumb drive that contains all the lectures, we are updating our Web site to make the lectures available through the Internet for downloading and review.

This year was the first time that we offered an advanced venous course for practicing attendings. We specifically kept the course limited to 50 participants, and we had registrants from literally all over the country. The reviews from the participants were terrific, and we actually had to turn people away. We intentionally wanted to keep the course small so that the participants could have direct access to our internationally renowned faculty. I think the intimacy of the course was a major reason for the high marks it received from participants. The ability of clinicians to ask the faculty questions that were pertinent to their practices gave relevance to the course.

What will be some of the highlights for the AVF annual meeting in February 2011?

We have changed the format of the program to allow the best poster presentations to be accompanied by a 3-minute oral podium presentation. Another new item is that Dr. Gregory Moneta is going to be moderating a session on the best venous papers from other societies. We have invited authors with high-impact papers that may or may not have been published in the *Journal of Vascular Surgery* to speak at our meeting. The leadership of the AVF believed that these papers were so influential that they deserved dissemination and recognition at our national meeting.

The really big news is that we are rolling out the American Venous Registry at the annual meeting. This registry will prospectively collect data on various

aspects of venous disease. We currently have two modules: one is a varicose vein module, in which we will collect real-world data on how patients with varicose veins are being treated in the United States, and the other is a stenting module, which is in the process of being revised to make it more user friendly. Vena cava filter, pharmacomechanical thrombectomy/thrombolysis, and upper extremity deep vein thrombosis (DVT) modules are also in the planning stages.

The nice thing about the registry is that all of the modules will be prepopulated with data so that physicians can perform comparative effectiveness research and outcomes measurements on their practices compared to a national data set. We will also provide participants with practice resource tools that can assist them with daily clinical practice management. Specifically, participants will be able to generate a history and physical, a letter to a referring physician, print a progress note for their files, and print an operative note for their office records. They can also perform five clinical practice outcomes analyses in which they will be able to compare their practice outcomes to that of a national dataset. Further benefits include compliance with maintenance of certification requirements for board certification and the ability to receive Medicare bonuses for using an electronic medical record. We are currently applying to the federal govern-

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ment for designation of the American Venous Registry as an approved Medicare electronic health record. There will be a specifically designated area at the annual meeting in San Diego where people can come and view the registry and sign up to become users.

What is the long-term vision for the American Venous Registry?

To obtain real-world practice data. One of the major complaints that we receive from government agencies and third-party reimbursers is that the data on venous disease, although voluminous, are not of high quality. Currently, the government is trying to move away from performing expensive multicenter, randomized clinical trials that may or may not be applicable to the general public. They are looking for more real-world types of clinical trials given the fact that the exclusion criteria in randomized trials are high and oftentimes do not translate into real clinical practice. So we are hoping to gather real-world data on the management of patients with venous disease and then take the dataset to the government and third-party reimbursers to show them what is currently being done in the United States, what the outcomes of these procedures are, and what we recommend in terms of medical decision criteria. We would also like to conduct registry-type research that will identify pertinent clinical questions for future randomized clinical trials through the AVF. I see the registry as being vital to venous practitioners, to the future of the society, and to our profession.

How do surgical and interventional options for treating venous disease complement each other?

I think the honest answer to that is that the majority of venous disease therapies are moving toward the more minimally invasive endovascular therapies. For example, in the United States, open stripping of the greater saphenous vein is no longer considered the standard of care and has been replaced by endothermal/endoluminal procedures. The management of patients with venous thromboembolism is also moving toward interventional procedures (eg, mechanical thrombectomy, chemical thrombectomy, and angioplasty and stenting). These minimally invasive procedures are now also being recognized as options for patients with obstructive disease. Even patients who have chronic occlusions can be treated with minimally invasive procedures, whereas in the past, they required an extraordinarily difficult open procedure. Open procedures are still options in patients who require venous valve repairs, emergency venous thrombectomies for limb-threatening ischemia, and vena cava reconstructions in patients with cancer.

How do you think the specialty of venous surgery is adapting to the increasingly prevalent minimally invasive therapies?

The reality of the situation is that physicians from various medical backgrounds, who were not traditionally trained in ACGME-approved residencies to recognize the full spectrum of venous disorders, are now providing medical care to venous disease patients. For example, there are interventional cardiologists, dermatologists, obstetricians/gynecologists, family practice doctors, internal medicine doctors, and plastic surgeons who all want to treat venous diseases. As a result, the type of training a physician has received, their cognitive skill set, and the quality of care that they deliver has become an issue in the United States. Vascular surgeons have always included venous disorders as part of their residency curriculum requirements. Therefore, they are familiar with the entire aspect of chronic venous diseases, which includes varicose veins, venous thromboembolism, obstruction, and angioplasty and stenting. The ideal venous specialist is a physician who can treat all venous disorders. However, there are physicians who are treating venous disease patients without possessing knowledge of the entire spectrum of venous disorders and treatment options.

I am extraordinarily concerned about the level of cognitive and technical skill sets of many physicians who are treating patients with venous disease. The skill sets required to care for venous disease patients are not currently standardized across all residency programs as they are in vascular surgery or interventional radiology training programs that are already part of the ACGME curricula. Fortunately, I believe that organizations like the AVF, the American College of Phlebology, and the Society for Interventional Radiology are all actively working together to address this disparity.

Which aspects of venous insufficiency treatment do you believe need the most improvement?

I believe that DVT needs the most attention. In 2008, the Surgeon General announced a call to action for the treatment of DVT and pulmonary embolism in which it was noted that although our cumulative knowledge base of all DVT therapies has increased, it has not transferred into actual practice. For example, the standard of care right now for treating DVT is anticoagulation with heparin and conversion to warfarin. There is little appreciation or knowledge of the development of postthrombotic syndrome, treatment of acute DVTs with lytic or mechanical therapies for the restoration of patency, or treating obstruction with angioplasty and stenting. So I would say that treating patients with DVT and pulmonary embolism in this country needs to be greatly improved. ■