AN INTERVIEW WITH...

Yann Gouëffic, MD, PhD

The vascular surgeon weighs in on the current reimbursement climate in France, concerns about radiation exposure, and what is needed most in future lower limb trials.

As a vascular surgeon with extensive endovascular experience, which superficial femoral artery (SFA) cases are you still commonly addressing with open repair versus endovascular therapy?

The first-line treatment for all SFA cases is now endovascular. Surgery is always a second line of treatment. We will try an endovascular approach first, and if we fail, we try again. If we fail a second time performing a retrograde approach, for instance, then we will go for open repair.

What capabilities would endovascular approaches need in order to treat these patients?

Now that we have more efficient tools to treat patients endovascularly, we are less likely to need to convert to open repair. For me, the main concern now is about x-rays. As we treat more challenging patients, the procedures are longer, and we have to protect ourselves against radiation. Two years ago, in the *Journal of American College of Cardiology: Cardiovascular Interventions*, there was an article that showed radiation was higher for peripheral procedures compared to coronary procedures,[1] so that is a concern. Most interventionists work with fluoroscopic guidance, but we should shift to hybrid rooms because the quality of the optics is better, and protection from radiation is more efficient. Hybrid rooms should not be restricted to aortic procedures—they should also be used to treat peripheral procedures, which are more frequent.

How extensively does reimbursement affect your personal practice in France? If reimbursement were not an issue, how much would your treatment algorithm for SFA disease or critical limb ischemia (CLI) change? In what way?

Device use is mostly driven by device reimbursement. So far in France, only implanted devices benefit from reimbursement. To apply for device reimbursement, a company should submit a dossier to the commission nationale d'évaluation des dispositifs médicaux (CNEDiMTS). In the case of approval from the CNEDiMTS and according to its comments, the commission d'évaluation des produits et des prestations (CEPP) determines the reimbursement price. The dossier quality (clinical and medicoeconomic data) is crucial to obtain the reimbursement and a good price. So far, stents and covered stents are not included in the DRG and benefit from a proper reimbursement. Each year, the price of this reimbursement is decreasing. A class effect is recognized for peripheral bare-metal stents (balloon- and self-expandable stents). Recently, French vascular interventionists have experienced difficulties using drug-coated balloons because the device is considered nonimplantable and therefore does not receive reimbursement.

Beyond your own practice, do you see reimbursement limitations as a setback in France?

Yes, in contrast to a country like Germany, where physicians have had the opportunity to access many technologies, we are limited. As previously mentioned, in France, reimbursement is limited to implantable devices, so that is a setback. However, the French authorities are making an ongoing effort to take innovation (eg, nonimplantable devices) into account to give physicians the opportunity to assess other devices. Currently, some university hospitals also have the opportunity to get grants from their institution to assess some nonreimbursed devices for 1 or 2 years.

Do you think there is a more ideal way to handle reimbursement?

They are, in fact, currently trying to set up a new line of device reimbursements in France to expand coverage to devices that are not currently reimbursed. I believe it will be more similar to the way reimbursement is handled in Germany, and we are hoping that it will be implemented next year.

What study would you most like to see in the SFA space—either a result from a study currently going on, or a study you would like to see happen in the future?

In the last 15 years, our treatment options have grown substantially, and we have many devices to use, which is

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great, but we have no comprehensive guidelines about the use of each device. We have few relevant studies to compare the devices and create guidelines for interventionists. In France and other countries, we should set up more studies to compare devices in all lesion types—TASC A through D, in-stent restenosis, and de novo lesions. There is also a huge difference in outcomes between claudicants and CLI patients, so we need to determine what to do about that.

For instance, a year ago, we launched the BATTLE trial in France and Switzerland to compare bare-metal stents with drug-eluting stents in the setting of primary stenting of intermediate-length femoropopliteal lesions (TASC A and B). The main objective of this study is to set up guidelines for the treatment of femoropopliteal lesions.

Who have been some of your greatest mentors over the course of your career, and what were some of their most lasting pieces of advice?

This is a very difficult question. Just today, I had two fellows in my department who are 33 or 34 years old—young with less experience than me—but I learn a lot from them. Because we are a team, I learn every day because they are innovative, brilliant, and have new ideas, so even though they have less experience, there is much to learn from them.

I also have mentors such as Prof. Patra and Dr. Chaillou, who were my surgical mentors. I also have a mentor for basic science—Jean-Baptiste Michel, MD, PhD, in Paris, from whom I have learned a lot and is still a source of support to me. He is very focused on basic science and medicine. Basic science is an important foundation to understand for development of peripheral artery disease treatments. For instance, we recently showed that arterial calcifications were not just passive calcifications but also an active process, because there is presence of osteoid metaplasia and bone marrow in more than 50% of femoral plaque presentations.[2]

As a member of the scientific committee and board for the MEET congress, what qualities do you look for in selecting a good lecture?

It is very difficult, because you could have a bad speaker with a good lecture, and it will not be exciting. On the contrary, you could also have a good speaker with a bad lecture, and it could be interesting. It's a very difficult mix to find, but I would say the most important is to choose the quality of the lecture, and it should be innovative. When I see an abstract, I focus on the scientific quality—is it prospective? Randomized? Has it been reviewed? What is the influence on routine practice? The interaction with the audience and a growing part of discussion is also a key point in the setup of new conferences. ■

1. Ingwersen M, Drabik A, Kulka U, et al. Physicians' radiation exposure in the catheterization lab: does the type of procedure matter? JACC Cardiovasc Interv. 2013;6:1095–1102.
2. Herisson F, Heymann MF, Chetiveaux M, et al. Carotid and femoral atherosclerotic plaques show different morphology. Atherosclerosis. 2011;216:348-354.

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