Martin Werner, MD

The Vienna-based vascular medicine specialist discusses endovascular training, partnering with allied health professionals, and the challenges of developing a new vascular center.

You were the recipient of the first annual VIVA/LINC Vascular Career Advancement award, given to physicians who have been in practice for 10 years or less and dedicated to improving the care and outcomes of patients with vascular disease. As someone relatively early in his vascular medicine career, how do you think your training differs from that of your predecessors? How do you foresee the training of future physicians changing in the years to come?

Training in vascular medicine has changed in the last few years. Aside from conservative treatment of vascular disease and the management of cardiovascular risk factors, the interventional treatment of arterial and venous diseases plays an increasingly important role now. Therefore, improving endovascular skills is becoming more important for future endovascular specialists. I experienced that at Park-Hospital Leipzig, where I had my training for 7 years with Dr. Dierk Scheinert's group. Within that time, dozens of young colleagues from all over the world came to our center as guests aiming to improve their interventional techniques.

In the coming years, increased cooperation between different vascular centers will be key to further improving endovascular training.

At LINC in January, you chaired the Nurse and Technician Forum. What suggestions do you have for physicians looking to improve their partnership with their allied health professionals?

As a physician, it is impossible to achieve ideal patient care without optimizing the partnership with allied health personnel. This is especially true in the cath lab, where the quality of treatment is determined by the quality of cooperation between nurses, technicians, and physicians. It begins with placing the order for the correct materials and ends with optimal teamwork in case of an emergency in the cath lab.

I'm absolutely convinced that improved training for the nurses and technicians will further optimize patient care. LINC's Nurse and Technician Forum covered a wide variety of topics, and the response was very positive. We addressed the most pressing queries that have been suggested by nurses, had talks on very practical issues, and step-by-step presentations, which provided a "how to" for specific procedures. Nurses were very interested in new technologies such as drug-coated balloons (DCBs), bioabsorbable stents, and next-generation closure devices, as well as the treatment of acute and chronic critical limb ischemia.

I know that the need for specific education for nurses is also recognized by industry, which is beginning to offer courses for technicians and nurses. I can only encourage every colleague to take these opportunities and either bring their staff to one of the international meetings, such as LINC, or talk to industry representatives that offer these educational programs.

What are some of the goals of the new center for vascular medicine you are working on building in Vienna?

The main goal is to implement new endovascular techniques and technologies into everyday practice. My preferred way to do this is through performing clinical studies. We provide optimal patient care and, at the same time, we take an active role in the vascular community's efforts to improve endovascular results through testing new devices and technologies.

In the center's development, what challenges have you come across?

The main challenge is to weigh possible clinical benefits against cost issues of new technologies, like the drug-eluting platforms. This is related to local reimbursement policies, which can make it difficult to implement new technologies to a significant extent.

What advice do you have for peers who might want to become involved with starting a center?

Take the challenge, find the right partners, and grow into the responsibilities.

Last year at LINC, you presented on pedal puncture and other retrograde recanalization techniques. In which clinical scenarios do you usually employ a retrograde approach?

I usually employ this technique when an antegrade approach fails. The question is, how much time do you invest into the antegrade approach? The more experience I get with retrograde techniques, the more I am willing to switch to a retrograde recanalization at an earlier point during the intervention.

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Earlier this year, you published results from the GAIA study, which evaluated the safety and performance of the Igaki-Tamai biodegradable stent in SFA occlusions. What were the key findings of this study?

The molecular mechanisms leading to in-stent restenosis in the peripheral arteries are not well understood—they have barely been scientifically researched. This is true for nitinol stents as well as for bioabsorbable stents.

The GAIA study has proven safety and immediate technical success for a bioabsorbable stent made from poly-L-lactic acid in the treatment of femoropopliteal lesions. However, patency rates were not better than conventional PTA in the SFA. In our experience with drug-eluting stents, we first had similar discouraging results from the SIROCCO studies. The ZILVER PTX trial, investigating another drug formulation, brought the drug-eluting stent technology back to the peripherals. The same may, of course, be true for biodegradable stents. Different formulations or combinations with antiproliferative drugs (as investigated in the ESPRIT I trial) could possibly result in improved efficacy while leaving nothing behind.

Are you aware of any studies on medical management after DCB therapy? Do you believe this needs to differ from what would normally be prescribed after standard balloon angioplasty, or is it still too soon to tell?

Unfortunately, no studies have been conducted to investigate the optimal duration of dual antiplatelet inhibition after DCB treatment in the peripheral arteries. Even in the coronaries, the evidence supporting an optimal dual antiplatelet therapy (DAPT) duration after DCB angioplasty is scarce. No definite recommendations can be given. In my daily practice, I comply with the protocols of some DCB studies, where DAPT was recommended for 1 month, followed by life-long aspirin. In cases of combining DCB treatment with bare-metal stenting, DAPT will be continued for 3 months.

What are your current research focuses?

Currently, I am involved with studies on SFA treatment with a new DCB, next-generation stents, and the combination of DCB with bioabsorbable stents. ■

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