Ramon Varcoe, MBBS, MS, FRACS

Dr. Varcoe discusses the upcoming VERVE Symposium, his passion for limb salvage, and the importance of good social media practices.

This December, you and your colleagues will host the third annual VERVE symposium in Sydney. What do you believe makes VERVE unique, and what are your goals for this year?

The VERVE symposium, in conjunction with LINC Australia, is one of a group of emerging meetings that have evolved beyond the historical congress paradigm. We are very much focused on practical education, where vascular colleagues can come together and hear talks that are relevant to their clinical practice, listen to discussion led by a group of global opinion leaders, and observe some of the world's best interventional practitioners performing challenging cases. We essentially provide a forum to observe new techniques and technology, which is really important given how quickly that space is moving.

We are the final meeting in the congress calendar, which gives it a nice celebratory feel, and it's a great time to be in Sydney with lots of warm sunny days. Everyone is really upbeat as we approach Christmas, and we make sure to showcase the natural beauty of Sydney by getting everyone out on the harbor during our social events. This year, we're holding the VERVE party on the harbor foreshore under the northern sail of the Sydney Opera House. We invite delegates, faculty, partners, and industry to all of our social events, as we think it's important to be inclusive.

As is the case with gaining experience in the angio suite, we imagine that meeting organizers learn a considerable amount in their first several meetings. What are the most important things you've learned from the first two VERVE conferences, and how are you applying them in planning the 2015 sessions?

We've been really fortunate to have had the opportunity to collaborate with our friends from the LINC Leipzig Interventional Course right from the outset. Tapping into their experience has certainly accelerated our learning curve.

I think the most important thing we've learned over the first couple of years is how to get the right balance between live cases, talks, and panel discussions. I believe that if you get this spot-on, you keep the delegates' attention and maximize the educational benefit. As soon as things become boring or predictable, people start drifting out of the auditorium and become distracted by all the other great attractions Sydney has to offer. You know you're doing something right when you have a packed room for the final session on the final day, even when the sun is shining and the surf beach beckons.

When inviting faculty for VERVE, which characteristics were most important to you?

VERVE relies heavily on its faculty. They must be thoughtful opinion leaders and experts in their field. Each is chosen as a credible and experienced operator who can convey the finer details of how they perform a procedure, as well as the tips and tricks to avoid complications and achieve success. It's really important that they be good communicators and enjoy both the discussion and the debate. After all, that's what VERVE is all about.

Your vascular practice is diverse, including complex aortic cases and lower extremity disease such as critical limb ischemia, carotid disease, and venous presentations. Are you trending more toward certain procedures, and if so, what factors have motivated your pursuits?

Like most Australian vascular surgeons, my practice is diverse, and I enjoy it all; however, my real passion is treating peripheral artery disease and critical limb ischemia. Not only do patients with critical limb ischemia present looking squarely down the barrel of limb loss, but the procedures themselves provide some of the most challenging interventions within very small and diseased arteries. I'm motivated by my intuitive desire to take a condition like an ischemic limb and cure it, as well as by the dexterous challenge. I also love working in an environment where technology plays such an important role and is evolving as rapidly as it is in the lower limb.

(Continued on page 96)

(Continued from page 98)

In April, you published your early experience using bioresorbable scaffolds below the knee. What can you tell us about the technology's potential ability to succeed in a very challenging population and about any possible pitfalls or complications that are unique to this type of device versus standard bare-metal stents, drug-eluting stents (DES), or drug-coated balloons?

For many years now, we've used metal DES in short infrapopliteal lesions. Of course, everyone is aware of the data for DES, which are pretty convincing. However, the downside to permanent metallic implants is that they can act as an impediment to future intervention or surgery, as well as creating an artifact on CT and MRI. We've been using the Absorb bioresorbable vascular scaffold (Abbott Vascular) for 2 years now because it offers the best of both worlds. It gives you a strong scaffold structure and delivers antiproliferative drug to the site of your angioplasty injury, then disappears so as not to be an impediment for future interventions, surgery, or imaging, and best of all, it seems to allow the artery wall to regenerate its contractile function over time.

So far, we've had some excellent results, at least as good as those we've seen with metal DES. There are, of course, a number of idiosyncrasies you need to be aware of when using bioresorbable technology. First of all, you can't see it on fluoroscopy, so you need to use other techniques to know when it's fully expanded and apposed to the vessel wall, especially as poor apposition seems to be a mode of failure. The structure itself has strut widths that are about the same size as the early generation DES, so careful pre-and postdilatation is really important. We think that dual-antiplatelet therapy is at least as important as it is with DES until the resorption process is well underway.

How would you summarize the published results, and are there any additional insights since that time?

We have published our 6-month pilot study and orally presented 12-month results at several conferences. So far, we have primary patency rates that are exceptional and at least as good as DES, which are a pretty high benchmark. Interestingly, the scaffold probably doesn't need to be better than DES, as they have significant advantages just by being bioresorbable. We are hopeful that, over time, we will see noninferiority.

What's next in the plan for evaluating this application in larger studies?

We have just started enrolling patients in the ABSORB BTK trial. This is a prospective, multicenter, single-arm study designed to evaluate the performance of the scaffold over a 3-year follow-up period. There is a 12-month, core lab–adjudicated, angiographic endpoint, which should provide a good comparison with previous studies that have evaluated metal DES.

To what degree do you feel it's important for vascular specialists to maintain a strong web presence, including social media?

Personally, I think an educated patient is a good thing, and I enjoy the challenge of being asked to justify my recommendations and treatment decisions. I encourage each of my patients to take part in those decisions around their own treatment as they're being made. I also encourage them to do some research on their own, which usually involves using search engines like Google. I see myself as an expert sounding board, who will formulate and recommend a management plan with my patients as part of the decision-making process.

My view is that vascular specialists should help to provide the community with digestible and up-to-date information on their own web platforms. If we don't, patients will find misinformation when they search the web, and that serves nobody well. So, that means getting a website up and running and writing good content. There are no shortcuts in that process, as poor content reflects badly on you, and it can be really obvious if someone else has written it for you.

I also think social media provides a great vehicle for dissemination of educational material. I use it to give patients updates on my practice, as well as provide snippets of information about new technologies and treatment results. Our team at VERVE spends a lot of time combing through relevant vascular journals, educational websites, and updates from regulatory authorities such as the US Food and Drug Administration and the Therapeutic Goods Administration of Australia. We also follow opinion leaders and retweet their best stuff. As specialists, we're all very busy, so we encourage others to consider following us on Twitter @VERVEsymposium so that we can do some of that work for you.

In your opinion, what makes a great research article? With dozens of vascular studies published each month, what moves the needle for you?

I put a lot of emphasis on and eagerly await well-conducted randomized controlled trials. The topics I'm most concerned with are those where we have a clinical question but no answer. I think the best research gives the clinician information he or she can convey to the patient when asked, "What treatment is best for me,

doc?" or "What is the risk of having a certain complication from the treatment you recommend?" I also pay close attention to the emerging evidence for new technologies. If you take your eye off that ball, you soon get left behind.

Before starting your medical career in earnest, you competed as a world-class sprinter. Please tell us about your experience as a runner, and how it may have influenced your vascular practice.

Competitive sports teach you so many things during those early, formative years. You learn really important lessons, such as effort translates to reward and how to turn failure into growth. Individual sports, like sprinting, also teach you how to take personal responsibility for your life and earn success through hard work. That experience probably shaped me more than anything else, and I use those lessons in my vascular practice every day. ■

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