Italy

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What is the prevalence of endovascular SFA therapy as compared to surgical?

High. Our group of interventional radiologists and vascular surgeons give preference to endovascular treatment in most cases of SFA pathology. When an outcome is not successful, surgery is the next step. A lot of scientific studies have demonstrated the validity of the endovascular technique, even in the presence of complex lesions (TASC C and D). This is secondary to the results reported not only for single, simple lesions but also for chronic total occlusions. Moreover, the excellent results reported with the introduction of drug-coated devices (DCBs and DES) stressed the efficacy of endovascular procedures.

How would you describe device availability in your country, both in the types of devices and different vendors within each class?

High. In Italy, as well as in Europe, any device available on the market can be used. Obviously, the CE Mark certification is mandatory. If new devices can be easily and freely tested, great care must be given to their practical validity and utility because some of them, having no recommendation from scientific studies, can be inefficient and unsuitable. This freedom of use is an advantage on one side but also a risk on the other, and that's why legislation in the United States is different.

In what ways does reimbursement (both government and private if applicable) affect device use? Which device classes are most affected?

The present economic crisis is still a problem that overall involves the most expensive devices. In Italy, every hospital has a different budget to spend, but the general rule is that the administrative office of each hospital must be informed why a certain device is purchased and why a more expensive one is chosen instead of a less pricey device. In my country, no reimbursement from the Ministry of Public Health is expected when buying an expensive device, such as a DCB or a DES. In all other cases, reimbursement is always inferior to the real price of a device. An example is atherectomy devices. We hope that in the near future a better reimbursement policy will be applied to facilitate the use of the new-generation devices.

Are there any historic or cultural forces unique to your country that have affected the penetration of endovascular options?

Italy has played a very important role in helping endovascular techniques grow and expand, especially thanks to the work of Prof. Plinio Rossi, who was a pioneer in introducing this specialty into our country. Today, Italy can surely be considered a leader in the field of endovascular procedures as well as of interventional oncologic treatments with the majority of the worldwide key opinion leaders.

How do most physicians receive training in endovascular therapies in your country?

At present in Italy, a fellowship in interventional procedures or interventional radiology doesn't exist, but fortunately, young physicians are allowed a longer training period during their specialization (residency). It would be advisable to arrange educational courses exclusively dedicated to endovascular procedures, and this project is now being discussed and studied at the national level.

What is your personal strategy or algorithm for treating:

According to the results reported in the literature and on the basis of our personal experience, we prefer to use drug-coated devices in most cases. This is the algorithm of treatment for:

- **Short, focal lesions:** DCB
- **Long lesions:** DCB + stent
- **Calcified lesions:** DES
- **CTOs:** DCB + DES
- **In-stent restenosis:** DCB or atherectomy + DCB
- **Claudicants:** > 50 meters maximum walking distance, medical therapy and a change in lifestyle habits; < 50 meters, medical therapy and endovascular treatment ■

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