

Australia



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He has disclosed that he is a consultant for Abbott Vascular, Boston Scientific Corporation, Gore & Associates, and Medtronic and is on the advisory board for Abbott Vascular.

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

Moderate to high and rising. Australian vascular surgeons are fully trained in endovascular procedures and for the most part are keen to perform their own lower limb interventions. TASC A and B lesions would usually be treated endovascularly. TASC C and D lesions may still be treated with an open surgery-first approach in some regions or individual centers. However, there is a growing movement toward treating all lesions with an endovascular-first approach.

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

High and stable. Most endovascular SFA devices are available in Australia. We have the full gamut of conventional, drug-coated, and focal force balloons; stents and drug-eluting stents; and most atherectomy, crossing, and reentry devices. Our regulatory authority, the Therapeutic Goods Administration, takes some time to consider the safety aspects of new devices, and it is therefore common to receive access a little later than Europe, but usually before the United States and Japan.

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

All devices are available for use in the government sector; however, Australia has an unusual reimbursement environment whereby a device must be implanted to be reimbursed in the private medical sector. This affects the use of high-cost, nonimplantable devices, such as drug-coated balloons and atherectomy, reentry, and crossing devices. Unfortunately, this results in a relative disparity, whereby privately insured patients miss out on many novel and beneficial technologies.

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

Vascular surgery evolved very early as an independent discipline in Australia. From that independent position, the early adoption of peripheral interventions was pioneered by a small group of individuals who went on to have a significant influence throughout the country. Surgeons such as Drs. John Anderson, Geoff White, Michael Denton, and Alan Bray were performing angioplasty at the earliest stages of its development, in line with the global trend. Those few individuals trained those who followed, which bred an autonomous group of endovascular surgeons in this country.

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

Most SFA interventions are performed by either vascular surgeons or interventional radiologists. Both specialties have a logbook-based minimum requirement and supervisor assessment system to determine competency for peripheral interventions. Training mostly takes place in the major teaching hospitals and some larger regional centers. A number of centers encourage their graduates to undertake international fellowships to centers of excellence to further their experience. At the Vascular Institute, Prince of Wales, we offer an international endovascular fellowship, and we have strong collaborative relationships with a number of centers in Europe and the United Kingdom; trainees are sent, and, in turn, we accept trainees. We feel that this has both vocational and cultural benefits for the trainees themselves and their units when they return.

What is your personal strategy or algorithm for treating:

- **Short, focal lesions:** PTA or DCB, with bailout stenting
- **Long lesions:** Stent (preference for interwoven nitinol or stent graft for very long lesions)
- **Calcified lesions:** Interwoven nitinol stent preferred

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- **CTOs:** We favor retrograde wire passage over reentry devices for recalcitrant CTOs. Once crossed and predilated, we favor routine stenting for most CTOs (preference is given for interwoven nitinol for calcified CTOs or stent graft for very long CTOs).
- **In-stent restenosis:** DCB or stent graft, depending on the location/collateral arteries
- **Claudicans:** Durability is key here. In short lesions, we may use a DCB or interwoven nitinol stent. Long lesions as above. We have a low threshold for bypass if the patient has a good vein conduit and is young with reasonably few medical comorbidities. ■