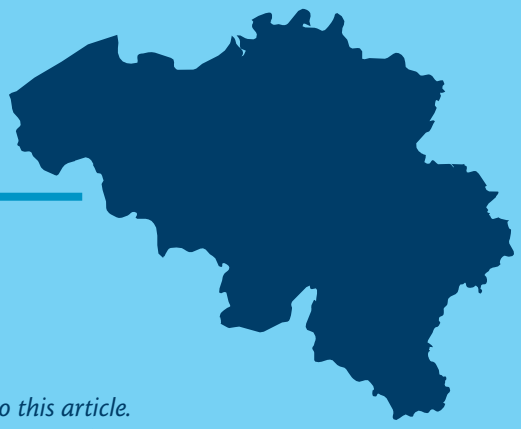
Belgium



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

The prevalence of endovascular SFA therapy is high in Belgium and still increasing. Almost all TASC A and B lesions and the vast majority of TASC C lesions are treated endovascularly nowadays. My impression is that there is also a trend with the more challenging TASC D pathology towards an endovascular-first approach. Factors leading to this ongoing minimally invasive trend include well-trained vascular surgeons, high availability of modern devices/newer accessorial materials, well-equipped hybrid rooms with outstanding imaging tools, and last but not least, the increased presentation of a more fragile, elderly population.

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

All CE Mark–approved devices are commercially available in Belgium. Every officially registered and notified medical device company and/or vendor has access to the Belgian market. Based on health economics and reimbursement considerations, however, I've noticed a change from the individual physician making the selection (ie, best device for the individual patient's situation) toward hospital or group administrators' preferences (ie, mainly based on prices and/or linked to other hospital products/services).

In what ways does reimbursement affect device use? Which device classes are most affected?

Nowadays, I personally think reimbursement is the most important factor in device selection in Belgium. An endovascular SFA intervention in Belgium is reimbursed by the procedure and varies between €450 (if you use balloons, POBA or drug-coated [DCB]) and €1,500 (if you implant stents, bare-metal [BMS] or drug-eluting [DES]), taxes and accessory materials included. If you treat inflow/outflow/contralateral lesions, an extra reimbursement of €250 to €1,000 can be added. Unfortunately, neither TASC classification, stenosis/occlusion difference, calcification grade, claudicant/critical limb ischemia (SFA pathology) nor native/ISR treatment play a role in this regulation. It is clear that standard therapy of straightforward lesions is adequately covered by this reimbursement. However, the more difficult, challenging (and frequent!) SFA pathologies, in which you need debulking devices, vessel prep, drug-eluting technologies, covered stents, etc, are currently insufficiently reimbursed and consequently less used. Higher rates of target lesion revascularization could be the result.

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

The fact that Belgian vascular surgeons were immediately involved in the endovascular field (some of them as pioneers) resulted in a positive and fast evolution in the minimally invasive approach of vascular pathology. Nowadays, well-trained vascular surgeons can offer—more or less unbiased—high-quality open surgical, endovascular, and hybrid solutions to the Belgian vascular patient. The previously discussed reimbursement issues are currently the biggest factors.

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

Most physicians involved in peripheral endovascular therapy in Belgium are vascular surgeons. During their last 2 to 3 years of training, they are widely exposed to all aspects of the endovascular approach to vascular disease. Dedicated training programs with simulators, virtual cath labs, and animal labs are also organized by the Belgian Society of Vascular Surgery working groups or private initiatives. Advanced national and/or international fellowships often are the icing on the endovascular cake. On the other hand, we must not forget to teach open surgical skills, as these are quite often the most complex rescue solutions in difficult (post endo) circumstances.

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Map of Belgium - Single Color by FreeVectorMaps.com

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What is your personal strategy or algorithm for treating:

- **Short focal lesions:** DCB
- **Long lesions:** Predilatation with POBA; if the result is OK, then DCB; if result is not OK, then BMS
- **Calcified lesions:** Vessel prep and Supera vascular mimetic implant (Abbott Vascular)
- **CTO:** Short CTO, DCB; long CTO, DCB + BMS (full coverage: spot stenting is, in my opinion, very unclear to define and often ends with very "big spots")
- **ISR:** Short ISR lesion, DCB; long ISR lesion, DES or covered stent
- **Claudicants:** The intervention is based on the previous lesion characteristics, of course always beside lifestyle modification and correction of risk factors. ■