Switzerland

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He has stated that he has no financial interests related to this article.
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What is the prevalence of endovascular SFA therapy as compared to surgical?

The number of endovascular procedures for SFA occlusive disease is on the rise both in absolute numbers (a moderate rise, probably due to demographic/epidemiologic causes) and by percentage as compared to surgery. The percentage increase is considered small, probably because over the last decade the endovascular option for TASC C and D lesions was already the preferred treatment modality.

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

In Switzerland, we are fortunate that all devices from the various manufacturers are readily available.

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

The reimbursement system in Switzerland incentivizes outpatient treatment, and this is reflected in the fact that full reimbursement is available for all devices used during a procedure, under the condition that the patient will be discharged on the same day as the admission and procedure. This system will also reimburse the cost of available devices, and this includes catheters, balloons, and stents, as well as closure devices. When a patient is treated on an "in-hospital" basis, a diagnosis-related group (DRG) system applies, similar to the German DRG, and in Switzerland, it usually takes some time before new devices will be reimbursed.

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

The penetration of endovascular options is probably enhanced by the fact that the first (coronary) angioplasty balloons were developed in Switzerland and by the aforementioned reimbursement system, which favors a therapy that needs only a short hospital stay. The reimbursement system is also one of the reasons why angioplasty and stenting of the SFA using 4-F compatible devices is used more often as compared to surrounding countries. As a matter of fact, the first 4-F–compatible balloon and stent systems were developed in Switzerland.

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

In Switzerland, interventional angiologists, interventional radiologists, vascular surgeons, and, to a lesser extent, cardiologists are performing peripheral endovascular procedures. Basic training typically is part of the residency program of each specialty, and some institutions offer fellowship training.

What is your personal strategy or algorithm for treating:

- **Short, focal lesions:** Plain balloon angioplasty for very short (diaphragmatic) lesions, DCBs for longer lesions
- **Long lesions:** Bare-metal stenting or DCBs (the latter are on the rise, after the presentation of a global registry that indicated results in long lesions [up to 25 cm] similar to those obtained in randomized trials that included lesions of < 10 cm)
- **Calcified lesions:** No debulking, optimal vessel preparation (long inflations or scoring balloons), followed by stenting
- **CTOs:** Subintimal recanalization and angioplasty with (spot) stenting
- **In-stent restenosis:** For short lesions, DCBs, for longer lesions (Tosaka class II and III), debulking with excimer laser followed by DCB
- **Claudicants:** All patients are sent for walking exercise for at least 3 months (preferably 6 months). Those who show persistent claudication are treated primarily with endovascular therapy as indicated above. The patient is only referred for bypass surgery if the endovascular procedure (by using antegrade and retrograde approaches) fails ■

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