

# The Netherlands



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

High, and it may rise during next few years. Other than the improvements in endovascular technique, more octogenarians and nonagenarians with multiple comorbidities have to be treated. Endovascular therapy is preferred in these high-risk patients.

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

So far, device availability is good, and we are lucky that we have access to most of the innovative products (drug-eluting balloons and stents, scaffolds, etc). Sometimes, participation in trials is essential to introduce new products into the hospital.

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

The majority of patients with peripheral artery disease in the Netherlands are treated in government hospitals. Over the next few years, reimbursement will become an issue because the general costs of health care are rapidly increasing. It may be difficult to continue using expensive devices unless their efficacy and added clinical value have been proven in robust (randomized) trials. Cost-effectiveness studies will be important, as well as clinical outcome parameters.

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

Over the last 2 decades, the Netherlands has been well known for high-quality, multicenter, randomized trials. A substantial part of the penetration of new endovascular techniques has been based on research and key leaders in the peripheral endovascular field. Moreover, the Dutch health care system is still one of the best in the world, which enables us to be on the forefront of endovascular treatment of peripheral artery disease.

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

In the past, endovascular interventions were exclusively performed by interventional radiologists. Increasingly, vascular surgeons are involved in endovascular treatment. Both vascular surgeons as well as interventional radiologists will have at least 2 years of specialized (endo)vascular training, in addition to their general training. In the near future, this will change from 2 years to 4 years.

## What is your personal strategy or algorithm for treating:

- **Short, focal lesions:** PTA (POBA); in case of recoil or flow-limiting dissection, additional stenting
- **Long lesions:** PTA (POBA); in case of recoil or flow-limiting dissection, additional spot-stenting (or use of Tacks, Intact Vascular, Inc.)
- **Calcified lesions:** PTA/stenting
- **CTOs:** DCB, spot-stenting
- **In-stent restenosis:** DCB
- **Claudicants:** Supervised exercise (physiotherapist) ■