# India

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

Moderate and rising. The population in India is aging and has more comorbidities with complex lesions—70% of our interventions are in patients with diabetes. Endovascular therapy is also increasing in affordability.

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

Most devices—including drug-eluting technologies, atherectomy systems, covered stents, etc—are readily available with no lag time and good service from the vendors. At our center, we also manufacture our own customized, off-loading footwear at our very busy foot clinic. This is important to heal the wounds, because most have ischemic lesions.

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

Nearly all patients pay out of pocket—less than 20% have reimbursement through insurance.

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

No such barriers, but there is very little availability of endovascular specialists and hospitals equipped for these procedures. There is a lack of awareness among the medical community and population here. Endovascular therapy is also expensive compared to surgery, which is a major factor inhibiting its uptake.

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

There are structured training programs in about a dozen centers leading to national board certification and MCh. Most vascular specialists who do surgery, endovascular, and hybrid procedures are exposed to centers in Europe, the United States, and Australia.

### What is your personal strategy or algorithm for treating various SFA lesions?

Most lesions are "endovascular first," except in long lesions in younger, healthier patients. We almost never do infrainguinal reconstruction in claudicants, never below the knee, and these are reserved only for patients with CLI. Only those with recurrent, clinically significant lesions are offered reintervention. ■

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