Peter Gloviczki, MD

Dr. Gloviczki discusses his goals as SVS President and treatment strategies for varicose veins and DVT.

What do you aim to achieve as President of the Society for Vascular Surgery (SVS)?

In January, we approved the SVS Patient Safety Organization (PSO) to support the prevention, diagnosis, and management of patients with vascular disease and to position the SVS as a national leader in quality control efforts of vascular interventions.

We are also continuing our efforts with the SVS Vascular Quality Initiative (VQI) to collect outcome data on open surgical and endovascular procedures around the nation to provide a strong base for quality improvement projects and an opportunity to answer questions that require a robust clinical registry. The SVS VQI is growing by leaps and bounds; by the end of August 2012, we had 188 centers signed up in 43 states in the US and Ontario, Canada, and collected information on well over 50,000 procedures. We are encouraging all SVS members and other specialties performing endovascular procedures to join VQI and establish or join a regional quality group. We already have eight regional groups, and another eight are in preparation.

We are working to brand the term "vascular surgeon" and the name of the Society for Vascular Surgery. We want the public, our patients, and referring physicians to know who vascular surgeons are and what vascular surgeons are doing. We also want the SVS and our Web site, www.vascularweb.org, to be the most reliable source of information for the public and referring physicians on prevention and care of vascular disease.

For many, the most important goal is continuing the education of our members and training future generations of vascular and endovascular surgeons. The SVS postgraduate courses and research initiative meeting, the VESAP2 (a web-based Vascular Education and Self-Assessment Program) and the new online education portal, the LMS (Learning Management System), focus on training and retraining of our vascular surgery workforce. Our new resident educational program has been very successful in the last 5 years, and our trainees and medical students come to the SVS Vascular Annual Meeting in large numbers. We have 105 vascular-independent programs that train 251 residents, but we also have a new training paradigm that lasts for 5 years and attracts the best students coming directly from medical school. These 39 Vascular Surgery Integrated Residency Programs (0-5) train 97 residents, and the programs will likely double in 3 years, with 40 new potential sites for training. Vascular surgery has become one of the most successful and most competitive fields for resident applicants.

How would you describe the challenges vascular societies face as they aim to remain strong and independent, yet also collaborate with other specialties to conduct research and further optimize care?

Teamwork and collaboration are essential to survive and prosper. The stronger you are as an independent society, of course, the better your position is in the team. But still, there are several specialties that participate in the care of vascular patients, and we work with them in multiple projects, including guidelines, awareness campaigns, reporting standards, and outcome assessment.

We would also like to strengthen our position in the international vascular surgery arena and attract foreign physicians as international SVS members to bring information on new treatments and discoveries to our meetings and publish them in the *Journal of Vascular Surgery*. Similar to the American College of Surgeons, the SVS has developed international chapters to encourage bilateral relationships with vascular societies around the world, foster fellowships, and exchange ideas.

What advice would you offer vascular specialists interested in adding varicose vein and related venous procedures to their practices?

Venous diseases, both acute and chronic, are important and highly prevalent vascular diseases. Vascular surgeons should embrace venous procedures—and they do. Ruth Bush, MD, Chair of SVS Clinical Practice Council, presented a recent survey of SVS members at the last SVS annual meeting in Washington, which showed that 93% of the responding vascular surgeons treated superficial veins, and 86% treated deep veins in their clinical practice; 90% also had an accredited vascular laboratory.

The SVS wants to increase awareness and entice

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interest among vascular surgeons in the care of patients with acute venous thromboembolism and chronic venous disease. With almost 1 million Americans suffering from acute thromboembolism each year and with more than 40 million having varicose veins or more advanced chronic venous insufficiency, vascular surgeons should be leaders in management of venous problems. We are dedicated to excellence in venous disease care and are ready to provide innovative, minimally invasive and endovascular treatment to our patients with venous diseases. In January, the SVS will launch the *Journal of Vascular Surgery: Venous and Lymphatic Disorders*.

Which methods do you prefer to use for treating varicose veins? Is it a blend of surgical and endovascular means, or do you lean heavily toward one particular modality? Do you have a preference between radiofrequency and laser ablation?

Treatment of varicose veins is and should be individualized. It is based on evidence, which was well presented in the SVS clinical practice guidelines by a multidisciplinary committee of experts, published last year in the *Journal of Vascular Surgery*. In addition to evidence-based guidelines, decisions on how to treat our patients are also based on the physician's clinical experience and the patient's preference.

Open surgery is less frequently used today than ever before. We use both radiofrequency and laser ablations to treat the incompetent saphenous vein. There is really no level one evidence that one treatment is better than the other.

What are some of the most important points from the SVS guidelines for early thrombus removal strategies for acute deep venous thrombosis (DVT), published earlier this year?

The Society for Vascular Surgery/American Venous Forum (SVS/AVF) guidelines on management of iliofemoral DVT were just published in 2012 in the *Journal of Vascular Surgery*. We found that data on early thrombus removal strategies were of low quality, but we do suggest patient-important benefits with respect to reducing postthrombotic morbidity. The guidelines recommended against routine use of the term "proximal venous thrombosis" in favor of more precise characterization of thrombi as involving the iliofemoral or femoropopliteal venous segments, and this was a grade 1A recommendation (high quality, strongly recommended). The guidelines also suggested early thrombus removal strategies in ambulatory patients with good functional capacity and a first episode of iliofemoral DVT of < 14 days in duration (grade 2C) and strongly recommended their use in patients with limb-threatening ischemia due to iliofemoral venous outflow obstruction (phlegmasia cerulea dolens) (grade 1A). The committee suggested pharmacomechanical strategies over catheter-directed pharmacologic thrombolysis alone if resources are available and that surgical thrombectomy be considered if thrombolytic therapy is contraindicated (grade 2C).

Do you use surgical and/or endovascular means for venous graft implantation? What factors most affect the patency of grafts in the venous system?

Our first choice is always endovascular—we place venous stents whenever possible. In patients with malignant tumors, in those with failed venous stents, or in very young patients, we favor open surgery. The best graft is the autologous saphenous vein, but it is not always available or is sometimes too small. In many areas, especially for vena cava replacement, expanded polytetrafluoroethylene grafts perform very well.

As a surgeon with a busy venous practice, is it ever difficult to shift gears to perform complex arterial procedures? How versatile does a facility need to be to accommodate this diverse case load?

People frequently ask me if I perform arterial procedures as well. I love the full spectrum of vascular and endovascular surgery, and I am more enthusiastic about progress and change in our diverse and amazing profession than any time before. I became a vascular surgeon to treat the entire vascular tree—from the tip of the toes to the base of the skull—to treat arteries, veins, and lymphatics. I have no problem if someone focuses on veins or arteries alone. For them, that may be the ultimate experience. I also understand that some facilities focus on special areas of vascular surgery, arteries, or veins. However, I love comprehensive vascular care. Treating the full spectrum of vascular diseases gives me full satisfaction. I feel extremely fortunate to work at Mayo Clinic, where I have the opportunity to do what I love doing most: taking care of a large number of vascular patients with arterial, venous, or lymphatic diseases. ■

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