AN INTERVIEW WITH…

Patrick Chong, MBBS, FRCS (Eng), FRCS (Gen Surg)

Mr. Chong discusses the current status of the BASIL-3 trial, NICE AAA guidance, and his advice for engaging in online clinical discussion platforms.

What was your reaction to the halting of recruitment in the BASIL-3 trial based on the meta-analysis findings by Katsanos et al, as well as the decision to recommence recruitment based on the June 2019 Medicines and Healthcare Products Regulatory Agency (MHRA) statement? What changes have been made to the recruitment or other processes in the trial?

My initial reaction to my colleagues was that we should examine the outcomes up to 5 years of our own local drug-eluting stent (DES) and drug-coated balloon (DCB) series to see whether our results mirrored those of the meta-analysis. I posed four questions to our team. First, how do we fulfill the duty of candor we have to patients who have had the treatment? Second, how can we incorporate the meta-analysis findings into preexisting patient information sheets for those requiring DCB or DES therapy? Third, should paclitaxel-based technologies be stopped in patients with intermittent claudication and restricted to those with symptoms of critical limb-threatening ischemia (CLTI)? Last, should we ensure that all our DES and DCB patients are on an additional locally managed registry rather than just the National Vascular Registry for longer-term follow-up? To date, our local audit has not shown any immediate concerns, and we are in the process of finalizing the wording for our duty of candor letters to all patients and changing our peripheral intervention patient information sheets. DES and DCB treatments are no longer offered to claudicants, and a device-specific local registry is now kept for all patients undergoing lower limb interventions.

Despite the fact that 89% of patients in the Katsanos et al meta-analysis were claudicants and therefore different than patients with CLTI in the BASIL-2 and BASIL-3 trials, I was not surprised that Andrew Bradbury, MD, and his team made the decision to stop the use of DCB or DES in BASIL-2 in December 2018 and halted BASIL-3 recruitment altogether in January 2019. The signals from the meta-analysis were hard to ignore, and given the medicolegal ramifications, it was the correct decision by the BASIL trialists. I am glad that both the MHRA statement and Global Vascular Guidelines (GVG) in June 2019 have provided clear recommendations supporting resumption of the evaluation of DES or DCB technologies through recruitment into appropriately controlled prospective studies that are specific to the CLTI population. The GVG statement is endorsed by the Vascular Society for Great Britain and Ireland (aka Vascular Society), British Society of Endovascular Therapy (BSET), and British Society of Interventional Radiology (BSIR) in the United Kingdom (UK). I would urge fellow clinicians to consider joining Dr. Bradbury and his BASIL-2 and BASIL-3 trials team to help contribute data to assess the effectiveness of current interventional options for the femoropopliteal segment and also, in doing so, help settle the question of safety for our patients with regard to DCBs and DESs.

As an IMPROVE trialist and National Institute for Health and Care Excellence (NICE) medical technologies evaluation program advisor, what are your thoughts on the forthcoming abdominal aortic aneurysm (AAA) guidance?

The final NICE guideline for AAA care was due to be published in July 2019, but at the time of this interview in August 2019, the timeline for finalization of the guideline has been extended. The NICE panel has written to all stakeholders, recognizing that further delay may lead to uncertainty among clinicians and service providers. They are keen to ensure that all the issues raised at consultation are properly addressed and that the final guideline

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has the confidence of both clinicians and patients. Results of a study of our own consecutive endovascular aneurysm repair (EVAR) series at Frimley Health presented at the Charing Cross 2019 symposium in London showed that if the drafted NICE guideline recommendations are implemented and EVAR is withheld from patients deemed not fit for open AAA repair, up to 40% of patients would be deemed unsuitable for intervention.

BSET together with the BSIR and the Vascular Anaesthesia Society of Great Britain & Ireland (VASGBI) have jointly issued a response statement to recommend that fitter patients with good life expectancy should be considered for open surgical repair (OSR), with EVAR as a possible option in some patients with good aortic anatomy. High-risk patients with clearly limited life expectancy should not be considered for intervention. The determination of fitness for intervention should include input from an anesthetist experienced in vascular anesthesia and multidisciplinary discussion. Patient choice is upheld, and therefore those with suitable anatomy and reasonable life expectancy who choose not to have OSR should be offered the option of EVAR. They also stressed that elective EVAR needs to be more cost-effective with short hospital stays, low readmission rates, and lower reintervention rates. Close adherence to device instructions for use is emphasized, and submission of cases to our National Vascular Registry remains mandatory. An audience vote taken at the BSET conference this past June agreed with the motion that, in its present form, the draft guidelines would not be implementable and would be detrimental for UK patients with AAA. My colleagues and I in the UK are waiting to see how the NICE AAA guidelines panel responds to the Vascular Society/BSIR/VASGBI recommendations in its upcoming final publication.

Can you tell us about your role as Chair of the London Postgraduate School of Surgery's (LPSS) Vascular and Endovascular Skills Simulation Training Committee and what this program offers to graduates?

I have been involved in setting up and running both the EVAR and the endovenous courses at the LPSS's Surgical Skills Program based at the Paterson Centre at St. Mary's Hospital in London since 2009 and was appointed Chair of the LPSS Vascular and Endovascular Skills Training Committee in 2014 to oversee the delivery of nine separate training courses. These cover topics including open AAA repair, EVAR, complex AAA therapies, lower limb bypass surgery, lower limb endovascular intervention, renovascular access, endovenous therapy, lower limb amputation, and carotid endarterectomy. Our postgraduate deanery trainees in vascular surgery in the London and Kent, Surrey, and Sussex regions are taught on our program in courses led by experienced consultant colleagues who aim to cover all the vital aspects of the UK Vascular Specialty Advisory Committee's curriculum.

The LPSS is proud that we were one of the first programs in the UK to offer our trainees the opportunity to practice their skills under the guidance of proctors on angiographic simulators. We started with the Simbionix platform in 2010 and then added the Mentice platform a year later. This is all made possible with the generous support from industry partners. It is vital that clinicians recognize the important role that our industry partners play in training our next generation of vascular surgeons.

You were also recently on the organizing committee and helped chair some sessions at the annual BSET congress. What do you believe were its greatest highlights?

This year's BSET congress was again another full house, taking place in the beautiful surroundings of Totworth Court in South Gloucestershire. The aims of BSET have been very close to my heart, as it seeks as a society to promote scientific research, education, and training for endovascular treatments for patients in the UK. Our current President is Rachel Bell, MS, and this year's conference was chaired by Bijan Modarai, PhD. My role in BSET is Joint Chair of the Education and Fellowship Committees with Paul Bevis, MD. We look forward to delivering next year's National Vascular Training Day. It was an enjoyable conference this year, and some highlights were a talk by Germano Melissano, MD, on strategies for achieving a uniluminal aorta after type B dissection; one by Mark Farber, MD, on salvage for failing endovascular stent grafts; Barend Mees, MD, speaking on the future of vascular training and competencies for newly qualified vascular specialists; the Presidents' Debate, titled, "The evidence for endovascular aortic repair is weak, open is best," which was won by Ian Loftus, MD, for EVAR arguing against Miss Bell; and of course the Chee Soong Memorial Lecture, which was in remembrance of CV Soong, MD, FRCS, one of the UK's pioneer endovascular surgeons in Belfast, who sadly died prematurely in the prime of his career. This year's lecture was delivered by Jonathan Boyle, MBChB, who highlighted the importance of keeping device-specific registries in our practice nationally to track outcomes regarding complications and reinterventions. I would really like to encourage colleagues internationally to consider attending the BSET conference, as it is one of the most rewarding events in the annual vascular calendar.

And what can you tell us about Vascular Society's STARS 2019 event taking place in September, as well as the overall enduring goals of the course?

The STARS event takes place annually in September in London and is chaired by Hany Zayed, MD, and Tarun Sabharwal, FRCSI. It is an opportunity to explore and discuss the latest developments and advancements in lower limb revascularization. I have been invited to chair a session focusing on "My Most Challenging Case" and am looking forward to meeting colleagues at this year's symposium.

You've listed "the role of human factors training on surgical outcomes" as one of your research interests. Can you share some details on your work in this area and any ongoing projects?

In 2009, I implemented a pilot study to look at the impact of performing the World Health Organization (WHO) surgical safety checklist on procedure volumes in theaters across several specialties and assessed outcomes such as mortality, complications, and incident reporting. It showed that the routine use of the WHO checklist did not lower theater efficiency but in fact reduced the number of electronically reported incidents in theaters over a period of 6 months. These data were presented at the UK Association for Perioperative Practice conference in 2010. It is important that vascular surgeons also consider the development of team skills in our day-to-day work. I was fortunate to be involved as faculty in the Team Training Course for Ruptured AAA run by the Royal College of Surgeons in the early days of the course. Successful outcomes in complex emergency situations such as ruptured AAA often hinge on teams that know each other well and work cohesively together.

What led you to start the Vascular & Endovascular Surgery group on LinkedIn and to what do you attribute its high engagement and success?

I started the online group for Vascular & Endovascular Surgery on the LinkedIn platform in November 2009 with three surgeons as members in the first month. By 2014, when I was invited to the Vascular Society's annual scientific meeting to give a talk about the impact of vascular surgeons online, we had 8,800 members. In 2019, there are now more than 16,000 members and this continues to grow each month. It is the largest online digital collective of multidisciplinary individuals who are interested in our specialty of vascular and endovascular surgery. By comparison, the largest conferences in cardiovascular care (eg, Transcatheter Cardiovascular Therapeutics) annually attract about 12,000 delegates to their conferences. The LinkedIn group for Vascular & Endovascular Surgery has the potential to reach out to all 16,000 of our members daily. It has taken over 10 years to reach this number of members, and we are the largest group on LinkedIn for any surgical specialty.

As the manager and curator of the group's content, I have always endeavored to be impartial in my views. I do not receive any payment from industry for any postings. It helps to be inquisitive, and I avoid bias by allowing our discussions to be as full and frank as possible. The group does not have allegiances to any political party or vascular society, but we are willing to promote all activities, including educational events, job postings, business opportunities, research projects, and clinical discussions that forward the cause of Vascular & Endovascular Surgery in good faith. It takes experience to curate relevant and interesting content, and sometimes I get it wrong, but I appreciate that it works best when there is an actual case at work that intersects with a current hot topic in the literature.

The LinkedIn platform is preferable to other platforms such as Twitter (too public) and Facebook (too informal), as we operate "Vascular & Endovascular Surgery" as a closed group. Our members are vetted and everyone is able to gain access to the professional profiles of other members and thus form valuable professional networks. There are now other highly commendable online groups in vascular surgery that are making an impact (a notable example is Vascupedia).

My five top tips to surgeons who wish to make an impact online are first to respect patient confidentiality. Second, always be professional and courteous in your comments and opinions, even when you disagree with the other party. Third, please check your facts before clicking the "post" button. Fourth, develop a sense of "digital EQ" and avoid spamming large professional groups with unwanted information. Last and perhaps most importantly, develop an awareness of professional responsibility when interacting on social media, as our views are rarely our own and may impact others around us. ■

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