AN INTERVIEW WITH…

Armen Roupenian, MD, FACS

Dr. Roupenian discusses what's in store at the upcoming American College of Phlebology Congress, as well as areas that most need awareness in venous and lymphatic disease.

What specific areas of venous and lymphatic disease need further definition, treatment guidelines, and patient/physician education?

I would start with the treatment of deep venous disease. Whether it's creating a validated test for iliac vein outflow compression or determining who benefits from thrombolysis, there needs to be an increased emphasis on research and use of registry data to make sure that those patients who undergo intervention benefit from treatment. Lymphedema is another area that demands our attention. This is especially true when one looks at what is available for patients in other developed countries. We need to demonstrate to insurers, especially Medicare and Medicaid, the benefit of ongoing lymphedema therapy and make sure that compression is fully reimbursed. Lymphedema patients are a forgotten and undertreated population and that has to be addressed. A universally accepted lymphedema severity score would be a good place to start, and there is movement to develop one.

Unfortunately, ethics continues to be a problem. This was addressed by the American Venous Forum (AVF) at its meeting last year, and the upcoming American College of Phlebology (ACP) Congress, in a joint session with the AVF, will be holding a similar session. It is important that we find a way of dealing with the very few among us who don't put the best interest of the patient first.

In your view, what are the best ways that the public can be properly educated about venous disorders and when it is appropriate to seek treatment?

First of all, as much I respect "Dr. Google," patients need to understand that the majority of information on the internet is marketing. There was a time in my career when no one wanted to treat venous disease. Now it's hard to think of a specialty that doesn't want to. Personally, I believe it's a good thing. By reducing the impact of superficial venous hypertension, we should see a significant improvement in the incidence of chronic venous insufficiency. This is especially true for venous stasis ulcers that seriously affect the lives of these patients and are an economic burden on the health care system.

All that said, consumers need to be wary. They should look at any incentives such as Groupon or free services with great caution. It may not necessarily mean their care will be inappropriate, but the red flag should be up and flying. Too often, patients are talked into treatment based only on imaging results instead of combining that with good clinical judgment. For that reason, it is essential that diagnostic ultrasound be performed by a credentialed ultrasonographer. This is important not only due to the expertise involved, but also the added ethical layer that makes overtreatment more difficult.

Lastly, I would encourage patients who have doubts about their treatment recommendation to get a second opinion. Everyone who treats venous disease can relate a story of a patient who came in for another opinion being told they needed three for four veins treated in each leg. Somewhere along the way, some have confused the terminal with the mitral valve.

What can we expect from this year's ACP meeting?

In one word, Austin. Bring your family and take some extra time off to get to know the live music capital of the United States. That alone should be reason enough to attend.

On a more serious note, the primary mission of the ACP is education and that has always been reflected by our congress. The diagnosis and treatment of deep venous disease is one area that has evolved significantly over the past several years, and we have made it a point of emphasis at this year's meeting. On the first day of the congress, there will be a day-long session dedicated to both venous thromboembolism and pelvic venous disorders. With the help of industry, a significant amount of time has also been allocated to allow participants an opportunity for hands-on exposure to numerous treatment modalities.

The ACP has also recognized the need to increase the skill set of sonographers and physicians in pelvic venous ultrasound. We are offering a unique proctorship to achieve that goal. We have selected five of the most experienced pelvic

(Continued on page 112)

(Continued from page 114)

venous ultrasonographers in the country to act as proctors. Participation will be limited, so at most, there will be a 3:1 proctor-to-student ratio. We have also recruited patients with pelvic venous disease from as far away as Canada. I am really excited about this course, and there are discussions to make this an annual offering of the congress.

For those who can't participate in the hands-on scanning portion, a separate session will be streamed on-site that allows attendees to view the didactic presentations and a streamed pelvic venous ultrasound study, with the proctor and moderator available to answer questions from the audience.

I am especially pleased to announce that Dr. Stanley Rockson from Stanford will be our first keynote speaker at the opening session on Thursday. Dr. Rockson's involvement in our congress reflects the increasing emphasis our society has placed on the diagnosis and management of lymphedema. On the following day, Dr. William Sage, who is Professor of Surgery and Perioperative Care at the University of Texas, will discuss "Obamacare and Beyond" in his keynote address.

As usual, there will be numerous workshops to take advantage of, lots of updates on superficial venous disease including the new nonthermal techniques, and a totally revised practice management session.

I encourage those interested to go to the congress website (www.acpcongress.org) and see all of the great sessions available this year. There is something for everyone, no matter the emphasis of their practice, so definitely not the "same old" as the expression goes.

What are the specific research goals of the ACP PRO Venous Registry? What is your pitch to venous specialists who aren't sure if they should invest the time to participate?

In general, we are concerned with regulatory bodies and how they are looking at the treatment of venous disease. We believe that it is up to us as an organization to document that what we do benefits patients. The emphasis is very much quality of care and patient outcomes.

If you're a community physician wondering, "Why should I have to be involved in the registry?" my answer is that you can't expect both insurance companies and regulatory agencies to look upon what you do favorably without providing them with data to analyze. It doesn't matter whether you're treating 100 patients per year or 10 times that number, every entry into that registry gives us the evidence that we need to go to those insurance companies and regulatory agencies and show them that what we do makes a difference. It also allows us to create best practices guidelines, not only for superficial venous disease, but also for deep venous disease and lymphedema, which are lacking.

What specific form of venous disease is most prevalent among the patients you see in your volunteer work in underdeveloped countries? Do you offer the same treatments there as you do at home?

During the years that I participated in the Hackett Hemwall Patterson Foundation's mission to Honduras, we treated thousands of cases of chronic venous insufficiency, especially neglected venous stasis ulcers. Most patients had suffered for years. Unfortunately, the majority were due to easily treatable superficial venous hypertension.

Our primary treatment is foam sclerotherapy targeting both the source of venous hypertension and the ulcer base. Although anecdotal, our treatment results have been excellent. The mission is in its second decade, and the veterans who return year after year have noticed the impact they have made on that population.

What made you want to pursue this work?

The first time I went was more out of curiosity than anything else. After that, participating became an important part of my life. I always considered myself very fortunate to be able to practice medicine, especially surgery. But, the stresses and obligations outside of patient care can really take a toll and cause one to lose perspective. I never left Honduras without being reminded of why I became a physician. The mission is only a week, but it's a very intense week. I would recommend that if this resonates with anyone reading this interview, they should go to the foundation's website and consider becoming part of the mission. My daughter accompanied me for 2 years, which was really great. I know other family members who attended while in high school and are now pursuing medical careers.

What did you learn in completing your graduate work at the University of Graz, Austria?

It had a significant influence on my life. It has certainly made me less ethnocentric on how I view and value the contributions of the international medical community. That is one thing that I enjoy about the ACP—the effort it makes to get our international colleagues involved in every aspect of our organization. ■

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