AN INTERVIEW WITH...

Jacques Busquet, MD

The president of ISES explains the society's impact on the worldwide endovascular community and the current state of this specialty in France.

What are the goals of the International Society of Endovascular Specialists (ISES)?

Since its creation in Bordeaux, France in October 1992 by a group of pioneers under the impulsion of Dr. Edward B. Diethrich, ISES has been entirely devoted to peripheral endovascular interventions and therapy in terms of education, development, research, and training. As a multidisciplinary society that unites endovascular specialists (vascular surgeons, radiologists, and interventional peripheral cardiologists) from all over the world, all aspects of endovascular techniques and technologies are expressed into a collaborative vision of our new specialty.

This panorama is naturally reinforced by the *Journal of Endovascular Therapy,* the bimonthly publication of the society that is in its 15th year of publication, which allows all ISES members to get a broad scientific multidisciplinary scope on the latest techniques via clinical or experimental reports, overviews, case studies, technical notes, and editorials.

How large is the society, and what has its impact been to date?

As of March 2011, the society is represented in 63 countries worldwide by a total of 1,585 members, 70% originating from the United States, 16% from Europe, 7% from Latin America, 6% from Asia and Australia, and 1% from the rest of the world.

We must especially congratulate Dr. Donald Reid from Scotland, former chairman of the ISES membership committee and new president-elect, and Shirley Nimsky, executive director of ISES, for their efforts during 2010 in bringing 270 new members to the society, showing a real and encouraging progression in terms of audience and interest.

Is ISES meant to complement existing national and continental specialty-based societies?

Most of our members belong to their respective national societies that are devoted to vascular surgery, interventional radiology, or interventional cardiology. In the recent past, these types of national or continental specialty-based societies did not always offer their members a global vision of the endovascular field, instead having a traditional approach and being isolated in a corporatist position leading to some interspecialty battles, and only recently fully opening their national congress or journal to the new specialty of endovascular intervention.

Our scientific publication, the *Journal of Endovascular Therapy,* intends to be a multispecialty vehicle for communication. It opens its columns to all specialties for articles, case reports, and opinions. In addition, our Web site, updated last spring, performs well, with increased functionality and more search options and access to the archives.

As a surgeon and vascular interventionist practicing in France, how might your perspective on endovascular therapies differ from physicians based in the United States?

Historically, except for the first arterial balloon dilatation performed by Dr. Andreas Grüntzig in 1973, the United States approached endovascular techniques early thanks to pioneers such as Dr. Thomas Fogarty, who performed the first embolectomy catheterization in 1963; Dr. Charles Dotter, with his intra-arterial dilatation catheter; and Dr. Julio Palmaz, who invented stent technology in 1985.

In 1987, after the completion of my cardiovascular and thoracic surgical residency in Bordeaux, France, I discovered some interesting publications from the United States regarding a new surgical approach to endovascular techniques. I immediately decided to visit Dr. Rodney White at UCLA (who had Dr. Geoffrey White as a visiting professor from Sydney, Australia) and Dr. Edward Diethrich in Phoenix, Arizona, who, at that time, had Dr. Richard Schatz on his staff as an interventional cardiologist performing the first Palmaz stent implantations in iliac artery obstructions.

These training periods in the United States instilled in me the "endovascular spirit" for treating vascular patients, which I put into effect right after my return in France, as did other French endovascular initiators in Paris, Nancy, and Marseille.

Twenty years later, endovascular techniques are uniformly recognized and have been adopted worldwide. Europe and the United States have the same conceptual and technical approaches with similar global results regarding aortic endografts, carotid endovascular techniques, and treating peripheral vascular disease. However, nearly all major industrial manufacturers are based in United States, which induces a strong collaboration among vascular physicians who bring

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their innovative expertise and technological experiences to the companies, and certainly constitutes a difference between our two continents.

How does your practice typically approach the treatment of carotid artery disease? Which data publications have been most influential in guiding your decisions, and how have the results of the CREST study been received in France?

In France, we have a long history and tradition of carotid endarterectomy, with excellent vascular surgical training, good operative practice, and satisfactory global postoperative results. This is because of great surgeons such as Dr. Edouard Kieffer in La Pitié-Salpétrière Hospital in Paris, who developed an extremely well-documented range of carotid surgical therapies.

The endovascular approach to carotid artery stenosis in France has been negatively influenced by the EVA-3S randomized study, which was conducted in 2009 in the major public hospital vascular services, demonstrating the superiority of carotid endarterectomy. Therefore, despite the encouraging results of the CREST study, a relatively low number of carotid artery stenting procedures are currently performed in France compared to endarterectomy because the technique is not reimbursed by Social Security. The technique is in fact reserved for undisputed indications such as postendarterectomy restenosis, postcervical radiation carotid stenotic injury, or anatomically high lesions. These specific indications are reimbursed after an official written request is made by the physician with previous agreement from the Social Security Central Office.

How do reimbursements and approvals for various endovascular procedures in France differ from those in the rest of the European Union?

Since 1945, the French population has been almost universally covered (99% of citizens and residents) by statutory health insurance, a branch of the Social Security system. In July 1998, under the control of the High Authority of Health, the French Health Products Safety Agency was created within a global context of reinforcing health monitoring and control of all products for human use. Therefore, the agency is the competent authority for all safety decisions concerning health products from manufacturing to marketing, and it carries out three core missions: scientific and medico-economic evaluation, laboratory control and advertising control, and inspection of industrial sites. The agency also coordinates vigilance activities relating to all products for which it is relevant.

The organizations ruling on reimbursement are the Health Minister, who determines if a medical product will be registered on the refundable list, and the Union Nationale des Caisses d'Assurance Maladie, a public health care organizational system created in 2004, which decides the reimbursement rate. Its first purpose is the coordination of the mandatory sickness funds with health care professionals to create better health insurance management. Its second purpose is the negotiation of agreements with medical professionals when using new products and health care reimbursement procedures. The Economic Committee on Health Care Products fixes the product price after negotiation with the industrial company.

The European Union is currently trying to organize a uniform European administrative health care system with the potential of creating a "European FDA" that would rule on the use and reimbursement of new drugs and medical products, but the remaining disparities between the respective European countries will probably slow down this process.

How have improvements in endograft technology affected the way you treat aortic disease?

The first procedures to treat abdominal aortic aneurysms were performed in France as early as 1994 using the only type of endograft that was available at the time. The next year, the French Health Administration reserved this practice exclusively to public hospitals in order to officially analyze global results and durability of the endograft systems. Since July 2004, the technique has been officially authorized in all hospitals, both public and private, with reimbursement of the endograft by Social Security, respecting selected indications on high-risk patients. This restriction has been suspended since 2009, opening the technique to all patients with abdominal aortic aneurysms that are ≥ 50 mm in diameter or that increase in diameter ≥ 1 cm during 1 year. Recently, endografts for exclusion of thoracic aortic aneurysms have also been reimbursed in France.

Because I was personally involved in the endovascular aortic procedures that were performed in France during their early stage, I favor this type of technique in my aneurysmal patients as a first option unless the proximal aortic neck anatomy and the iliac access are not suitable, as these are situations that potentially reduce the chances of a safe outcome. The miniaturization of the introduction systems and the improvement of endograft fixation will surely extend the indications to more difficult patients in the near future. ■

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