



33 Years

EUROPE'S LONGEST RUNNING AND LEADING VASCULAR SYMPOSIUM

Vascular and Endovascular Consensus Update



by Roger M Greenhalgh

**CX St George's Vascular Access
Consensus Update**

by Eric Chemla

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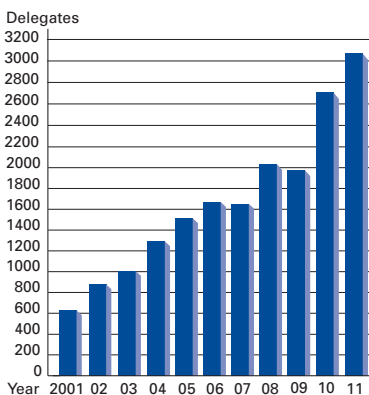
VASCULAR AND ENDOVASCULAR CONSENSUS UPDATE

ATTENDEES

Charing Cross is the longest running and leading international vascular and endovascular symposium in Europe.

Over the past 33 years the Charing Cross International Symposium has continued to grow. The figure below shows the increase in participants in recent years. It can be seen that there was a 10% increase in attendance in 2011, with a total of 3,002 delegates attending from 75 countries. This was an extraordinary attendance given the prevailing financial environment.

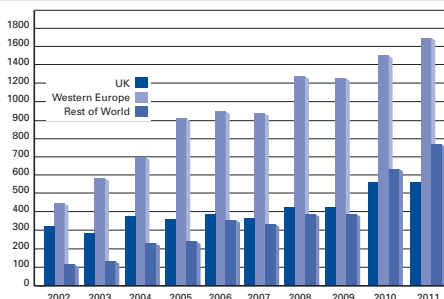
Delegates



Delegates by Country Breakdown

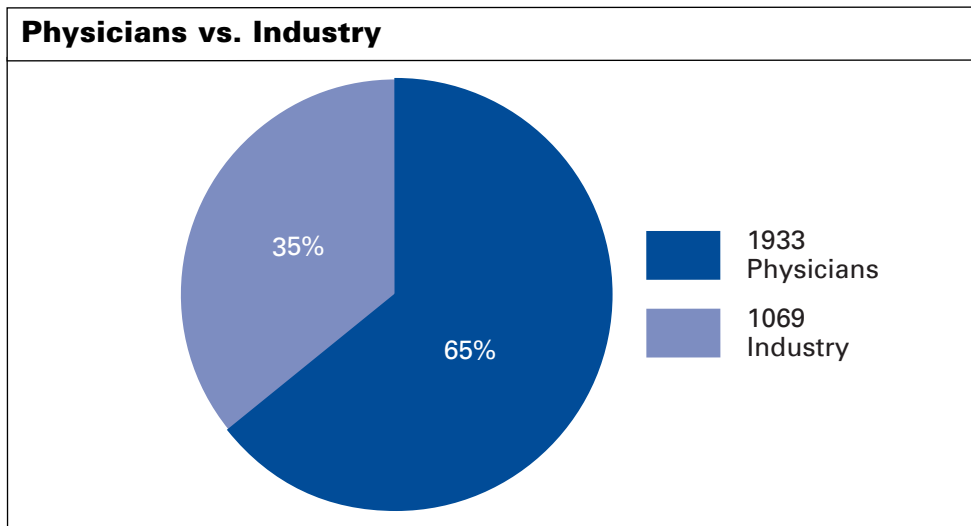
The chart below shows the delegates by country breakdown. It can be seen that in 2011 Western Europe still contributes the largest number of specialists, but growth has appeared also in the rest of the world.

Delegates by location



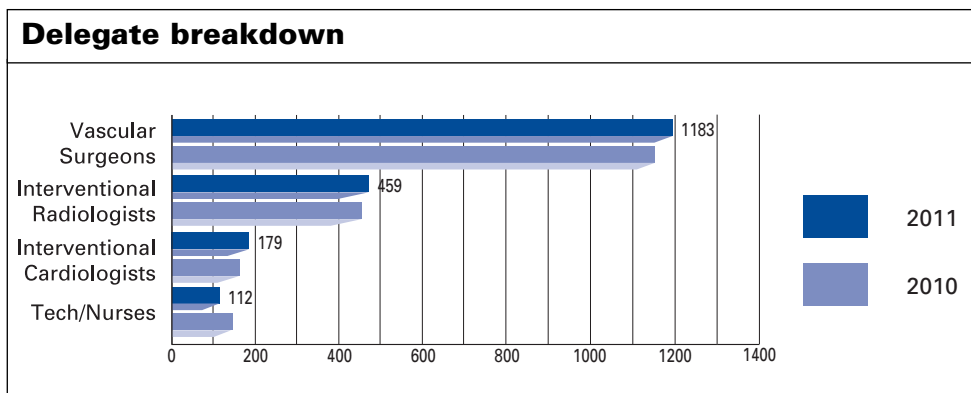
Physicians vs. Industry Breakdown

The pie chart emphasises that nearly 2,000 physicians attended and there were around 1,000 attendees from industry.



Charing Cross provides a multi-disciplinary forum for senior vascular and endovascular specialists

A feature of the Charing Cross is that it attracts a wide variety of disciplines interested in vascular disease management. This was no different in 2011, as shown by the above charts and figures.



The breakdown by specialty is given in the following chart. Vascular surgery is the largest group with 1,183, followed by interventional radiology 459, interventional cardiology and angiology 179, technologists and nurses 112.

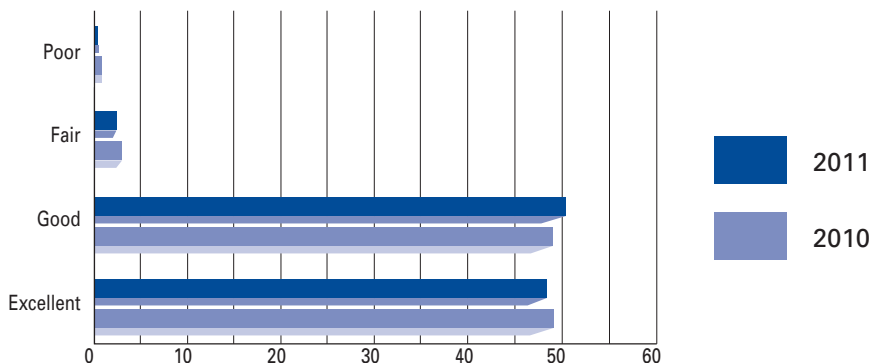
CME REVIEW OF 33RD CHARING CROSS INTERNATIONAL SYMPOSIUM

The summary includes data from 692 delegates who completed the official UEMS evaluation form of the 3002 delegate total:

1. Overall

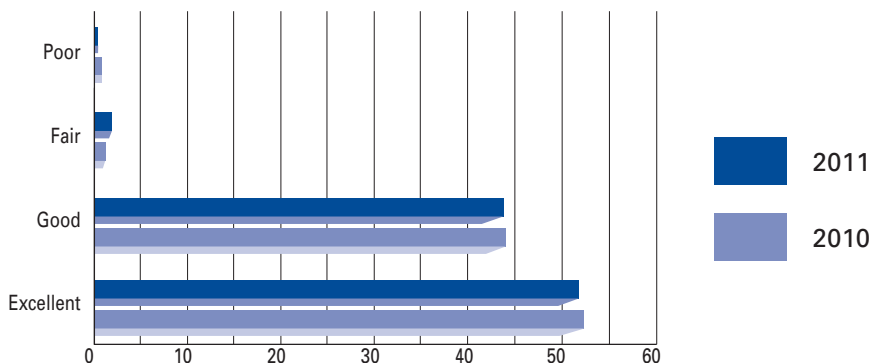
Over 97% of the delegates rated the **overall CX Symposium** as excellent or good:

Overall Charing Cross Symposium



Over 97% of the delegates rated the **overall CX Programme** as excellent or good:

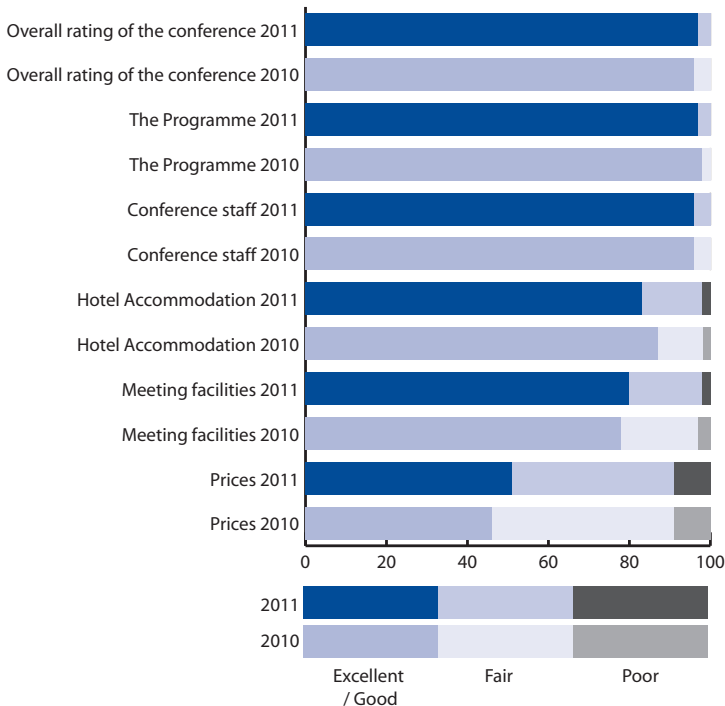
Overall Charing Cross Programme



CME REVIEW OF 33RD CHARING CROSS INTERNATIONAL SYMPOSIUM

The ratings for CX meeting facilities and prices improved but were slightly down for hotel accommodation:

Overall Charing Cross Ratings



Delegates were asked what they had learnt that would be helpful when they returned to their practice:

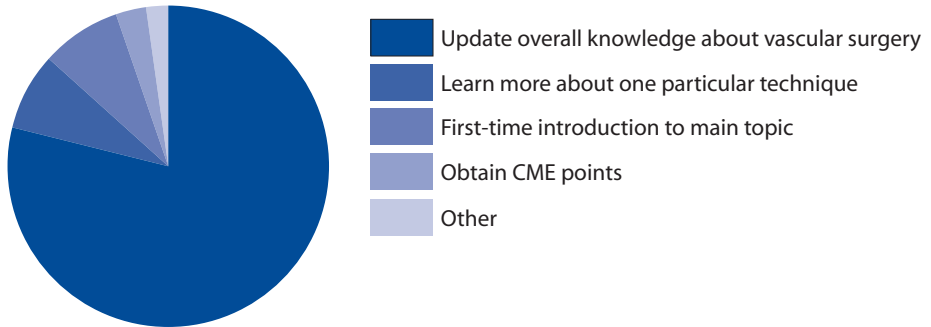
“Congratulations on an excellent meeting as always”; “Discussions were stimulating”; “Excellent discussions make this symposium unique”; “It is a great symposium to know more about new technologies and devices”; “Excellent comparison of methods, very experienced speakers”; “The book will be very useful”; “Have received an update of new techniques and current thinking which I will be putting into practice”;

“Hands on training was very helpful”; “Very important training courses with simulators for young surgeons”; “The thoraco-abdominal session was very interesting and something that we are developing right now.”; “The vascular access course, office based vein course, update on results of endovascular treatment of abdominal aortic aneurysms will all have an impact on my work as a surgeon”; “See you next year!”

CME REVIEW OF 33RD CHARING CROSS INTERNATIONAL SYMPOSIUM

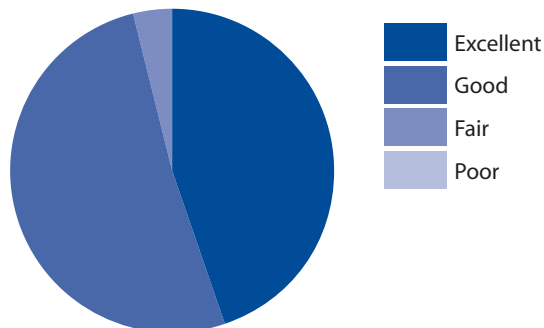
Delegates said that the primary reason for attending the CX Symposium was to update their overall knowledge of vascular surgery

The primary reasons for attending the symposium



Nealy 50% rated the CX Symposium programme as excellent and over 96% rated the programme as either excellent or good in achieving their purpose for attending the meeting

How well the symposium programme achieved the purpose of attendance



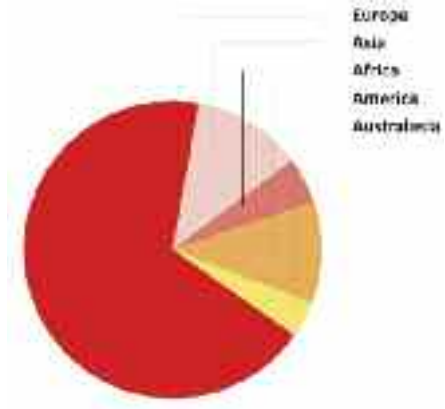
VASCULAR AND ENDOVASCULAR CONSENSUS UPDATE 2011

This is a summary of the highlights of the Vascular and Endovascular Consensus update discussions at the 33rd CX International Symposium which took place from 9-12 April 2011.

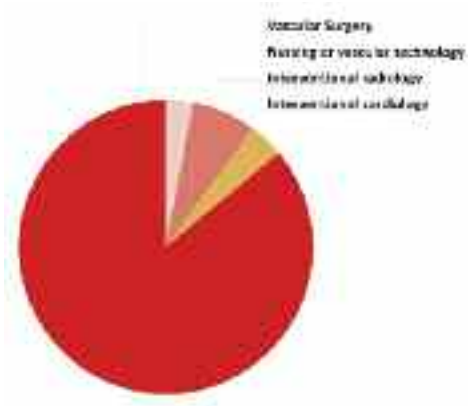
The participants received a copy of the book Vascular and Endovascular Consensus Update and the relevant chapters are to be found in this book published by BIBA Publishing, a division of BIBA Medical Ltd. The presentations are to be found at www.CXsymposium.com.

The CX 33 audience was asked to state their discipline and where they came from and the results are shown in the diagrams below. 68% of CX delegates came from Europe; 12% from Asia followed by America, then 5% from Africa and 4% from Australasia. Over 3,000 vascular specialists and industry professionals attended Charing Cross 2011.

Country breakdown - polling data of audience



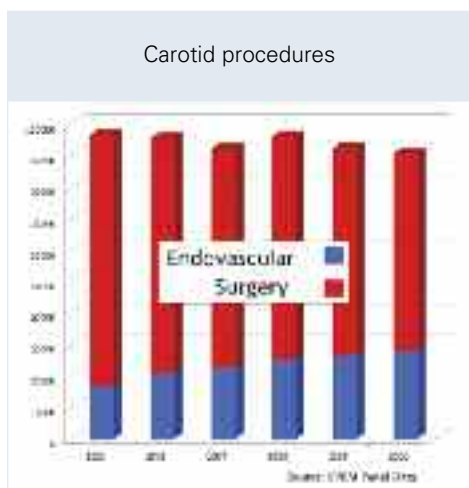
Specialty breakdown - polling data of audience



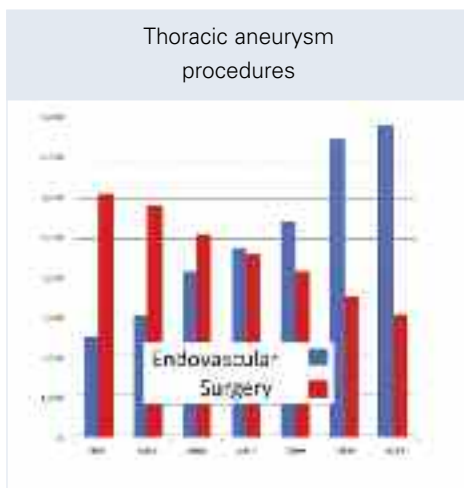
The relentless trend to endovascular, as demonstrated by the European Vascular and Endovascular Monitor (EVEM)

Stephen Greenhalgh highlighted the EVEM trends, which are demonstrated here in the diagrams in the CX Innovation Showcase. The domains discussed were carotid, abdominal aorta, thoracic, aorto-iliac and femoro-popliteal. There is a relentless trend towards endovascular in all of these domains.

The concept of EVEM is based upon membership of vascular specialists who own the data. The 250 or so specialists report a simple feedback sheet every three months and report on their estimate of the number procedures performed in the previous three months. This does not track sales but number of procedures. It has proved a very enlightening method of following treatment change across the continents. A feature of EVEM and USVEM is that each member of the panel received the data and they are able to refer to their data in publications and presentations. It is gratifying to see the EVEM and USVEM data quoted all over the world.

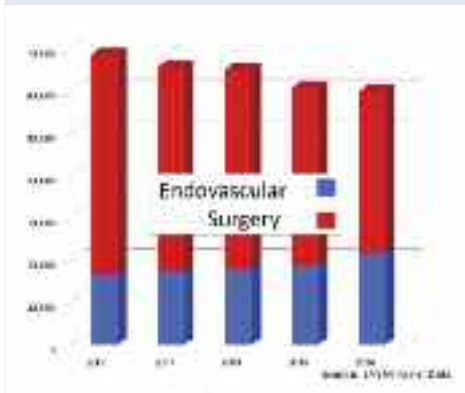


These EVEM data show the slow increase in carotid stenting but it is evident that open endarterectomy is still a much more common procedure.



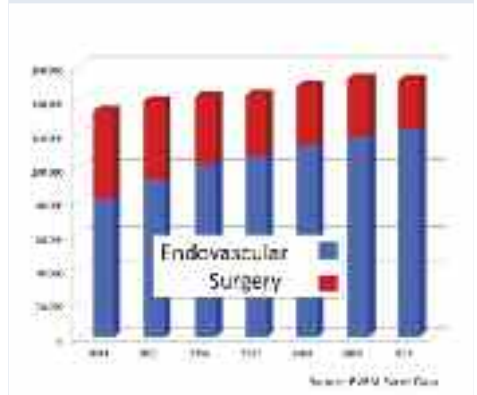
Between 2007 and 2010 the growth of endovascular has moved from near equally with open procedures in 2007 to more than twice as many procedures in 2010. In addition, because of the availability of endovascular procedures, the total number of interventions has greatly increased over the last three years (2007 both methods together approximately 9,000 procedures, 2010 both procedures together approximately 11,000).

Relative number of abdominal aortic aneurysm vascular and endovascular procedures



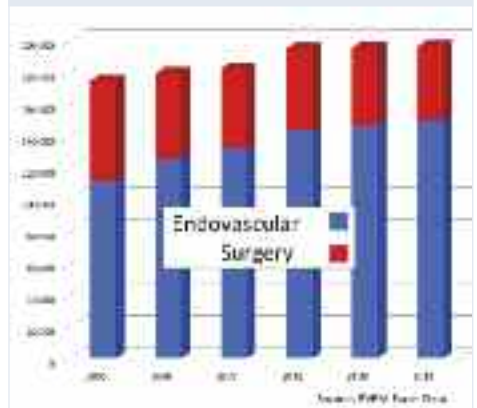
Endovascular abdominal aortic aneurysm procedures are increasing but the rate of the increase is different in various parts of the world. These European data show clinicians return of 21,422 estimate of endovascular procedures of the centres asked and against 38,470 open procedures in the same year. In England and Wales, we know that it is approximately 50/50 currently and in the United States it is 75% EVAR against 25% open repair. There has to be an explanation for this and it could relate to the lack of availability and training of EVAR in certain areas.

Aorto-iliac procedures



The open procedure numbers fall and endovascular interventions increase relentlessly.

Femoropopliteal procedures



Likewise, femoropopliteal procedures follow the same relentless pattern.

Training Consensus Update

This was approached from the trainee's and the trainer's point of view and we then asked the audience the following question.

Do you think today's vascular/endovascular surgeon is trained as well as 10 years ago?



Clearly the more common view is that training is not as good as it was 10 years ago. This is a problem that requires attention and should be taken very seriously indeed and is hardly a surprise.

The audience were then asked the second question with the following result.

Do you think today's vascular surgeon is trained in open surgical techniques as well as 10 years ago?



As you can see, open surgical techniques are taught much less well today than 10 years ago in the opinion of the CX 33 audience.

Carotid Consensus Update

Current carotid stent design is inadequate and contributes significantly to procedure related stroke



Here is the result of this debate in which Sumaira McDonald narrowly lost the motion to Bill Gray who opposed it. It was very close and clearly the 2011 audience were not holding their breath for altered stent design.

Surgery is the best at preventing stroke and remains the "gold standard"



Ross Naylor for the motion won this hands down. It has to be remembered that there was a majority of surgical trained specialists in the audience and given that, the results are not surprising.

Editorial comment:

There remained discussion in 2011 on open surgery or stent use, with many quotes of the ICSS and CREST trials. The confusing issue to many of the audience is the variety of interpretations of the same data, particularly in the CREST trial sponsored by Abbott Vascular. It is resolved to some extent by introducing the concept of not one but two important endpoints. The surgical concept is to remove the cause of stroke and success rate is based on stroke issues alone. CREST tended to favour surgery, in terms of stroke. However, what has also emerged from CREST is that more cardiovascular events accompany open carotid surgery. Fewer cardiovascular events and higher stroke rates appear to accompany carotid stenting. At the time of CX 33, there was no clear winner and the argument has swung to the relative importance of these two endpoints. It is a little confusing to the surgeon that cardiovascular events has no direct relationship with cardiac mortality or cardiac infarction. But it is argued that the cardiac event is an unwanted problem and the future is more bleak after such an event. This has been discussed with the Food and Drug Administration in the US. Apparently, this led to a greater FDA acceptance of carotid stenting in the US.

Thoracic Consensus Update

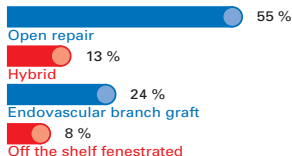
There was much discussion about the possibility of a choice of endovascular device relating to aortic pathology. This concept is not well accepted and so it was a surprise when the according question was asked. Large majority of the CX 33 sophisticated audience were clearly in favour of noting the aortic pathology and choosing a device with respect to it as indicated below.

Do thoracic aortic pathologies alter your choice of endovascular device?



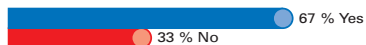
The best option for a type IV thoraco-abdominal aortic aneurysm was discussed and there were many different ways to approach this. It was a surprise that so many of the audience chose open repair and it will be interesting to see what the same question produces in a couple of years time. Here are the results for 2011.

The best option for a type IV thoraco-abdominal aortic aneurysm?



Because of the poor showing of the off-the-shelf fenestrated endografts, it was considered that this may be because so few devices are used at present.

Do off-the-shelf fenestrated endografts bring more patients for treatment?



The audience accept that more patients will come within the bounds of treatment when these devices become widely available.

Juxta-Renal Consensus Update

Easily the hottest topic was renal artery revascularisation. When we heard the ASTRAL trial results last year, Jon Moss was opposed by three eminent Faculty members, Michael Jaff, Bill Gray and Jim Reekers. The argument was that the very patients for whom renal revascularisation could produce a benefit were excluded from the trial. They found the findings from the trial counter-intuitive. The trouble is that the evidence is with Moss and intuition is with the other three. Jon Moss could not be persuaded to be here in 2011 and the vote went this way. Clearly a large majority in 2011 do not accept the ASTRAL trial results. This topic is not settled.

Renal artery revascularisation is a dead duck



Abdominal Aortic Aneurysms Consensus Update

There is some controversy over the importance of the internal iliac artery as to whether it should be conserved in aneurysm reconstruction. The conservation enthusiasm seems to vary according to whether it is the first side of the internal iliac artery in question or the second side.

Does the internal iliac artery require conservation for the first side?



Does the internal iliac artery require conservation for the second side only?



As can be seen, in the audience, it is quite clear that internal iliac artery conservation is favoured especially on the second side.

Are you fixing abdominal aortic aneurysms less than 5.5cm in diameter?



There is often a difference between what should be done and what is actually practised. In a secret vote, 52% to 48%, a small majority do fix abdominal aortic aneurysm less than 5.5cm in diameter. This is against all of the evidence but in line with instinct of many, including me, before the trials showed that I was wrong!

Should we intervene for sac expansion after EVAR with the defined cluster of factors associated with rupture?



The audience were treated to a “head-turning” moment, when Thomas Wyss drew attention to the importance of a cluster of factors associated with secondary EVAR sac rupture. As can be seen, 93% of the audience were in favour of intervention in the presence of this cluster. The full publication can be found in the November issue of *Annals of Surgery* 2010.

Andres Schanzer, using M2S database which started as an anatomical classification, noted the increase in off-label use of EVAR devices as clinicians became more confident of EVAR techniques. Far from the expectation of newer devices being shown to be better than earlier ones, the results actually show that results could be worse, possibly not because the devices are worse, but because those deploying the devices are becoming more liberal and less disciplined. Taken together, the Wyss and the Schanzer papers had a big impact on the CX 33 audience and Schanzer received huge applause.

Jean-Pierre Becquemin made a timely intervention, reminding us of the durability of open repair. This was very much in contrast to the lack of data on the effect of lower profile endovascular devices. Whilst the manufacturers will hope to sell more devices with lower profile, we hear no evidence and gain no comfort that the devices with low profile will be as durable in the long-term.

Ruptured Aortic Aneurysms Consensus Update

Professor Janet Powell discussed recruitment for the IMPROVE trial for the endovascular treatment of ruptured abdominal aortic aneurysm. There is some evidence that the incidence of aneurysm rupture is decreasing, but not from the increase of elective procedures and therefore not as a result of screening programmes. The audience were asked the following:-

Is your inflow of ruptured abdominal aortic aneurysms reduced compared with 5 years ago, do you think?



This view was favoured by the audience. The reasons why aneurysmal rupture is decreasing remain unclear. An unsolved problem.

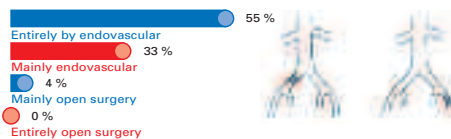
Lower Limb Consensus Update

In the past we have considered Trans Atlantic Societies Consensus (TASC) for the various lesions A, B, C and D. This year, it was reported that there was indecision between the Societies, with the consequence that findings emerged with great reluctance from the speakers who were under orders not to make the results known publicly.

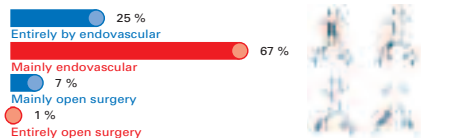
In addition, it emerged that since 2000, with update in 2008, the anatomy of TASC lesions has changed. In the results below, we give the TASC lesion definition, as we knew it in 2008 and question why these defined lesions have changed. Apparently, the change of the anatomical lesion definition is towards an expected outcome of therapy, such that a particular TASC lesion is managed entirely by endovascular methods or not. It is a moot point whether the lesion should change or whether the proportion of endovascular treated patients is seen to increase using the same anatomical definition which we have grown to understand. This is a fundamental issue and many of the audience favoured that the lesion should stay the same so that they could see the time over time proportioned change.

With all of this confusion, votes were taken on how the audience would manage the lesions.

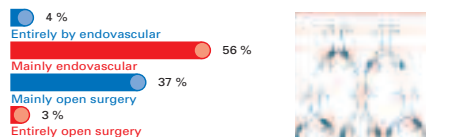
TASC A Aortoiliac lesions are managed by



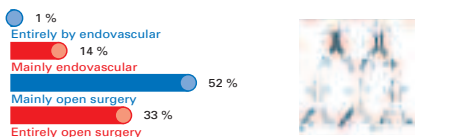
TASC B Aortoiliac lesions are managed by



TASC C Aortoiliac lesions are managed by

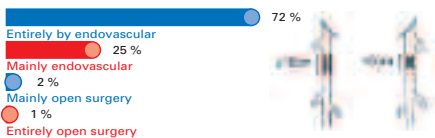


TASC D Aortoiliac lesions are managed by

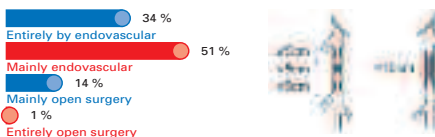


Lower Limb Consensus Update

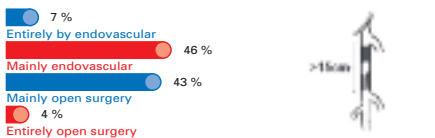
TASC A Femoropopliteal lesions are managed by



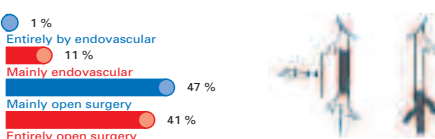
TASC B Femoropopliteal lesions are managed by



TASC C Femoropopliteal lesions are managed by



TASC D Femoropopliteal lesions are managed by



The actual votes cast at this symposium must be interpreted against the background of the TASC headquarters uncertainty, which ripples across the world.

There were several presentations at CX 33 on the use of Bare Metal Stents (BMS) and Drug-Eluting Stents (DES) in the various parts of the arterial tree leading to the foot.

Are good bare metal stents as good as drug-eluting stents in the superficial femoral artery?

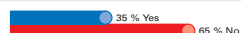


This is a vote which underlines the uncertainty in the opinions of the CX 33 audience. This can be taken as a slight endorsement for drug eluting femoral artery stents such as Zilver PTX but it cannot be described as a resounding win.

Do you find drug elution cost-effective in the superficial femoral artery?

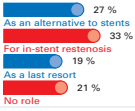


Do you think drug-eluting stents are cost effective below the knee?



There is enough uncertainty to raise the question whether drug eluting is cost effective. For this, there would have to be substantial demonstrated clinical benefit at an affordable cost. It can be seen that the CX 33 audience was unconvinced on this. The audience is however clearly interested in whether drug elution is of any benefit or not, rather than the cost of it.

What is the role for drug-eluting balloons?



We have introduced the concept of Drug-Eluting Balloons and the results are shown. It is a very controversial area and many of the audience implied that they would be interested in a precise answer.

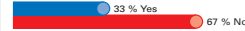
Many of the presentations on excellent anatomical restoration of patency below the knee had a very short follow-up. It is encouraging to know that, even in the short-term, an excellent anatomical result is achieved by experts and they are the first to say that longer follow-up is desirable.

Does angiogenic gene therapy have a future in your view?



Following the presentations on below the knee, angiogenic gene therapy intervention was discussed a majority was against.

Is stem cell therapy a big no-no?



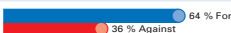
This question focused on stem cell therapy and the audience gave it a big no-no.

A controversial topic came up under the DEFINITIVE LE study by James McKinsey who promoted use of the atherectomy device. A memorable intervention from Giancarlo Biamino denounced atherectomy as he had done every decade for about 30 years. He questioned exactly why atherectomy was being introduced once more and sounded very offended.

It sounds encouraging to actually remove the atheroma, but the results are not very reliable and this could be because the remaining lumen is far from smooth. This is the opposite of the unexpected excellent results after subintimal angioplasty. In the latter case, the blood flows along smooth walls in a rather unconventional way.

Venous Consensus Update

Office based vein practice wins and should do so



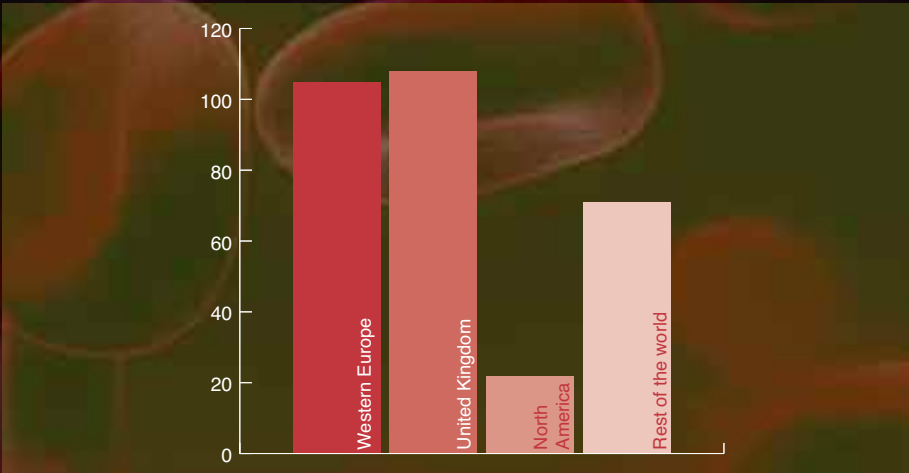
Office based vein practice is very much talked about in meetings such as CX, were there is also a excellent practical course. There remains substantial uncertainty as to

which modality is superior, including laser or radiofrequency or various other methods. However, the concept of fixing varicose veins in a single short outpatient visit, like going to the dentist, is exactly what the CX 33 audience finds preferable. It is a great shame that the majority of the patients undergoing varicose vein correction in the world are still offered the open surgical method.

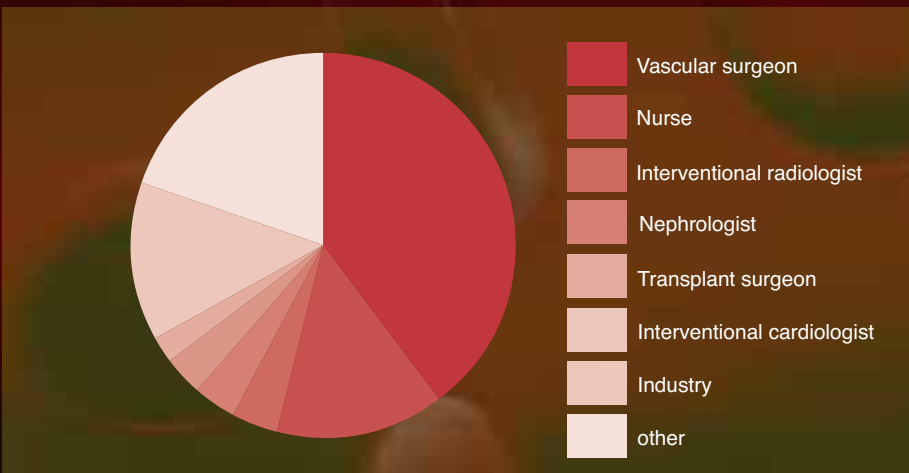
CX ST GEORGE'S VASCULAR ACCESS CONSENSUS UPDATE 2011

The 6th International St George's Vascular Access Meeting-under the auspices of the Vascular Access Society will take place again at the Charing Cross Symposium. The theme this year is "Vascular Access Consensus".

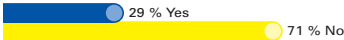
Country breakdown data



Specialty data

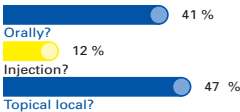


Do you believe that soon one drug will be available to mitigate myo-intimal hyperplasia?



One of the hot topics in the vascular access world is myo-intimal hyperplasia and its consequences. They are many ongoing trials using topical drugs or devices trying to mitigate that phenomenon. The audience was asked whether they believe in an early resolution of that serious problem. Obviously most do not think so currently.

If available would you be happy to prescribe it:



It is clear though that the vast majority of the audience, even if pessimistic on the outcome, would welcome it if it does become available and would use it either topically or orally. They would be reluctant to inject it, although 12% would be ready to consider it.

Do you currently perform surgically created vascular accesses in your patients aged above 80 years old?



Age has now to be considered very seriously as our haemodialysis population grows by 5 to 7% every year. This is mainly due to older patients and one has to consider the feasibility of our surgery on this population. When the question was asked, a vast majority felt that age was not a problem when performing vascular access Surgery.

Do you feel that maturation is clearly defined?



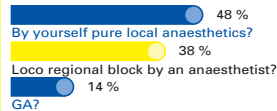
What is a mature fistula? What is the definition? It is a crucial problem, as it lays out exactly how to report the results of vascular access. It is clear that a clear definition has not yet been found.

For a native access, do you always wait more than 5 weeks for the first cannulation?



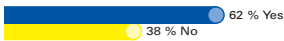
When a fistula is considered mature, then cannulation could start. Clearly, as there is no consensus over the definition of maturation, nor is there one for the delay before first cannulation.

Do you prefer your patients anaesthetised:



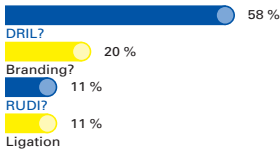
The group then went on to examine whether there was a consensus with regard to the type of anaesthetics we use for vascular access. It is clear that loco-regional means are favoured by the vast majority of the audience.

Do you perform inflow reduction surgery for high inflow fistulae?



High inflow fistulae could put a serious strain on the heart. In the context of renal failure, that generates uraemic cardiopathy. It is important to consider it when following up these patients. Yet, despite this, nearly 40% of the audience would not consider inflow reduction.

When treating steal syndrome, do you favour:



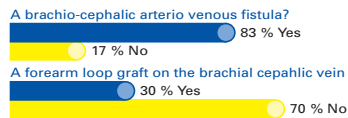
Steal syndrome is an important feature which has been described as happening in excess of 2% of the dialysis population. Its treatment could be tricky and has attracted a lot of controversy. On this occasion, the audience has favoured the DRIL procedure over all other available solutions.

Central venous stenosis – Is your first treatment option:



Central venous stenosis could occur in up to 40% of the patients who have had a temporary central venous catheter. It is crucial to discuss what kind of treatment is first proposed to the patients. An overwhelming majority decided for endovascular over surgery first for central venous stenosis.

When all forearm options (native) are exhausted; do you perform:



Native options have always been advocated over grafts, yet with new material available like xenografts or early cannulation grafts, it seems that forearm loop before native could prevent central line insertions and their complications. It did not convince the audience.

Do you believe that xenografts will one day supersede PTFE grafts in vascular access indications?



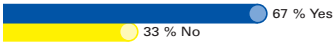
Xenografts have always been available, with uneven successes or results. The audience seems optimistic about their future potential.

Do you think that soon PTFE graft will be coated with drugs that will inhibit myo-intimal hyperplasia on the venous side?



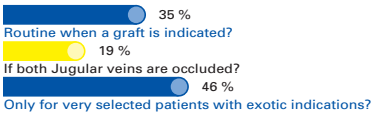
It is clear that the audience believe firmly that hybrid technologies which ally drug and synthetic material will represent the future of vascular access. We already have grafts coated with heparin which have just been granted CE marking for vascular access.

When an arterio venous fistula (AVF) or graft is failing, do you tend to try:



A big chunk of our practice is dedicated to the revision of failing vascular accesses. Endovascular revisions seem to be the preferred way for the audience.

Your indication for early cannulation graft is:



As more and more performing early cannulation grafts are coming on the market and as the pricing is nearly the same as classical grafts, the question about their indication had to be asked.

Do you prefer an early cannulation graft than a groin line even if temporary?



A consensus on the avoidance of central lines at any cost, specifically femoral, seems to be imminent!

If early cannulation grafts are priced like regular PTFE would you consider always as first choice when indicating a graft?



Cost remains a very important feature when indicating a graft.

Considering your local setting and resources – if a universal algorithm for access placement was published – do you think that you would be able to implement it?



When asked whether a consensual approach would be a good thing, the audience voted yes by a substantial majority. They would favour a universally admitted algorithm and would implement it, if it was available.

DEBATE: We need to organise our discipline like any other, based on evidence collected by large randomised controlled trials.



The latter was reinforced during the debate. A vast majority agreed with the motion and is crying out for a better structured speciality which carries out large, properly conducted randomised controlled trials.

CX33 through the lens



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