

November 8/9, 2018

Madrid

HOTEL EUROSTARS SUITES MIRASIERRA



Front cover

The keys of the VI Symposium

1. There will be **five panels** on some of the most current topics and professional interest
2. **Innovative techniques** will be displayed that open up new possibilities
3. **Surgeries of high complexity will be broadcast** for the first time from international hospitals
1. It will be an opportunity to verify the increasing research activity of the members of **the Endovascular Surgery Chapter**



The thematic axes

1. **New advances** in the aortic arch and aorta ascending
2. Endovascular treatment of **Compressive Venous Syndromes**
3. Complications of endovascular treatment of **complex aortic disease**
4. An update on endovascular therapy of the **superficial femoral artery**
5. Endovascular treatment of **supra-aortic trunks**



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Interview

JOSÉ MANUEL LLANEZA COTO, Chairman of the panel 1 'Advances in endovascular therapy for treating ascending aortic and aortic arch pathologies'

The aortic arch is a new challenge for endovascular techniques

Why do the endovascular treatment of the ascending aorta and aortic arch take part in the program? What issues make it topical and relevant to attendees?

The aortic arch is a new challenge for endovascular techniques in which they have yet to prove their worth compared to conventional surgery, as was done in the descending, visceral and infrarenal aorta. So far, specific devices for this area are scarce and few patients have been treated. There is wider experience with customized prostheses and parallel conduits, which allow us to treat patients with high morbidity, or complex aneurysms, who are not candidates for conventional surgery.

What are the latest advances in the endovascular treatment of the ascending aorta and what are the difficulties or challenges that have not yet been reached? And in relation to the aortic arch?

In the ascending aorta we are taking the first steps in their pure endovascular therapeutic approach, while in the aortic arch, the double branch prostheses are already a reality, although with access still restricted in the therapeutic arsenal of our hospitals.

When is it indicated endovascular surgery in the treatment of aortic arch and ascending aorta? When is open surgery indicated?

Open surgery is still the reference treatment for this type of pathology, while these techniques are

currently an alternative, although in aneurysms that affect the aortic arch itself, in many centers, the endovascular option is already offering good results, once the initial stage is over.

What percentage of ascending aortic surgeries represents endovascular surgery? And the aortic arch?

The treatment of the ascending aorta endovascularly is still anecdotal and the arch still scarce compared to open surgery, since endovascular procedures are currently performed in selected centers.

What percentage of survival is achieved with these surgeries? What survival was achieved before the endovascular techniques?

It depends to a great extent on the selection we make of the patients and their general conditions, as well as on the area of the arch where we have to do the proximal sealing with the endoprosthesis and, although the series are very short, in the most complicated cases it's possible to reach values comparable to open surgery. In addition, in almost 40 per cent of cases these patients are rejected to perform conventional surgical techniques, due to the morbidity of the patient.

What is the level of Spanish endovascular surgery in this type of surgery, compared to the most advanced countries in the world? Where would you say that the most advanced surgery is practiced?

We are walking at a good pace, although we are still far from some centers in Japan, Europe and the United States pioneers in this type of treatment. In Spain we have professionals of the highest level, without any doubt.



Do Spanish hospitals count on equipment and resources necessary for this type of surgery? Is there homogeneity of the assistance provided throughout Spain?

As I said, the vast majority of Spanish hospitals have competent professionals with solid training in vascular surgery to perform these techniques; However, in many centers it is still lacking to have the appropriate technological equipment, such as hybrid operating rooms and state-of-the-art diagnostic support techniques. On the other hand, we must keep in mind that, at least for the moment, this type of procedure is not frequent due to their high economic cost, so it would be reasonable to consider the convenience, as it happens with other types of pathologies, that they were carried out in certain centers of the country.

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Interview JM Llaneza Coto

And in prevention, and management and control of the patient already treated, what should be our rating?

A very high one. In Spain, the vast majority of patients treated for vascular pathology are followed properly, according to well-established recommendations. This fact contrasts with what we see in other countries, such as the United States; where, in daily practice and outside of studies and records, in more than a quarter the patients will get to lose the follow up. Therefore, in this sense, the rating would be a high good. Although it is true that there is still room for improvement as they would be, for example: the more widespread application of new information technologies that greatly facilitate monitoring; and insist on awareness about healthy lifestyle habits and cardiovascular prevention.

What advantages and risks do you think the technological super specialization of the specialty and the accelerated pace of implementation of new technological advances?

The Specialty of Angiology and Vascular Surgery has undergone an important transformation and development in the last decades due to the irruption of the endovascular treatment. This has supposed a new way of handling the pathology with the incorporation of a wide variety of techniques; Therefore, the advantages are evident in being able to offer solutions and treatment to patients who were not candidates for conventional techniques, either due to high surgical risk or anatomical conditions. Given the wide availability of endovascular techniques, it should be mentioned here that we should not forget to consider the patient as a whole avoiding overreacting by performing procedures that may have difficult justification from the patient's point of view. On the other hand, this technology is in constant development and this requires, on the one hand, a constant ongoing training of professionals and, on the other hand, can sometimes make it difficult to rigorously

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assess the long-term results of a technique by the modifications or the evolution experienced in the devices. From another perspective, super specialization is always expected to contribute to excellence in results, at the expense of losing a global vision of the specialty. In this regard, it is worth mentioning the importance of training courses in vascular surgery that have been carried out from different areas.

From 0 to 100, at what moment of progress would you say that we are in the specialty in the individualization of treatment, surgery and clinical management of each patient?

I could not specify with figures where we are, the impression would be that we are halfway there. We have lived a long journey of technological development since the early 90's when the first endoprostheses were implanted in abdominal aortic aneurysms and great limitations and drawbacks have been overcome. In surgery we must look beyond the immediate results and also consider the long-term results. In this sense, we have learned to understand the reasons for failure of a therapy or device. Research and technological development are constantly advancing with the appearance of improvements and new devices. We are aware of the importance of selecting the right device for each situation and although currently the industry already offers a wide range of technology for it; however, there is still a long way to go: as an example, we have the same coated endoprostheses to treat a nonspecific aneurysm (arteriosclerosis) than to treat an aortic dissection, or with the same coated stent for treatment of occlusive arterial disease that to use as a bridge stent in case of fenestrations or branches. At the same time, making an adequate selection of patients for each type of therapy is key when looking at the efficiency of a treatment.

Let's talk about big data. Science fiction or upcoming reality? What can be expected from big data?

It is present in multiple areas of daily life, trade, industry, communications, research, etc ... and of course also in health. It is therefore already a latent reality that as vascular surgeons we must know how to bring it to light and take advantage of it, since the high volume of data that we can count on, supposes a great contribution in different fields that go from the management and cost analysis (analysis of supply and demand, forecast of needs and

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distribution of resources...) to health care (provide insight into the origin of the pathology, its prevention, diagnosis and early treatment, follow-up, adherence to treatment, ..), through the research (promoting inclusion in studies, providing training and basic information for research, ...). Vascular surgeons should be aware of this reality as described by Dr. Rosa Moreno in an interesting special article of the latest issue of the journal *Angiologia*.

What would you highlight from the papers that will be presented at your panel, and from the speakers?

As expected from an event of these characteristics, all the speakers are professionals of recognized relevance in the treatment of these pathologies. It is about taking advantage of the opportunity that is offered to us to discuss the different endovascular therapeutic options used in aortic arch pathology, analyzing results, technical aspects and tricks; as

well as the analysis of future perspectives and the limits of these treatments.

The symposium is becoming increasingly international. What can Dr. Spanos, from the University Medical Center of Hamburg, contribute to the Symposium ?

His experience in the aortic arch is clear and is one of the European references in this type of treatment.

DR. ALEJANDRO RODRÍGUEZ MORATA, Chairman of the Panel II. 'Endovascular treatment of Compressive Venous Syndromes: Paget-Schroetter, Nutcracker and May-Thurner'

Why the choice of compressive venous syndromes as one of the main themes of the Congress?

The answer is simple: more than half of the patients who consult an Angiologist do so because of venous problems. These are less serious than arterial ones, in general terms, but they are so prevalent that society demands specialized attention, and the specialist trained in venous pathology is the Angiologist and Vascular Surgeon.

What are the elements that give relevance and scientific interest to the endovascular treatment of these pathologies?

Until a few years ago, the venous pathology in its therapeutic version was restricted to the treatment -in one way or another- of the Chronic Venous Insufficiency of the Lower Extremities. Currently the specialist in Angiology and Vascular Surgery knows that even a good part of these patients with this venous insufficiency, have their origin in an abdominal or pelvic venous pathology and that, if not treated properly, won't be achieved a lot by treating only the peripheral part.

What are the latest advances in the endovascular treatment of each of the Compressive Venous Syndromes that will be addressed: Paget-Schroetter, Nutcracker and May-Thurner ?

As summarizing in a difficult way to three statements what could be given for innumerable pages, we could leave these three "headlines" 1) do not implant subclavian venous stents without prior surgical decompression; 2) the treatment of endovascular Nutcracker is complex and is not valid for all patients; 3) before the acute thrombosis in the May-Thurner, the time of the syndrome went down in History and the Angiologist should try to clear the sector whenever possible.

When is endovascular surgery indicated in each of these syndromes and what are the alternative therapeutic options? What degree of consensus / controversy is there?

The endovascular indication in Paget - Schroetter is direct in acute venous thrombosis, in order to make the sector more permeable. This is in general agreement. Subsequently,



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venous stenting, if there are residual lesions, should be avoided, especially if it is not decompressed surgically. In the Nutcracker endovascular treatment is not by common agreement at all and the anatomical difficulty of the sector imposes criteria of patient selection that we have developed in the book that will be presented in this Symposium. In the May-Thurner, the endovascular indication is clear both in the acute phase of the thrombosis and if it is a chronic case and with more than six months of evolution.

What is the degree of safety of this type of intervention and what are the risks? What have these techniques contributed in the treatment of these pathologies?

Safety is very high in the May-Thurner, where it is really difficult to have a stent migration, especially if chronic post-thrombotic cases are treated. In the Nutcracker, late migrations are described in up to 7 per cent of the implants, and this should make us carefully screen these patients. In the Paget-Schroetter, safety is just the opposite: if a venous stent is implanted without resection of the 1st rib underlying the vein, it is sure to be thrombosed in a few months. Therefore, it should be avoided, as we previously commented.

What is the level of Spanish endovascular surgery in this type of operation, compared to the most advanced countries in the world? Where would you say that the most advanced surgeries are practiced?

In Spain the level of development of Angiology and Vascular Surgery is extremely good, and of course all these surgeries are developed, although it is true that in England and Germany are taking several steps ahead because of the diffusion in networks and events of these surgeries, but there are no technical differences - I am not talking about volume of cases - compared to what is done in our country. In Spain there is not a single technique that is not done equal or better than abroad, neither in venous or arterial pathology and

there are enough samples of it throughout our geography.

“before the acute thrombosis in the May-Thurner, the time of the syndrome went down in History and the Angiologist should try to re-clear the sector whenever possible,”

Spanish hospitals count with the necessary equipment and resources for this type of intervention and the complications that may arise? Is there homogeneity of the assistance provided throughout Spain? What is the level of training of Spanish specialists?

Any hospital where an aortic endoprosthesis can be implanted is more than endowed for the treatment of a venous pathology endovascularly. However, there are many centers where, due to the pressure of care, this type of pathology is not treated, but because of lack of interest.

It is true that venous pathology is less serious than arterial, and if a health system is lacking in budgets for professionals and materials, the health budget is prioritized to arterial pathology. However, some venous pathologies are subject to permanent disability (serious

post-thrombotic syndromes) and for this reason, more and more hospitals are trying to incorporate these techniques into their portfolio of services.

And in prevention, and management and control of the patient already treated, what should be our rating?

For each hospital and each Service must -as in everything- do their self-criticism to improve as much as possible in those points that can be improved. Answering that question in a generic way is not possible.

What advantages and risks do you think the technological super specialization of the specialty and the accelerated pace of implementation of new technological advances?

This topic is complex, but in all the Services with a large number of staff, the profile of each one makes it more or less suitable for certain pathologies. I know a lot of Units where not all the doctors do all the surgeries in their scheduled work, but they dedicate themselves to a specific sector, with excellent results, and in the emergency surgeries they do the rest of the pathology if necessary. It is a way to improve the results. In other specialties this is done, for example, Cardiology, Traumatology, General Surgery, etc. It is not logical, following the examples, that a traumatologist whose destination is the Column Unit during his usual day, suddenly dedicate himself to implant shoulder or knee prosthesis, although he can do it. That is why I believe that in Angiology and Vascular Surgery the moment will come when it will be seen normally that each physician is super specialized in one way or another, and it will be seen as something positive, which is in my opinion.

From 0 to 100, at what moment of progress would you say that we are in the specialty in the individualization of treatment, surgery and clinical management of each patient?

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So in general terms referring to the venous pathology, I would say that we are halfway there. We are expert experts in the infrainguinal venous pathology, and now we have to remain in the abdomen-pelvic and subclavian-axillary.

Let's talk about big data. Science fiction or upcoming reality? What can be expected from big data?

I am not very up to date on these big-data issues, and I think the generalization is negative for the specific patient. In fact, we always say classic phrases like "each patient is a world" or "you have to individualize the treatment", etc.

and this goes exactly in the opposite direction to this question. I do not know exactly to what extent this big-data can help our patients, but the information of the user is not useful if his health system is not accessible or does not treat his pathology for different reasons.

What would you highlight from the papers that will be presented at your panel, and from the speakers?

The three Spanish angiologists who make up the panel do not need a presentation. They are preceded not only by their professional prestige, but by that temperance and simplicity that many times distil people of noble spirit as is the

case of Drs. Juan Fontcuberta, Ignacio Lojo and Enric Roche.

The symposium is becoming increasingly international. What "plus" will bring to the participants the attendance of Dr. Teijink, of the Catharina Hospital of Eindhoven, and Maresch, from the University Hospital of Bratislava?

Both Drs. are Vascular Surgeons with great experience in endovascular venous pathology and of great prestige in their respective countries, for which we believe they will offer an interesting view on their assigned topics and the rest of those that will be discussed in this panel.

We SPEAK OF ...

Endovascular Surgery and Social Networks with Dr. Miguel Muela

Dr. Miguel Muela, from the University Hospital of Guadalajara, has been feeding the social networks of the Symposium since its inception as if it were a community manager. He is one of our most active surgeons in Twitter and he is convinced of the advantages that the medical professional can take out of social media, as well as of his kindness as tools to share and bring true scientific knowledge to the citizen. We talk to him...

- Why is it useful for a vascular surgeon to be on Twitter, and in general on social networks?

For every vascular surgeon it is very important to keep updated: the latest clinical trials, new clinical guidelines, surgical techniques, devices

in development ... Social networks provide a fast and global way of communication, so I can be informed of, for example, the endovascular techniques that are being used in any part of the planet, and even being able to ask or discuss certain aspects with renowned vascular surgeons around the world.

In addition, nowadays it seems that pseudo sciences are booming, due to its diffusion mainly by internet ... I believe that vascular surgeons, and health professionals in general, have the responsibility to disseminate scientific knowledge in a truthful manner, and that knowledge can reach citizenship. Twitter, Facebook, LinkedIn and in general social networks allow us to spread this knowledge to the general public, as well as new techniques, healthy lifestyle habits, recommend links to websites with contrasted information, and of



course deny any hoax or pseudo therapy that may arise.

- Do you think it is possible to spend some time every day? In your case, what use do you make of this social network and how?

Nowadays anyone with a smartphone can have instant access to social networks. Each of them has its own application to install it and access it in a more direct way. So it is not difficult to find a time a day to use them. In my opinion, the most important thing is to properly select who to follow, so that the publications that appear to us will be useful. Even the leading high impact of scientific journals have

November 8/9, 2018

Madrid

HOTEL EUROSTARS SUITES MIRASIERRA



their visibility on social networks. Personally, I use them to be aware of the publications of certain scientific journals, as well as to see the techniques and results of other Vascular Surgery services, and to share the ones we perform in our Unit.

-In your opinion, what would be the most interesting social network for a healthcare professional?

I mainly prefer LinkedIn, since it has a more professional approach, it has a good contact management system and it is rare to find publications that are not very relevant in our field (jokes, photos or personal videos, etc.). Twitter is also good, especially because it is used by a large number of users and allows a great diffusion, but sometimes it is difficult to find scientifically relevant content.

- And how should a healthcare professional be in the networks? Tell me three or four basic rules.

I believe that the priority is to maintain the

confidentiality and privacy of the patient, especially when images of techniques or diagnostic tests are published. It is necessary to watch that the patient's data does not appear in the image by accident, or that it can be recognized in a photograph.

It is very important to be honest and transmit accurate information. Usually it is about information on sensitive health issues, and both patients and other colleagues can access it, and therefore it is our responsibility that what is published is true and with scientific rigor. And above all, communication and exchange of opinions must be done in an educated manner. The heated arguments and the insults do not do anything well.

And of course, a social network can never replace the medical attention ruled in the consultation or in a hospital. It is relatively common for some users to expose their personal medical problem seeking online health care but that is dangerous as long as you can

not perform a proper physical examination, and therefore the recommendations may not be appropriate. It is important in these cases to recommend that patients ask a qualified healthcare professional for advice.

- There are very active scientific societies and health professionals, how do you see in this sense the level of the CCEV and the SEACV? Do we live a little apart? We are making progress? Do you identify among vascular surgeons some " influencers " on Twitter or Facebook ?

Both the SEACV and the CCEV are present in social networks (mainly Twitter and Facebook), but it is true that they still have few followers. However, little by little they are gaining followers and in the future I think they will have more visibility. Regarding the " influencers " in Vascular Surgery, possibly Dr. Pascual Lozano is one of the most relevant. With more than 1,300 followers on Twitter, in Spain is among the Top 100 surgeons regarding influence on social networks.

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