LAS CLAVES Y GRANDES NOVEDADES DEL VII SIMPOSIUM

Por primera vez, completamente telemático.

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1. Cirugía en directo desde cinco hospitales internacionales…
2. Todo el avance tecnológico en terapias endovasculares en época de pandemia
3. Mesa formativa interactiva abierta a la participación ciudadana
4. Cómo mejorar la atención clínica durante épocas de confinamiento
5. Telemedicina a disposición del paciente vascular
6. Presentación del Libro Blanco de Cirugía Endovascular

Y 4 RAZONES MÁS PARA NO PERDÉRSELO

1. Para descubrir que otro tipo de eventos on line es posible: dinámico y basado en el aprendizaje práctico y el intercambio de opiniones en directo.
2. Para participar estar al día de las últimas novedades en cirugía endovascular a nivel internacional, contadas por sus protagonistas con casos reales e intervenciones en directo
3. Para debatir sobre el impacto de la pandemia en nuestra especialidad y compartir ideas sobre cómo mejorar la atención clínica
4. Para escuchar la voz de los pacientes y poder ayudarles mejor en estos tiempos de pandemia

INTERVIEW

Endovascular Solutions in venous pathology. Live Cases from São João Universitary Hospital Center, Porto, Portugal

- **DR. JOÃO ROCHA NEVES:** *"Pragmatic randomized controlled trials are also a profound gap in this area. There are no stepping stones to build our observational evidence and national registries are scarce"*

Can you briefly explain what kind of live surgery we will see from your hospital?

Deep venous stenting has been one of my struggles since I have started my way on vascular surgery. Since it is a relatively new technology, surgeons and general practitioners are too used to medically manage these patients. Patients experience chronic pain, discomfort and severe complications with few effective therapies being available. Stenting of the iliac veins is increasingly considered in the presence of symptomatic chronic obstructive venous lesions, and besides being a low-risk procedure, it is associated with marked symptom and quality of life improvement.

The patient we are presenting today has a chronic occlusion of the left common and external iliac veins and clinically presents a healed venous ulcer and left leg edema, which has been affecting her for years. Me and my colleague Marina Neto are trying to recanalize the iliac axis all the way from the common femoral vein. The fibrosis and atrophy are extensive, making this a challenging case.

What are the main elements of scientific interest to the topic that is going to be discussed?

The main concerns and topics of investigation in the area of deep venous intervention are the long-term results. Patients are very young and most are part of the country's workforce, suffering high levels of morbidity. Much of the decisions in this area are based on the clinician's experience, not on hard evidence. We have to ensure long-term symptom relief to the patients with some data backing us, they cannot afford to undergo repeated interventions or even complex follow-ups.

What is the main scientific evidence and what are the doubts to be solved yet regarding the innovations your speech is focused on?

As I have stated previously, long term results are a main issue since we must face patients with 50 or more years of healthy life ahead of them.

Pragmatic randomized controlled trials are also a profound gap in this area. There are no stepping stones to build our observational evidence and national registries are scarce, with the existing ones not working on full steam and are yet to provide large scale real world evidence.

Randomized trials on anticoagulation and its role on long term primary and secondary patency, are one of the priorities. May thurner type 1 (isolated compression of common iliac vein without signs of previous thrombosis or sinequia) is also criptic, and establishing selection criteria for intervention are mandatory. It is estimated that up to 20% of the population have compatible radiologic signs, and the clinical anamnesis and the symptomatology is simply not enough to protect patient and clinician.

What upcoming technological advances are foreseeable and desirable in that field?

I believe the next frontier is the common femoral vein. Although some groups present good results on these patients, the crossing of the inguinal ligament is one of the main predictors

of longterm outcome. Personally, I only revascularize CEAPs C5 or C6 patients when the disease affects this segment. There are some stents emerging that address this issue, and I hope the matter is closed soon enough.

Another emerging area is the treatment of the femoropoplital segment. The current strategies for the treatment of malfunctioning venous valves are invasive with a high recurrence rate. There are many prosthetic venous valves in the industry pipeline, although I believe the technology is still too immature for us to dream on clinical intervention over the next few years.

Regarding the pandemic, how is the coronavirus affecting the care activity in vascular surgery in your country?

Have patients stopped going to hospitals for fear of contagion, thus harming the evolution of their disease?

Retrospectively reviewing our databases and comparing the first 6-week period after the pandemic affected Portugal with the prior 6 weeks, we could verify that the ward occupancy rate decreased from 101.41% to 64.61%, while outpatient clinic visits decreased 87.7% (≈ 83.7% appointments performed in this pandemic era were via telemedicine). Furthermore, there was a huge surgical impact with ≈ 87% decrease, with a higher reduction in elective surgery being registered, as expected (≈ 90%). However, even urgent interventions had a significantly reduction, ≈ 57%, raising the concern if the fear of COVID-19 infection was preventing the patients to address the emergency department.

Although we have only measured the activity during the period and not the clinical results, we expected a catastrophic repercussion in our results. We are closely monitoring the national and local major limb amputation rate, but no greater change was observed to date referring to the homologous period from 2019. Definitive results will only be available at the end of the year.

Do you think that the pandemic will have a negative impact on the evolution of vascular diseases, by damaging the monitoring and early diagnosis?

Although we are classically a tertiary care specialty, and regarding peripheral artery disease, it was clear and strategic to us to avoid new emergent referrals and monitor the progression of the disease. Telemedicine played a crutial role on this. We have facilitated the access to our outpatient clinic, and the possibility of a domiciliary nurse supervision was made available.

Limitations on the OR were profound, and our rate of aneurysm repair and carotid surgery have decreased to all time lows. The months following confinement were very labour-intensive to recover the surgical the waiting list time. We are now in line with referral, although the next winter might prove heavy.

Is telemedicine helping to address the situation?

One of our cornestones on the assistance care has been telemedicine. It is unavoidable to believe that the technology based medical assistance should have been more implanted in our daily routine by now. Looking on the bright side, the days we are living have forced our hand to embrace these methods. We have learned new ways to provide for our patients, in most cases, even with better performande than pre-pandemy.

I am eager to see the changes and improvement we will be left with.

What technological advances would be necessary so that the healthcare activity of this specialty does not suffer in a context like the one we are experiencing?

Individually, doctors are very keen on new technologies, and the penetrance of new devices or drugs in our country is very high, maybe one of the highest in the world. We like to provide new solutions and answers to our patients. Most of the perfecting should be on the administrative and organizational level. That is what has lacked during years, which is clearer during stressful times to the system.

The Portuguese national health system is based on a Beveridge financing model. It is true that this system keeps costs low, pushes towards ambulatory care and a strong primary care system, however leads to oversuse and a lack of adaptability due to the chronic underbudgeting.

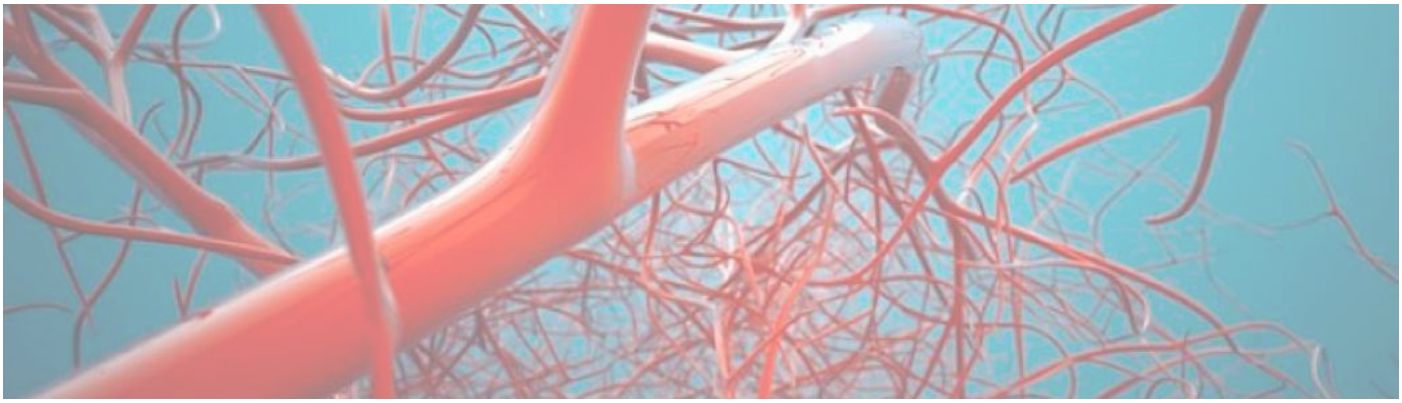
Releasing the doctors from administrative tasks is paramount, since we have lost the time to put our full energy and thought on patients.

An international and especially a national level god-view over the system with pragmatic non-draconian strategic is probably the default step to overcome the era above us.

What lessons do you think we can draw from the pandemic for angiology and vascular surgery in general and for endovascular surgery in particular?

There are no simple solutions for complex problems. Personally, I never believed that pressing pause on everyone and everything was the solution. At Porto, we have spent all summer recovering from the confinement of April and March, and the patients keep coming and we have to answer their call.

On the year of 2019, we performed over 70% of our lower limb revascularizations under endovascular intervention. With the confinement, its levels increased to over 90%, since we were lacking on anesthesiologists, and ambulatory care was almost mandatory to leave room for urgent cases.



INTERVIEW 2

Advances in arterial recanalization devices. Lives Case from Pederzoli Hospital. Pescheira del Garda. Italy.

- **DR. BRUNO MIGLIARA:** *"There are a lot of different devices to try to obtain an adequate vessel preparation, but there are not evidence of superiority of one to the others"*

Can you briefly explain what kind of live surgery we will see from your hospital?

We'll have a male CLTI with distal necrosis in the toes, Wifl class = 232, then with high risk of major amputation.

This patient has a heavy calcified long sub-occlusion (>15cm) of the last third of the SFA.

We would like to crosse this sub-occlusion and to performe the calcium debulking using Jetstream atherectomy system, by Boston Scientific, 2,4/3,4 mm and then to use DCB, Ranger balloon.

What are the main elements of scientific interest to the topic that is going to be discussed?

The need to prepare adequatly calcified lesion in the SFA and POP artery to avoid stent use and to improve paclitaxel effectiveness.

What is the main scientific evidence and what are the doubts to be solved yet regarding the innovations your speech is focused on?

There are a lot of different devices to try to obtain an adequate vessel preparation (scoring balloon, lithoplasty, laser, different type of atherectomy, etc.).
But there are not evidence of superiority of one to the others. This is an important discussion point!!

What upcoming technological advances are foreseeable and desirable in that field?

An improvement of the atherectomy devices to be more effective to remove the calcium and to reduce the vessel wall damage, injuries.

Regarding the pandemic, how is the coronavirus affecting the care activity in vascular surgery in your country?

First of all, COVID stopped our activity in the last spring, then we lost some limbs due to the impossibility to treat this patients on time. Currently, we have some venous and arterial thrombosis related to the COVID infection.

Have patients stopped going to hospitals for fear of contagion, thus harming the evolution of their disease?

Of course, a lot.

Do you think that the pandemic will have a negative impact on the evolution of vascular diseases, by damaging the monitoring and early diagnosis?

Of course.

Is telemedicine helping to address the situation?

Could be, but in case of CLTI it's realy difficult to evaluate patients using tele-medicine.

What technological advances would be necessary so that the healthcare activity of this specialty does not suffer in a context like the one we are experiencing?

I don't know, but I think it will mandatory to have some hospital, with specific features, COVID-free.

What lessons do you think we can draw from the pandemic for angiology and vascular surgery in general and for endovascular surgery in particular?

In many vascular patients it's mandatory do not waste.
This in order to lose limb and, above all, to lose lives.

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