Coronary artery disease as detected by coronary CT angiography

Meanwhile there are more than 41 studies performed with more than 2500 patients comparing multi-detector-row CT with coronary angiography for the detection of coronary artery stenoses. According to these papers, a sensitivity and specificity of 96% and 76% has been reported, respectively (2). But more than only displaying the contract-filled lumen like in cardiac catheter, CTA as a cross sectional modality also has the ability to display the coronary artery wall. Coronary atherosclerotic changes may appear as calcified, non-calcified or mixed plaques. In a recently published study, Leber et al. reported that non-calcified lesions were predominantly found in patients with acute myocardial infarction, whereas calcified plaques were found more often in patients with chronic stable angina (3). In patients with an acute coronary syndrome a non-calcified lesion in the coronary artery may correspond to an intra-coronary thrombus (4).

Studies comparing intravascular ultrasound as the gold standard for plaque imaging with CT have shown a good correlation between the echogenicity and CT density of coronary atherosclerotic lesions (5). The sensitivity and specificity for CT to detect calcified and non-calcified coronary atherosclerosis is between 78 and 94%, respectively (6).

Future application of cardiac CT

Dual-source CT offers another potentially promising feature in characterising atherosclerotic coronary plaques. If the two X-ray tubes operate at different energy levels, e.g., 140 kV and 80 kV, the datasets originating from the two detectors allow for spectroscopy-like visualisation of atherosclerotic lesions. Apart from morphology, PET/CT with F18-FDG may deliver new insights into the inflammatory activity of plaques, e.g., in the carotid arteries (7).

A second development pathway is rotating C-arm CT. The combination of catheter intervention and CT will provide a variety of new applications for invasive cardiology, such as aortic root catheter directed coronary CT angiography (8) or time resolved 3D imaging of left atrium and pulmonary veins (9).

References:
Express Yourself with Clinical Confidence

**Primary Endpoint**

**Definition**
- Angiographic mean percent loss of luminal diameter at 6 month post-procedure, defined as \[
\text{POST MLD} - \text{FUP MLD} \times 100
\]

**Outcome**
- Non-inferiority established at 6 month with a mean percent luminal diameter loss = 10.2%.

**Primary Endpoint at 6 Months**

- Objective: Improvement in luminal diameter.

**Long Term Results**
- Excellent safety profile for Express™ Vascular LD with 85.9%, 90.2% TLR at 1 and 2 years and zero device / procedure related death.
- Sustained Stent Target Lesion Patency measured by CTA with 92.2% at 1 year and 94.1% at 2 years.
- High follow-up rates at two years = 87% (Clinical), 86% (CTA).
- Continued clinical success at 1 and 2 years as measured by ABI improvement and Fontaine stage classification.

**Effectiveness Measures**

- Success Crossing Lesion (per Lesion): 100.0%
- Technical Success (per Lesion): 99.1%
- Procedure Success (per Patient): 99.0%

**Sustained Clinical Outcomes at 2 Years**

- Sustained Improvement of Hypertension
- Sustained Stabilization of Blood Pressure

**Conclusion**
- This study demonstrated that renal artery stenting with the Express™ Vascular SD Stent was superior, in terms of binary restenosis, to an objective performance criterion based on outcomes with balloon angioplasty alone (21.3% vs 40.0%, p<.0001).
- The measurements of the secondary endpoints at 2 years demonstrated an improvement in systolic blood pressure, and similar creatinine levels.

**MELODIE TRIAL**

A prospective, multi-center, single arm study to obtain additional data on the safety and efficacy of the Express™ Vascular LD stent implantation in the treatment of stenosed or occlusive atherosclerotic disease (de novo or restenotic) in iliac arteries.

**RENAISSANCE TRIAL**

A prospective, multi-center, single arm study evaluating the Express™ renal (Express™ Vascular SD) pre-mounted stent system in the treatment of atherosclerotic lesions in the aortorenal segment.
CIRSE Goes Global

CIRSE has been growing at an outstanding rate over the past years. Group Membership has significantly contributed to this development, enabling national societies to join CIRSE in their entirety at preferential conditions.

Following a global strategic plan, CIRSE offers very favourable conditions to all those national IR societies bringing in their entire membership. This has allowed many societies to join forces with CIRSE which is becoming a global network of Interventional Radiology ranging from Brazil all the way to China.

Group Members - Europe

BSIR – British Society of Interventional Radiology, www.bsir.org
Bulgarian Society of Invasive Radiology
CSR – Czech Society of Interventional Radiology, www.csr.cz
DeGIR – German Society of Interventional Radiology, www.degir.de
DFIR – Danish Society of Interventional Radiology, www.dfir.dk
Finnish Society of Interventional Radiology
Helena Society of Interventional Radiology, www.helrad.org
ILSR – Israeli Society of Interventional Radiology
NGIR – Dutch Society of Interventional Radiology, www.ngir.nl
OGR – Austrian Society of Interventional Radiology, www.oegr.at
PLTR – Polish Society of Interventional Radiology, www.polradiologia.org
RISOR – Russian Society of Interventional Oncology
SVCVR – Swiss Society of Cardiovascular and Interventional Radiology
TGDRO – Cardiovascular and Interventional Society of Turkey

Group Members - Overseas

CSR – Chinese Society of Interventional Radiology
ISVIR – Indian Society of Vascular and Interventional Radiology, www.isvir.in
PAIRS – Pan Arab Interventional Radiology Society
SoBRIC – Brazilian Society of Interventional Radiology and Endovascular Surgery, www.sobrice.org.br

CIRSE Membership

CIRSE gratefully thanks its Corporate Members for their support throughout the year.

Applicants (Members in progress)

2,576
24
2,500

Corresponding and Full Members

1,680

Total

4,280

The Pan Arab Interventional Radiology Society (PAIRS) - A brief profile

PAIRS extended an invitation to Prof. Lammer and the officers of CIRSE to attend its second scientific meeting in Jordan. In the spirit of continuing and strengthening the collaboration between the two societies, members of PAIRS were offered the opportunity to benefit from group membership of CIRSE. This is testimony to the forward thinking of the leadership of CIRSE in their efforts to encourage international collaboration in the field of IR. Furthermore PAIRS was subsequently invited by current CIRSE President Prof. Jim Reekers to take part in CIRSE 2008 under the successful format of the “CIRSE meets…” sessions.

PAIRS third scientific meeting took place in Cairo in February 2008 maintaining the high caliber of contributions from the invited faculty. The presentations by members of PAIRS also reflected their increasing experience. Discussions had already started with SIR to build a collaborative initiative particularly in regulatory & training issues. We hope that this collaboration will also help to enhance the work of our society. Initiatives to expand the membership of PAIRS across the Arab World are being formulated and put into effect under the guidance of the new Board and current CIRSE President Dr. Hazem Haboub.

At “CIRSE meets PAIRS” in Copenhagen three members of our society will present topics that were chosen to reflect the different aspects of IR practice in the Arab World, treatment of diseases that are common in the region, novel methods of treatment for universal conditions and regulatory issues facing the practice of IR.

Hybrid disease is endemic in large parts of the Middle East as well as parts of Eastern Europe. Percutaneous treatment represents one of the most efficient methods of dealing with this menacing condition. Dr. Maurice Haddad who has published extensively on the subject will present his experience.

Male impotence secondary to venous incompetence is probably largely under-diagnosed and presents a challenge in management. Dr. Hazem Haboub will present his experience in treating this condition using the new embolic material Onyx.

Regulatory issues relating to the practice of IR may be approached in different ways depending on the legal framework of the respective country. Dr. Adel Ahmad will present the Kuwaiti model of introducing regulations to safeguard the specialty and ensure the highest standard of healthcare. These regulations may be applicable and adaptable to other countries.

The collaboration between our young society and CIRSE is of great importance for the development of IR across our region and will hopefully continue to grow. I think that through CIRSE Group Membership and the CIRSE meets PAIRS session we have made important steps in this direction.
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Vascular Surgery and Interventional Radiology - Time for integrated fellowships and eventually a merger

Torben V. Schroeder
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University of Copenhagen
Consultant Vascular Surgeon,
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Vascular Surgery has changed markedly over the last decade for a number of reasons, most importantly the developments in endovascular techniques. Physicians and patients want the best results using the most recent technology. Patients are particularly attracted to the least invasive methods. Although the long-term durability of many of these minimally invasive procedures seems somewhat inferior to that of open surgery, the attraction lies in the lower perioperative morbidity and mortality (1). Moreover, recurrences may still be handled with endovascular techniques. The lower M&M has enabled management of patients otherwise considered unfit for surgery, though in direct comparison the benefit of endovascular repair may in fact be more convincing in the fitter patients (1). Today at least a third of vascular surgical patients are primarily managed endovascularly after clinical assessment including non-invasive imaging. In single centres the number is even higher - and the proportion is still increasing.

The endovascular evolution

Although many vascular surgeons have been personally involved in the endovascular revolution, most have been spectators, referring their patients to catheter skilled radiologists. The vascular surgeon has the patients, while the interventional radiologist masters a technique which under certain circumstances is the preference of the patient and the attending physician. The developing minimally invasive procedures in most instances outside of the department of Vascular Surgery, i.e. in the department of radiology, and under the responsibility of the interventional radiologist. These two, the interventional radiologist and the vascular surgeon, have planned the endovascular treatment together, but except for the endovascular handling itself patients remain under Vascular Surgery service and are not seen by interventional radiologists, neither before nor after the treatment. This organisation seems prevalent in most Scandinavian and many European countries with Vascular Surgery and Interventional Radiology collabo- rating closely and being complementary.

Interventional Radiology has also undergone substantial changes since initially being a vascular subspecialty. Today Interventional Radiology has the application for the diagnosis and treatment of multiple pathologies of many other organs than the vessels and interacts with many specialties. Based on a national survey in Denmark covering all interventional radiological activity in 2007 performed by the Danish Society for Interventional Radiology (DSIR) (12) of Marc Hansen and John Sotgiu, a total of 5,380 procedures were performed (6). Of these, 60% were "classical" vascular, i.e. arterial PTA, EVAR, venous procedures, including dialysis fistula interventions. Another 20% were "the classical non-vascular interventional radiological" procedures, such as embolisations (tumour, uterus, GI-bleeding, etc) and managing liver diseases with percutaneous transhepatic cholangiography (PTC) or transjugular intrahepatic portosystemic shunt (TIPS). The remaining 20% were nephro- or uroembolemias or suprarenal balloon catherisations. These urological procedures were unevenly distributed throughout the country, as most were performed by the urologists themselves or by radiologists under ultrasound guidance. Thus, leaving out the urological procedures, the distribution was close to 75% vascular and 25% non-vascular.

The peace is threatened

However, as volume - relative as well as absolute - of endovascular practice has increased over the years, this peaceful scenario of two specialties being complementary is threatened. Firstly, vascular surgeons find it increasingly problematic that other skilled craftsmen treat 30-50% of their patients, just because the vascular surgeon has not mastered that technique. Had it been a new open surgical technique, the surgeon would have attended meetings and visited skilled colleagues to learn the technique and would then have added it to their existing repertoire (2). However, endovascular skills are not that easily acquired. Moreover, did it only concern 5-10% of patients - which was the case 10 years ago - it would seem reasonable, but today the number is much higher with figures still increasing while the number of patients treated with open surgery is declining. This situation may be tolerated by the elderly generation of vascular surgeons, but not by the next generation. Recently UK surveys have clearly identified a wish among vascular trainees to make endovascular training mandatory (3). Moreover it seems that most interventional radiologist would not mind training vascular surgical trainees. In the UK a joint training pathway in Vascular Surgery and Interventional Radiology has been proposed and a curriculum developed aiming at creating vascular specialists trained to provide vascular service utilising open as well as endovascular techniques (4). In the United States they have been implemented in a number of centres (5,6).

Secondly, a number of papers have addressed the fact that interventional radiologists have limited clinical responsibilities and that this should be changed (7-9). It has also been suggested that Interventional Radiology is suffering an image problem (7).

A survey has shown patients’ awareness of Interventional Radiology to be lower that that of virtually any other specialty in medi- cine. Furthermore it has been aired that there is an insufficient number of Interventional radiologists to deliver treatment, partic- ularly on an acute basis (4).

Thirdly, the increasing number of patients needing endovascular procedures consti- tutes an economic incentive for other physi- cians who have catheter skills, for instance cardiologists or vascular surgeons, who no longer accept that Vascular Surgery and Interventional Radiology should continue to be complementary and instead do the endovascular procedures themselves. In some institutions there may even be con- frontations between interventional radiolo- gists, cardiologists and vascular surgeons over who should perform percutaneous non- cardiac peripheral vascular interventions.

Some vascular surgeons participated in the evolution of Interventional Radiology, others have taken up catheter-based procedures themselves. Cardiologists have also wanted to take part in the blooming catheter-based "peripheral arterial industry". This has led to several headings like "Who is trawling our waters?" (2006) and "The battle for peripheral interventions" (11,12). Between 1997 and 2002, procedure volume in abdominal aortic aneurysm interv-entions grew at faster rates among cardiolo- gists, vascular surgeons and other physicians than it did among radiologists. As a result, the radiologists’ share of this market declined during the interval, although the absolute numbers increased. The vascular surgeons’ relative share increased, but in 2002 still only by 10%. Cardiologists were responsible for more that one third of the procedures (11).

Finally, with the increasing numbers the trad-itional separation of vascular surgeon and interventional radiologist may be criticised for inefficient patient care, management and training.

The future

You may well ask whether Interventional Radiology can survive and flourish as a tech- nology-based non-vascular specialty (7,9). And similarly you may ask whether Vascular Surgery can continue in isolation without taking part in the minimally invasive surgical treatment of up to one half of their patients. Moreover, the above listed problems may seriously hamper the recruitment of the next generation of vascular physicians.

From a vascular surgical perspective I see only one sensible solution for the future, which is an increasingly close synergy and a move towards leading to a merger between the two special- ies (12). The first step is an integrated fellow- ships - vascular surgeons need to develop pro- ficiencies in endovascular techniques and inter- ventional radiologist need to develop full responsibility for the longitudinal care of the patients they treat (6). The current organisation will not survive.

In the future the majority of vascular specialists should be able to perform basic operations, as well as endovascular procedures, whereas only a more limited number of vascular specialist will be responsible for the complicated open and the advanced endovascular procedures, respectively. The less attractive alternative is that vascular surgeons somehow achieve the necessary technical skills and do the proce- dures themselves - like the cardiologists did years ago.

An argument from interventional radiologists against merging with Vascular Surgery is that this would make interventional radiologists move away from their mother specialty radiol- ogy. However this has already happened in many countries for Vascular Surgery which has been recognised open surgery, and in the countries where it has not happened, the vascular surgeons are fighting for individuality.

Another argument against a merger is related to the substantial technological development. This has been referred to as medical drift from merely being a vascular subspecialty to treating multiple pathologies of many other organ systems. Again, in comparison Vascular Surgery involves a number of patients not con- sidered suitable for endovascular management or who need no intervention at all.

References:
About Abbott Vascular

Abbott Vascular, a division of Abbott, is one of the world's leading vascular care businesses. Abbott Vascular is uniquely focused on advancing the treatment of vascular disease and improving patient care by combining the latest medical device innovations with world-class pharmaceuticals, as well as investing in research and development and advancing medicine through training and education. Headquartered in Northern California, Abbott Vascular offers a comprehensive portfolio of vessel closure, and endovascular and coronary products, which are recognized internationally for their safety, effectiveness and ease of use in treating patients with vascular disease.

Dedication to Service

Abbott Vascular is committed to offering the best service to its customers and end users, through ongoing physician training and support, as well as reimbursement initiatives for new and existing therapies. In addition, Abbott Vascular has a global team of around 1,000 representatives and clinical specialists devoted to providing personalized customer solutions.

Driving Innovation

In its relentless pursuit to drive innovation, Abbott places great emphasis in leading the creation of next-generation products by investing in and developing new technologies and products. With highly experienced R&D, clinical, and regulatory teams, Abbott Vascular is committed to advancing vascular care through investments and research in the areas of vulnerable plaque, structural heart, and bioabsorbable stents. The company is also at the forefront of advancing knowledge on vascular care through industry-leading investment in R&D and clinical trials.

Strong Leadership in Clinical Trials

Abbott Vascular's commitment and leadership in advancing vascular knowledge is reflected in pioneering trials such as SPIRIT Women, the first-ever clinical trial focusing on cardiovascular disease in women. One of Abbott Vascular's latest studies is STRIDES, a single-arm clinical trial that seeks to evaluate the use of an everolimus-eluting, self-expanding stent system for the treatment of peripheral arterial disease. STRIDES has finished enrolment with 100 patients at 15 European sites.

The STRIDES trial will evaluate the combination of a fracture-resistant, self-expanding stent system specifically designed to withstand normal leg movement, with the anti-proliferative drug everolimus as a longer term treatment alternative for blockages in the superficial femoral artery (SFA).

What makes Abbott Vascular a global leader:

- A singular focus on the vascular market-place and commitment to quality
- A portfolio of products designed to serve the broad needs of physicians and patients
- A focus on the use of an everolimus-eluting, self-expanding stent system for treating peripheral arteries in iliac, SFA, and infra-popliteal occlusive disease.
- A strong emphasis on providing best-in-class educational and training support to physicians and associated healthcare providers.

Education

Founded in 2000 and located in Brussels, Belgium, the Crossroads Institute for Cardiac and Vascular Education (formerly known as the Guidant Institute for Therapy Advancement) provides a real-world educational experience for healthcare professionals at all stages of their careers.

With an international faculty of over 70 expert physicians, the Crossroads Institute provides training on the latest developments in cardiovascular care in cooperation with major societies such as CSIRSE / ESVIR (European Society for Interventional Radiology), EBCIR (European Board for Accreditation in Cardiology) and ESVS (European Society for Vascular Surgeons).

Training programs cover various therapies such as carotid stenting and treatment of diabetic patients with CLI. Hands-on courses include working on close-to-reality flow models in an operational cath lab as well as VR simulation training. Discussion Forums for experienced physicians are provided on a regular basis.

Product Portfolio

Abbott Vascular offers a comprehensive range of vascular solutions with an advanced portfolio of carotid, peripheral and vessel closure products to assist physicians in a broad range of interventional procedures.

Peripheral Intervention Products

Abbott offers broad lines of self-expanding and balloon-expandable stents for treating peripheral arteries in iliac, SFA, and infra-popliteal occlusive disease.

- The Absolute Self-Expanding Stent System for SFA has clinically proven superiority over the use of PTA alone [N Engl J Med 2006; 354:1879-88]. The established durability of the stent implant shall be leveraged in designing the SFA DES stent in future. Our new generation of Absolute Pro Self-Expanding Stent System enables physicians to treat even more challenging cases. The innovative delivery system improves the push and the tractability.

- The Omnilink stent has a multiple linked corugated ring design and is one of the newer generation low-profile flexible balloon-expandable stents with good radial force used for the treatment of iliac arterial occlusive disease.

- The Xpert stent system has been specifically designed for small vessels. This self-expandable stent system is available in diameters from 3mm to 8mm, with excellent clinically-proven one-year results in limb salvage with CLI patients.

- Carotid Stents and Embolic Protection Devices

Abbott Vascular offers a full portfolio of carotid stents and embolic protection systems, giving the physician the power of choice in treating the patient:

- The RX ACCUlink Carotid Stent System is a widely-used, low profile, highly flexible and conformable carotid stent designed to provide easy and accurate stent placement in patients who have carotid stenosis and are at high risk of conventional surgery.

- The RX ACCUNET Embolic Protection System is used by hundreds of physicians worldwide and features a dual strut filter basket and two different recovery catheter choices with a fixed wire design.

- The Xact Rapid Exchange Carotid Stent System offers accurate sizing, minimal fore-shortening, high scaffolding, and high radial force at the lesion.

Vessel closure

A pioneer in closure technologies, Abbott Vascular offers products designed to facilitate secure closure of the vascular access site following diagnostic or interventional vascular procedures.

- The Prostar vascular closure device is a suture-mediated closure device which offers early hemostasis, early ambulation and improved patient comfort to patients undergoing large hole closure. The Prostar is a time tested product indicated for 9 to 10F sheaths.

- The Proglide is the device of choice for secure reliable closure for those who prefer suture. Featuring monofilament prolene suture, the Proglide device can be used by a single operator with a short wire, and is our easiest Perclose ever.

- The Emboshield PRO Embolic Protection Device is one of the latest embolic protection systems, based on bare wire technology with a highly visible filter and catheter tip to allow accurate and easier handling, a short filter parking length, and a highly visible retrieval tip.

Information contained herein is for outside the U.S. and Japan only.
Please check the regulatory status and availability of the products mentioned in area where CE marking is not the regulation in force.
Additional information on Abbott Vascular, its products, clinical trials and news is available on the company’s website www.abbottvascular.com.
The results of the EVAR3 trial were disappointing for many who have independently reviewed outcomes for CAS and felt that they were (and are) not nearly as bleak as they were within this trial (1). As if then to add insult to injury, it became clear that the authors of the paper, published in the New England Journal of Medicine, considered the experience of the interven- tivist (whatever their background) did not influ- ence the outcome for patients in the CAS limb of the trial. For those who are familiar with this, 527 patients were randomised to either surgery or CAS for symptomatic carotid stenosis (>60% by NASCET criteria). The recruitment centres were a mix of both academic and non-academic centres totalling 20 and 10 respectively. No dif- ference in outcome was seen in centres that enrolled <21 vs >40 patients. When com- paring the enrolling physician's experience, no statistical difference was seen between those with >300 procedures and those with <50 procedures, and those still being proctored after training (major adverse event - MACE rates 1.2%, 11.0% and 7.7% respec- tively).

This would appear to be counterintuitive and a cyanic would argue that it is the first ever demon- stration of a reverse learning curve. Of course the trial was never planned to come to a statistically meaningful conclusion with respect to learning curve and there is not insubstantial risk of a Type II error on the grounds of relatively small numbers. In reality, only 80% of those performing CAS were performing between 21-40 procedures a year. When com- paring the enrolling physician's experience, no statistical difference was seen between those with >300 procedures and those with <50 procedures, and those still being proctored after training (major adverse event - MACE rates 1.2%, 11.0% and 7.7% respec- tively).

The six independent case series include Boulbich et al (2005) (8), superseding Ahmad et al (2001) (9). Lim et al (December 2005) (10), Lin et al (2005) (11), Roubin et al (2012) (12), Verzi et al (2006) (4) and Santos et al (2001)(13). Each of these studies improved results with time in 5 of 6 series, with the differences reaching statistical significance in 4. Three of these papers aimed specifically to evaluate the learning curve. Ahmad et al (2001) (9) (eventually superseded by Boulbich et al) 2005, evaluated three hundred and twenty CAS procedures as four groups of eighty cases (although this precluded technologi- cal advances in CAS such as rapid exchange sys- tems and cerebral protection devices) showing a significant reduction in the frequency of neurological complications after the initial 80 interventions (p < 0.03), but technical success was significa- ntly improved with increasing experience there- after. It was concluded that a relatively large number of interventions (ie. 80) should be per- formed to overcome the negative effects of the initial learning phase. This paper showed temporo- nal improvement in outcomes even when protec- tion devices were not employed at any time- point.

Lim et al presented their results in two hundred consecutive protected CAS procedures in 182 patients in 2005. The results were analysed in four sequential groups of 50 procedures. The 30- day stroke and death rate was 8% in the first cohort, 2% in the second and zero incohorts 3 and 4. This paper would suggest a learning curve of 50 procedures or continuous improvement despite the use of protection devices from the start of data collection (10).

Verzi et al (2012) (12) reported 627 CAS procedures performed with cerebral protection and dedicated carotid stents between 2001 and 2006 (4). When comparing the outcome between CAS procedures performed after the first 100 CAS procedures (ie. CAS procedures) with the second three years (532 CAS procedures) the 30-day major stroke and procedure-related neurological deficit decreased from 2% to 0.7% (P > 0.05). The authors concluded that the “experience” of an operator is important in maintaining a plateau that involves a caseload larger than that generally accepted by practitioners. The cost of the independent carotid registries is the ‘Global Carotid Artery Stent Registry’. The first report from this registry was published in 2000. The registry involves 12541 patients for the analysis of experience and outcome. Randomised trials tend to have polar opposite results: (2) and many operators would con- clude that operator experience is a critical element in improved results.

The Pro-CAS registry, another sizeable German registry, evaluated 627 CAS procedures performed with cerebral protection and dedicated carotid stents between 2001 and 2006 (4). When comparing the outcome between CAS procedures performed after the first 100 CAS procedures (ie. CAS procedures) with the second three years (532 CAS procedures) the 30-day major stroke and procedure-related neurological deficit decreased from 2% to 0.7% (P > 0.05). The authors concluded that the “experience” of an operator is important in maintaining a plateau that involves a caseload larger than that generally accepted by practitioners. The cost of the independent carotid registries is the ‘Global Carotid Artery Stent Registry’. The first report from this registry was published in 2000. The registry involves 12541 patients for the analysis of experience and outcome.
As part of its efforts to offer a complete range of learning possibilities to interventionists, CIRSE has launched a new online learning tool; www.esir.org. The comprehensive database contains more than 1,900 titles, including high quality streaming videos from the CIRSE 2006 and 2007 congresses, all recent CIRSE abstracts and EPOS posters, slide material of the CIRSE 2006 and 2007 congress presentations and ESIR course material.

**Result**

Browse through all articles or the 5 interventional categories:
- Vascular
- Embolization
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**Profile**

The area 'My profile' leads to a very useful page with the entire range of offers available to CIRSE members at a glance.

You can:
- book ESIR courses
- register for the CIRSE congress
- view and print congress/course related documents
- make hotel reservations
- edit your personal data, etc.

To try out www.esir.org free of charge visit the CIRSE booth, the Internet Café or the EPOS area.

www.esir.org is kindly supported by Cook Medical
As you can see the Foundation has been very active and the possibilities for additional activities are practically endless. I invite all of you to take advantage of the Foundation’s many educational services and look forward to seeing you at one of our meetings.

The Structure of the CIRSE Foundation

The CIRSE Foundation is a non-profit organisation based in Switzerland. It is governed by the Board of Trustees which is the ultimate authority of the Foundation and is in charge of its overall governance and subordinated agencies.

CIRSE Foundation Board of Trustees Members:

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The CIRSE Advisory Council defines the strategic direction of the Foundation, keeping with the guidance provided by the Board of Trustees and is actively engaged in the fund-raising and promotion of educational aims.

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The European School of Interventional Radiology keeps expanding

After its introduction in 2006 with the first two courses on vascular interventions, further ESIR courses were introduced in 2007 covering more treatment methods in host cities all over Europe. Topics included radiofrequency tumour ablation, non-vascular upper GI interventions and basic as well as advanced vascular interventions. The response to the ESIR programme has been overwhelming, young interventionists from the individual host countries are keen to learn about interventional procedures and even colleagues from as far as Japan have joined the courses.

In 2008 there have been 5 ESIR courses and 8 more will be held until the end of the year including 4 Institute Courses held at the Cordis Cardiac & Vascular Institute (CCVI) in Hamburg (DE) and at the Crossroads Institute in Diegem (BE). Due to the great success of the 2007 RFA course in French language, another RFA course was held in French in 2008. Additionally one course on Embolisation Therapy will be held in Spanish in Valencia, Spain. The ESIR course programme 2008 is kindly supported by educational grants from Cook, Cordis, Abbott, Boston, Celen, CeloNova, ev3 and St. Jude Medical.

The CIRSE Foundation - A Catalyst for Education

After my two year term as society president ended in 2007, I took on the great responsibility of leading the CIRSE Foundation in the next two years. I am honoured to be given this great opportunity to support the development of Interventional Radiology in Europe through the CIRSE Foundation’s many activities.

While the society supports interventional radiologists in issues concerning their daily practice, the CIRSE Foundation must be a catalyst for education, making sure that Interventional Radiology continues to be carried out by innovative and well trained physicians, as it has in the past. To achieve this purpose and with the support of our industry partners we base our activities on the following four pillars:

- Education grants: Every year the CIRSE Foundation awards € 100,000 in grants to young interventionists who wish to learn new procedures in other hospitals. Thanks to this programme numerous physicians have been able to widen the range of their skills and disseminate new procedures in their hospitals.
- The European School of Interventional Radiology (ESIR) is the educational arm of the Foundation, providing onsite education on a wide range of procedures at low cost. The two day courses include lectures of European experts as well as case discussions in small groups. In 2008 we have increased the number of courses to 13. They will take place in various European countries and include vascular and non-vascular topics as well as “hands-on” courses in the learning centers of Abbott (Diegem) and Cordis (Hamburg). Up to now 470 physicians have taken the opportunity to attend the ESIR courses. In this context I would like to thank the local course organisers and the lecturers for their work and enthusiasm.
- Topic-related Special Focus Conferences: every spring will support our main CIRSE meeting in September. All of those who are unable to come to the CIRSE Annual Meeting or who want to get in depth education on special topics will have the opportunity to update their knowledge during these meetings. After an excellent kick-off with the first European Conference on Interventional Oncology and the first European Conference on Embolotherapy ET ECO 2008 attended by 1,200 delegates the Foundation will organise an educational meeting every spring. In this context I would like to thank Tony Nicholson and Riccardo Lencioni for their superb organisational work. In April 2009 the CIRSE Foundation will organise a GEST Europe meeting together with the GEST founders. A second ECO will be organized by the CIRSE Foundation in early 2010.
- In addition to low the cost courses of the ESIR and the educational spring meetings mentioned above, the CIRSE Foundation offers interventional radiologists online education accessible through a new dedicated website. www.esir.org is a fantastic new tool comprising all material from recent CIRSE congresses and EPS presentations.
Angio-Seal™ Vascular Closure Device is designed to provide efficient, reliable hemostasis for both interventional and diagnostic catheterization procedures. As the market leader among vascular closure devices, Angio-Seal features a fully bioabsorbable active closure system that is clinically proven to be effective, even in highly anti-coagulated patients.

THIS IS VASCULAR CLOSURE.

Experience Control. Visit our booth at CIRSE.

Re-Use Only.

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Absolute: proven* clinical benefits for your patient

- Less binary restenosis
- Longer walking distance
- Better ABI values

Absolute Pro: delivering Absolute performance in more challenging cases

- Superior deliverability**

Come and join us at booth 13
Expanding roles for simulation technology

Today clinical practice does not offer the same opportunities as it used to for beginners to start training endovascular procedures through traditional angiography, as non-invasive modalities such as CT, MR and duplex ultrasound are increasingly used before a decision is made to treat a patient. Alternatives such as animal labs provide the opportunity to operate on a living creature, but form other obstacles. Notwithstanding the ethical issues, animal anatomies vary significantly from the human model, medication metabolism and reactions are drastically different and the costs of such experience can be prohibitive. These circumstances challenge a facility’s ability to train even the most basic endovascular skills in a controlled environment.

A foreseeable increase in the incidence of peripheral vascular disease and thus minimal endovascular procedures translates into an increased need to train the next generation of interventionalists. Endovascular simulator training of basic skills answers this training need and offers the ability to provide an introduction to endovascular procedures, including demonstration of the selection and the subsequent manipulation of different devices in a correct sequence order for a specific procedure.

As simulators offer several patient cases, trainees learn how different device shapes and sizes work within various anatomies. These exercises help to reduce the manipulation of equipment required to selectively engage specific vasculature. Awareness and understanding of which C-arm projection angles will work best for certain anatomic regions and lesions is another skill learned via working on the simulator. A key benefit to the fluoroscopy functionality of a simulator is that the learner experiences no exposure to radiation. Simulation therefore equates to the safest ‘practice’ field available for the operator and the patient.

With current advances in simulator development, there will be simulators that offer objective feedback in the form of an evaluation report afterwards as well as the immediate response in case a mistake is made by the trainee. In this event there will be a tactile response to the operator which will be accompanied by the appropriate hemodynamic responses to mimic a realistic scenario. This type of interaction makes simulators more realistic for a wider range of users from the novice to the expert.

Simulation allows an experienced practitioner to train how to avoid and, if necessary, how to manage a complication during a procedure. The associated training would more fully prepare the trainee for the rare occasions that do occur in clinical practice after all. Simulators can ensure that a variety of complications have been presented and a minimum threshold of competency met, regardless of the experience level of the learner.

In order to readily translate technological progress in simulator design into a situation where simulators are widely adopted and the type of interaction makes simulators more realistic for a wide range of users from the novice to the expert.

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In order to readily translate technological progress in simulator design into a situation where simulators are widely adopted and accepted for their contribution to clinical practice, there is a need for the professional community to do evaluation studies that validate the functionality and metrics used in the simulator. This is a challenging task, as simulators constitute a moving target. However, without validation of simulator behaviour and metrics simulators may not attain their full potential. With validated data a much improved acceptability of simulators for other purposes such as regular quality assurance, assessment and training of experienced clinical staff can be expected. Important issues may be to train optimal imaging projections, to minimise radiation exposure and to train minimal use of contrast media.

Validated simulators may be used both in initial certification of medical specialists and in regular testing for physicians to maintain their credentials. Also the medical device industry may have to prove to regulatory authorities that their medical doctor customers have been correctly trained to ensure a safe and efficacious deployment of their clinical devices in a simulated clinical setting.

Today simulators have become widely accepted by medical educators and simulator centres have been established at many teaching hospitals. However, it is generally agreed that even once simulator centres are established the services they provide are often underutilised in the existing medical curricula and hospital-international quality assurance routines.

It should be recognised that Simulation Centre Training capabilities have demonstrated a cost effectiveness of the teaching methods employed. These methods and results have yielded patient safety benefits as well as a safe work environment for those who have the opportunity to experience and learn from the available technologies and expertise. Maybe regulations similar to the aviation simulation model are needed in the health care sector in order to reap the full benefits that simulation has to offer. The use of simulators in certification and credentialing is proposed to enhance patient safety by ensuring that medical professionals have been properly trained and tested.

In conclusion the incorporation of virtual reality simulation in training is already here, despite lack of proven efficacy in randomised double-blind studies. In the future the adoption of this training might well be patient driven rather than doctor driven. A structured training program, i.e. curriculum, must be developed in order to merge cognitive and clinical skills with pure technical knowledge.

In cooperation with the SIR, the CIRSE Simulator Task Force led by Dr. Derek Gould from Liverpool has been doing continuous work in this field. Other important research groups include Professor Anthony Gallagher’s, as well as Professors Nick Cheshire’s from the Imperial College in London (the EVEREST team). A few Education and Simulation Centres also exist within Scandinavia: Oslo, Norway, Stockholm and Lund, Sweden. In Denmark, the respective centre is located in Copenhagen; the Centre of Clinical Education in Copenhagen led by Professor Charlotte Ringstedt.

Patrik Hidefjall is a Mentice Employee. Lars Lönn is a paid consultant for Mentice.
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Photo Exhibition + Contest

In our many years in radiology we have had the chance to attend numerous congresses, getting to know colleagues from around the world. In these encounters we have noticed that many of us share a hobby: photography. To us this shows that some people were simply born to be imagers.

To share this passion with all our colleagues, CIRSE has organised the first CIRSE Photo Exhibition featuring photographs created by its members and congress delegates. The exhibition is located vis-à-vis the Abbott Lounge at the main auditorium foyer and can be visited throughout the congress. To vote for your favourite picture, please use the computer next to the exhibition. The winner will be announced at the Foundation Party.

We hope that you will enjoy this interesting new feature of the congress and look forward to the Photo Exhibition and Contest becoming a regular feature of the CIRSE meeting!

Jim Reekers
James Spies

A sunny danish coast by Frank Meijer
Chimney rock in Cappadocia, Turkey, by Erol Akgül
La vie en rose by Rick Shoenfeld
Red sea fan at Balicasag by Pierre Thoorens
Lake Louise, Alberta, Canada by Kirsteen Burton
Myself entering the water by Milan Totev
Sunrise at the Floe Lake, Rockwall, Kootenay National Park, BC, Canada by Jan Namyslowsky
Cow with a view by David M. Kasper

[nature] by Iftikahr Ahmad
Sams by Linda Scott
Freefall on the hill by Josh Burnill
GEST 2007 by Petr Duras
Vascular Surgery by Wojciech Cwikiel

Cappadocia at dawn by Peter Nye

Don’t forget to cast your vote for the best CIRSE 2008 Photo Exhibition picture vis-à-vis the Abbott Lounge next to the main auditorium entrance.

Don’t forget!
DVT and Pulmonary Embolism

Patrick Haage
Professor and Chairman, Department of Diagnostic and Interventional Radiology Region West, HELIOS University Hospital, Wuppertal, Germany

Various strategies in the diagnostic process for suspected deep vein thrombosis (DVT) and pulmonary embolism (PE) have been developed and introduced, including clinical pre-test probability assessment, D-Dimer testing, ultrasound imaging and CT and MRI pulmonary angiography (CTA, MRA). PE should be assumed in every patient with inexpliable dyspnea, tachypnea or acute chest pain, its adequate diagnosis often relies on imaging techniques.

DVT itself is a potentially life threatening disorder particularly due to the associated risks of pulmonary embolism, renal failure and phlegmasia cerulea dolens. Chronic venous hyper tension resulting in the “postthrombotic syndrome” as a consequence of DVT has been estimated to affect 500,000 individuals in the United States alone. Thus, timely diagnosis and treatment are essential measures to provide adequate care for the patient. This postulation is substantiated by the fact that the organization of a venous thrombus proceeds much faster than that of an arterial thrombus, thereby aggravating successful treatment strategies. Subsequent pulmonary embolism is a frequent, observed consequence of patient morbidity and mortality. Particularly patients with iliac and inferior caval vein thrombosis are at serious risk for pulmonary embolism and long-term clinical consequences of post-thrombotic syndrome.

Approximately 50% of patients with central deep vein thrombosis have pulmonary perfusion defects characteristic of pulmonary embolism. Thus patients with symptoms consistent with DVT should in the beginning receive a determination of pre-test probability utilizing established prediction models (Table 1). After determination of the clinical pre-test probability, a D-Dimer test should be performed if the pre-test score is >1 (Figure 1). A positive D-Dimer test entails an ultrasound examination followed by treatment in case of thromboembolism.

Appropriate anticoagulation therapy is considered the standard DVT treatment. Interventions like thrombolysis and IVC filter placement are reserved for few individual indications, especially in case of contraindications to thrombolysis. For patients requiring treatment beyond heparin anticoagulation due to massive PE causing circulatory collapse, systemic thrombolytic therapy must be administered to patients. For patients requiring treatment beyond heparin anticoagulation due to massive PE causing circulatory collapse, systemic thrombolytic therapy is advisable if there are no absolute contraindications.

Unfortunately the rate of lysis-associated major haemorrhage and intra-cerebral haemorrhage is in the order of 20% and 3.5% of patients, respectively. Catheter-directed percutaneous therapy employing combinations of mechanical thrombolysis “rotating pigtail” fragmentation, aspiration and intra-thrombus lytic is a feasible alternative. Advantages include fast hemodynamic shock relief, in part by offering the lytic drug a greater surface area for lysis after mechanical fragmentation.

In conclusion, any patient with clinically suspected PE must be risk stratified, in an ideal setting with a criteria-validated clinical decision pathway. Following the assessment of pre-test probability, D-Dimer assays quite reliably exclude PE in low risk groups. In 2008 CTA is the preferred initial imaging modality in the majority of cases.

Anticoagulation with low-molecular-weight heparin is considered the treatment of choice in DVT and stable PE. In unstable PE patients systemic thrombolysis and alternative catheter directed thrombolysis, especially in case of contraindications to thrombolysis, can be advocated.

References:
As radiologists, first and foremost, many of us know that imaging has become the do fact currency of modern medicine. Few patients, certainly from the surgical intervention end of the spectrum, can be usefully discussed without concurrent review of their radiology. It is our ability to understand and manipulate this currency which places both diagnostic and interventional radiology at the centre of patient care. Nowhere is this more evident than in the arena of interventional oncology.

At the recent ECIO meeting in Florence, and in keeping with the tradition of interventional oncology, we heard about no end of new embolic agents and ablative devices. The underlying theme however was the role of imaging in a new era of non-extirpative treatments for cancer. As cancers get smaller at the time of reliable detection and characterisation, it becomes less necessary to invoke major resections - for example, the right hepatectomy for the solitary 2cm liver metastasis. In such circumstances outcomes from chemotherapy (and in particular newer biologic agents), embolization and ablation are jockeying for position against the morbidity of conventional resection. These interventions are however inherently non-extirpative, i.e. the treated cancer is not removed. Whilst the surgeon looks to the pathologist for the single negative resection margin, we must judge success against the pathologist for the single negative resection margin; we must judge success against the pathologist for the single negative resection margin, we must judge success against the pathologist for the single negative resection margin, we must judge success against the pathologist for the single negative resection margin.

In reporting these critical imaging studies, accurate post-procedural imaging will be essential to interventional oncology and we must take into account the knowledge that FDG-avidity in the treated tumour now shows clear progressive involution. Thus, whilst the effects are dramatic, a more clearly defined method of reporting treatment outcome will have to be sought.

Therefore an ability to accurately confirm tumour eradication is essential to the practice of interventional oncology. Non-enhancement at post-procedural imaging is the current arbiter of treatment success, but can be limited by contrast, spatial and temporal resolution. Besides this in situ treatments invoke collateral changes, such as post-ablation marginal hyper-aemia and subverted perfusional changes following embolization. Accurate post-procedural imaging will be essential to interventional oncology and was in fact the underlying theme of the recent ECIO meeting, linking both embolic and ablation approaches together.Whilst non-enhancement is useful, better characterisation following ablation or embolization awaits major developments in functional imaging where for example we know that FDG-avidity is poor, if at all, defines treatment success in areas such as hepatocellular and renal cancer and the present spatial resolution remains limited.

5-year outcome data remains the gold standard for cancer therapies, but given the current rapid evolution of drugs and devices we must look to a common language which defines treatment outcomes. Various groups have sought to standardise the language used in reporting post-procedural imaging resulting from these treatments (1,2). This will be an important step forward if those undertaking such procedures are to convince oncological and surgical colleagues that these interventions are anything other than tinkering with the overall tumour biology.

The unifying theme here is the critical interpretation of post-procedural imaging following intra-tumour therapies. Imaging - and its interpretation - is a critical component of ‘Interventional Radiology’ and remains one of our key skills, placing us at the centre of the discussion of clinical case management. In the rush to train more IRs there has, in recent years, been pressure to reduce the diagnostic component of the training schedule so as to allow more time for the development of technical skills. The understanding and ability to manipulate imaging - the currency of cancer interventions - has never been more important to the IR and we must not compromise on this aspect of our training or practice.

Table 1: Clinical model for predicting pre-test probability of deep-vein thrombosis (DVT)

<table>
<thead>
<tr>
<th>Clinical Feature</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active cancer (treatment ongoing, administered within previous 6 mo or palliative)</td>
<td>1</td>
</tr>
<tr>
<td>Paralysis, paresis or recent plaster immobilization of the lower extremities</td>
<td>1</td>
</tr>
<tr>
<td>Recently bedridden &gt; 3 d or major surgery within previous 12 wk requiring general or regional anaesthesia</td>
<td>1</td>
</tr>
<tr>
<td>Collateral superficial veins (nonvaricose)</td>
<td>1</td>
</tr>
<tr>
<td>Localized tenderness along the distribution of the deep venous system</td>
<td>1</td>
</tr>
<tr>
<td>Swelling of entire leg</td>
<td>3</td>
</tr>
<tr>
<td>calf swelling &gt; 3 cm larger than asymptomatic side(measured 10 cm below tibial tuberosity)</td>
<td>-2</td>
</tr>
<tr>
<td>Pitting edema confined to the symptomatic leg</td>
<td>1</td>
</tr>
<tr>
<td>Previously documented DVT</td>
<td>3</td>
</tr>
</tbody>
</table>

A score of 2 or higher indicates that the probability of DVT is “likely”. A score of less than 2 indicates that the probability is “unlikely.”

Table 2: Clinical model for predicting pre-test probability of pulmonary embolism (PE)

<table>
<thead>
<tr>
<th>Clinical Feature</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pulmonary embolism or deep venous thrombosis</td>
<td>1.5</td>
</tr>
<tr>
<td>Heart rate &gt; 100 beats per minute</td>
<td>1.5</td>
</tr>
<tr>
<td>Recent surgery or immobilization</td>
<td>1.5</td>
</tr>
<tr>
<td>Clinical signs of deep venous thrombosis</td>
<td>3</td>
</tr>
<tr>
<td>Alternative diagnosis less likely than pulmonary embolism</td>
<td>1</td>
</tr>
<tr>
<td>Hemoptysis</td>
<td>2</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
</tr>
</tbody>
</table>

A score of >4 indicates that the probability of PE is “likely”. A score of 4 and less indicates that the probability is “unlikely.”

References:
Film Interpretation Panel

Case 1
Pelvic Hemorrhage
- 27 year old female
- Previous cervical cancer treated by surgery and nodal resection
- One year after surgery severe vaginal bleeding > 2 l

Describe the abnormalities and treatment options

Case 2
Chest pain
- A 66 year old man was involved in a minor car accident while driving his car and wearing a seat belt.
- He suffered no injury but felt a sharp chest pain and sought medical help in the emergency room of our hospital.
- Chest X-ray revealed bilateral pleural effusion (not shown).
- A contrast-enhanced CT scan was obtained.

Selected coronal reformat of arterial phase of CT

What is your diagnosis?
Predisposing conditions?
Treatment?
Case 3
Foot pain and ulceration

- 22 year-old male of North African origin
- The symptomatic left leg always larger than the right
- Since 2 years hypertrophic violaceous plaques
- Last 2 months increasing pain in foot and ulceration

Biopsy performed
Diagnosis?
Treatment?

Case 4
Biopsy - yes or no? That is the question

- 65 year old male
- History of rectum cancer
- One year after surgery suspicion of local lymph node metastatic disease

Biopsy yes or no?
If yes, how?

Coaxial biopsy performed with and 18-gauge needle. Jet of blood through the coaxial needle after removal of the biopsy needle.

What happened? What should you do?
Treatment options?
Gore Scientific Program at CIRSE Copenhagen, 13 - 16 September 2008

Meet the Expert Workshops - Gore Learning Center (Room M1)
Saturday, 13 September, 2008 | 12:00 - 14:00
Mini Advanced AAA Workshop
Participation on invitation only.

Sunday, 14 September, 2008 | 12.00-13.00
Discussing the Future of TIPS For the Treatment of Portal Hypertension
Moderator: Dr. F. Fanelli, Rome, Italy
Lessons Learned Using GORE VIATORR® TIPS Endoprosthesis
Prof. P. Goffette, Brussels, Belgium
Results of a Controlled Randomized Trial Comparing GORE VIATORR® TIPS Endoprosthesis with Banding for Cirrhotic Patients with Acute Variceal Bleeding. Current and Future TIPS Indications
Dr. A. Luca, Palermo, Italy
Sunday, 14 September, 2008 | 13.30-14.30
The Role of GORE VIABL® Biliary Endoprosthesis to Treat Biliary Obstructions
The Role of GORE VIABL® Biliary Endoprosthesis to Treat Malignant Biliary Obstructions
Prof. W. van Steenbergen, Leuven, Belgium
Technical and Clinical Results Using GORE VIABL® Biliary Endoprosthesis - A 6 Years Experience
Dr. F. Fanelli, Rome, Italy

Monday, 15 September, 2008 | 12.00-13.00 and 13:30 - 14:30
The Role of GORE VIABAHN® Endoprosthesis - Endoluminal SFA Bypass for Treating Complex SFA Lesions - A Critical Debate of Burning Topics
Moderators: Dr. R. Nyman, Uppsala, Sweden, Dr. A. Rampoldi, Milan, Italy
Dr. R. Chopra, Chicago, USA
Dr. R. Kruse, Den Bosch, The Netherlands
Tuesday, 16 September, 2008 | 12.00-13.00
Endovascular Treatment of Popliteal Aneurysms: Tips and Tricks, Lessons Learned Using the GORE VIABAHN® Endoprosthesis for Endovascular PAA Treatment
Dr. E. Verhoeven, Groningen, The Netherlands
Indications, Contra-Indication, Lessons Learned Using the GORE VIABAHN® Endoprosthesis for Endovascular PAA Treatment
Prof. M. Maynar, Las Palmas, Spain
Case Review Session - Gore Learning Center (Room M1)
Sunday-Tuesday, 14-16 September, 2008
Bring your own case and consult the experts at the Gore learning center! Meet with the experts directly after the workshop to discuss your case and to get direct advice. You might win a scientific voucher of 250 EUR. Please bring your case on CD or memory stick.

Sunday (TIPS, BILIARY) 14.30-15.30
Monday (SFA) 13.30-14.30
Tuesday (PAA) 13.30-14.30
Gore Satellite Symposium - Room C
Monday, 15 September, 2008 | 8.00-8.20
Long-Term Results of Total Endoluminal SFA Bypass with the GORE VIABAHN® Endoprosthesis
Moderator: Dr. E. Verhoeven, Groningen, The Netherlands
GORE VIABAHN® Endoprosthesis - An Endoluminal SFA Bypass and the Future Role of the Heparin Bioactive Surface
Dr. R. Chopra, Chicago, USA
A New Controlled Randomized Trial to Compare GORE VIABAHN® Endoprosthesis with Bare Nitinol Stents for Long SFA Lesions
Prof. J. Lammer, Vienna, Austria
For Meet the Expert Workshop reservation please visit the Gore booth at CIRSE.

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CIRSE Initiative for UFE Patient Information

The UFE dedicated website www.uterinefibroids.eu provides detailed information on fibroids, treatment options and UFE and is intended to make this highly successful non-surgical procedure more widely known among patients and referring doctors in Europe.

As so often with medical treatments, and particularly with innovative treatment methods, their availability and practice varies widely across Europe. UFE is now an accepted alternative treatment to hysterectomy and myomectomy in a good number of countries in which it is readily accessible to many patients. However, in other countries its status is yet to be determined, with some countries offering no UFE treatment at all to date.

Similarly, the information available online in the multiple European languages differs greatly with excellent websites available in some languages, principally in English, and a total absence of information in others. Whilst enhancing traffic to existing websites through selected links, www.uterinefibroids.eu will first and foremost seek to provide information in languages in which information on UFE is currently lacking.

Should you be willing to contribute UFE related content or links to existing websites in your national language, please contact us at info@cirse.org.

More stuff you should know about Denmark

Petra Mann
CIRSE Office

Greenland - the land where your drink needs no ice cubes

Greenland is defined as a self-governing Danish province (whatever that means) and is mostly known for being, well, bloody cold with an average annual temperature of -11°C even the toughest nipple will stand to constant attention. Apart from cold, Greenland is also immensely huge; it comprises roughly 2,000,000 km². Discounting 81%, which are covered by the Greenland ice sheet (The name Iceland was probably already trademarked), that still leaves 7km² for each of its 56,000 inhabitants. I guess my point is that they must have really big back yards or a lot of golf courses or something.

Although historically linked to Denmark, Iceland and Norway, Greenland is ethnically associated with North America, the majority of Greenlanders being of Inuit origin. It is common knowledge that Inuit languages will have up to 20 words for different types of snow, but what is less known is that Western Greenlandic, for example, has immensely long words which can sometimes express what other languages need entire sentences for. So when two Greenlanders speak about last night’s TV programme, you might hear one of them say Aliikuseullammassaaunatrasagasagualaupeaali, expressing his disagreement about the qualities of an entertainer. The most interesting fact you should know about the Inuit culture, however, is that they kiss with their noses, so if you do go there you might want to reconsider that nose job.

Danish Food
On: When does love for herring become too intense?

As in the other Scandinavian countries, Danes eat a lot of meat. Frikadeller and karbonader are popular dishes of fried meatballs with gravy, and although eating marinated reindeer sounds like something you would have to do on Fear Factor, it is actually worth a try.

Of course the Danes would not be a sea-faring nation if they did not also eat a fair share of fish on their smørrebrød. Marinated herring and smoked eel are some of the specialties and are a common sight at breakfast buffets. Although it was not a culinary experience I had hoped I would ever make, having fish for breakfast is not all that bad and most Danes will insist that it is the best hang-over cure (not that any of us would ever need such a thing).

Another Copenhagen classic are hot dogs with røde pølser (red sausages), which are sold in little hand-pulled carts around the city. If you’re feeling a little frisky, go up to one and ask for a hot dog ‘med det hele’, which will get you the works for your street meat.

You will see that in terms of restaurants Copenhagen really leaves nothing to be desired. It offers a wide range of exquisite establishments, 11 of which have been awarded Michelin stars. The Noma Restaurant has recently even been awarded a second star, so if you can get a reservation (for 2011, that is), do go there! I must warn you though: upon receiving your check you might have to part with the idea that both of your children will go to college.

Danish Beer

Denmark is the European country with most breweries per capita - around 60-70 in total, many of which are located in Copenhagen and offer guided tours followed by a tasting of the establishment’s products. Incidentally, this is where I say good-bye to my male audience.

Until recently the Carlsberg brewery virtually held a monopoly on the Danish beer marked, during which it acquired many local breweries and shut them down in order to increase its market shares. Angered by this development, a consumer movement called Danske Ølentusiaster ("Danish Beer Enthusiasts") was founded in an Odense pub in 1998. I daresay that the founding fathers of this illustrious society were as intoxicated as a sailor on leave, which explains the movement’s great success. Today the society boasts almost 11,000 members, holds two beer festivals per year and has achieved an outstanding revival of beer variety throughout Denmark, which of course explains why Copenhagen is one of Europe’s most popular conference destinations.

For more information go to www.ale.dk or consult the closest pub for an immediate sampling.
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