APDVS Core Surgery and Defined Minimums for Case Logs Committee

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Committee Questions Last Year

- Whether we should add other categories like dialysis and venous minimum cases
- Decline in open operative experience and inability to meet current procedure minimum numbers—Should we modify current procedure minimums
- Variability in core rotations
- Experience variation among different institutions
- Can some of the core curriculum be taught during vascular surgery rotations
  - Other subspecialties reduced months on general surgery

PREVIOUS YEAR SUGGESTIONS

1- Add venous and dialysis categories
   - Case range 10-20, 20-30 respectively
   - Can some of these cases roll over from GS?

2- APDVS should endorse some of the rotations/courses offered around the country
   - Simulation, high volume centers

3- Consider reducing GS core rotations to 18 months and make them institution specific with no minimum case requirement
   - Emphasis on: critical care, acute care surgery and trauma
Venous and HDA Case Minimums

Q1 At the March 2018 APOVS Spring Meeting, case minimums in dialysis access and venous were suggested. Twenty venous cases (ablative laser of superficial veins, open venous surgery, endovenous procedures) and fifteen dialysis access cases (AVF/AVG creation, revision open/ends) were suggested. Would your program be able to meet these requirements?

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<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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<tr>
<td>Yes</td>
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<td>3</td>
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<td>Tying</td>
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COMMENTS

1. The numbers still seem low, but it is a great start.
2. 20 venous cases seems like plenty but 15 dialysis does not seem like enough for proficiency.
3. I would not add venous case minimums. Easy cases that do not require many to be proficient.
4. Easily.
5. It is a significant gap in current case requirements that these categories do not have minimums. Expertise in these areas is essential for the well-trained vascular surgeon.
6. Silly. Any program that can't meet these low bars shouldn't be training vascular surgeons.
7. We'd be fine with dialysis access minimums as proposed. But we'd struggle to get venous cases for that work is handled elsewhere in our hospital and region.
8. It would be tight for the venous cases.
Focus

• GS procedure minimums
  • Do we need them?
  • How many? Similar to requirements for PGY1 and PGY2 GS residents?

• Open Aortic procedure numbers declining
  • There are recent graduates with 0 reported open aortic procedures
  • Understand specific program challenges
  • Change Open Aortic Category to Torso (Committee will review and propose appropriate CPT codes to be included)
  • Potential solutions

• Should open vascular procedure minimums be modified?
  • Need recent trends to better map out changes across the programs

How to help Programs that cannot meet minimum numbers

• Lower requirements (?)
• APDVS sponsored programs
  • Teaching courses
  • Simulation
• Mini Fellowships in high-volume programs
• Away rotations
  • In the USA
  • Abroad

Inability to meet Case Minimums

Would you allow your residents to go to another program that has high case volumes in other required categories (e.g., open AAA, CAS, complex ETCV, etc.) to get additional experience?

Would APDVS endorse courses (e.g., open AAA, CAS, sample from AAD, etc.) to help meet requirements?

Would you send your residents to an APDVS endorsed course (e.g., open AAA, CAS, sample from AAD, etc.) to help them broaden their experience and/or meet requirements?

Would you hire a graduate who attended an APDVS endorsed course (e.g., open AAA, CAS, sample from AAD, etc.) but didn't meet the case requirement during training?

Would you hire a graduate who was below the minimum in one of the core categories during training but the Program Director signed off that they were competent in that area?

Would you allow your resident to go to another program that has high case volumes in one of the required categories (e.g., open AAA, CAS, complex ETCV, etc.) to gain additional experience?
QUESTIONS?