APDVS CASE MINIMUM SURVEY 2017

Carlos Bechara MD on behalf of the adhoc committee
Associate Professor, Program Director
Houston Methodist hospital
• I have nothing to disclose in relation to this talk
• Mitchell Cox, MD
• Randy Shafritz, MD
• Frank Schmieder, MD
• Christian Ochoa, MD
• Vincent Rowe, MD
• Apostolos K. Tassiopoulos MD
• Paul W. White, MD

• Kathleen Lamb, MD
• Zack Nash, MD
• Melissa Loja, MD
• Julia Glaser, MD
• Matthew Wooster, MD

• Special thanks to
  – Gina Dickinson
  – Emily Kalata
WERE WE LEFT OFF LAST YEAR REGARDING CASE MINIMUMS AND CORE SURGERY ROTATIONS:

- Whether we should add other categories like dialysis and venous minimum cases*
- Decline in open operative experience*
- There is variability in core rotations
- Experience varies among different institutions
- Can some of these be taught by vascular surgeons
  - Other subspecialties reduced months on general surgery

*affects fellowship and integrated programs*
• Fellowship
  – Trained GS
    • Laparoscopy/robotic
  – Less vascular exposure
  – GS certificate not a requirement now

• IVR
  – GS experience varies
    • Concern for abd exposure
    • LOA
    • Laparoscopy
  – Early on vascular experience
  – Are they better off being on vascular rotations
We are not going to solve all these problems

Have an understanding from other PD’s about their struggles

Are some of the issues faced by all programs or few?
THE COMMITTEE CAME UP WITH

• 12 Questions FOCUSED ON
  – MINIMUM CASE LOGS
  – Core general surgery rotations

SURVEY SENT TO 180 PD’S
45 RESPONDED (25%)
Q1 SPECIFY YOUR CURRENT DETAILS BELOW.
ANSWERED: 45 SKIPPED: 0
My vascular surgery training program offers the following paradigms:

- Information
  - 0+5
  - 5+2/4+2
  - Both 0+5 and 5+2/4+2
Q2: SHOULD THE FOLLOWING CATEGORIES HAVE SET MINIMUM CASE REQUIREMENTS?
Q3: SHOULD CAS (TCAR AND TRANSFEMORAL CAS) WITH CEA BE ADDED UNDER THE CEREBROVASCULAR MINIMUM CASE REQUIREMENT?

- Yes - Minimum Case Requirement of 10
- Yes - Minimum Case Requirement of 20
- Yes - Minimum Case Requirement of 30
- Yes - Minimum Case Requirement of >50
- No
Q4: WHAT SHOULD HAPPEN TO THE 100 DIAGNOSTIC CASE MINIMUMS?

- Leave requirement as is
- Remove
- Reduce to 50
- Add it to endovasc therapeutic and keep it at 100
- Add it to endovasc therapeutic but reduce to 50
Q5: PLEASE ANSWER THE FOLLOWING QUESTIONS:

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

Should APDVS endorse courses (e.g. open AAA, CAS, complex Endo AAA, etc) to help meet requirements?

Would you send your trainees to an APDVS-endorsed course (e.g. open AAA, CAS, complex Endo AAA, 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, complex Endo AAA, 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?
Q6: WHAT ARE ACCEPTABLE MINIMUM CASE REQUIREMENTS WOULD YOU SUGGEST FOR THE FOLLOWING PROCEDURES?

- Open aortic surgery...: 18
- Extremity open arterial bypass: 28
- Extremity endovascular: 59
- CEA: 31
- CAS: 10
- EVAR: 25
- TEVAR: 14
- Complex open: 13
- Complex endovascular: 16
Q7: SHOULD THERE BE A SEPARATE BILLING CODE FOR FEVAR PLANNING?

Not unless there is going to be some type of universal "pre op planning" time-based billing code for ALL complex procedures (reviewing CTs and venograms, prior and outside medical records, etc) to plan for complex HD access, aneurysm repairs, re-do peripheral arterial reconstruction, etc. Anyone can do the simple cases.
Q8: DO YOU FEEL VASCULAR SURGERY INTEGRATED VASCULAR RESIDENCY PROGRAMS ARE PRODUCING GRADUATES WHO ARE SUB-SPECIALIZED LIKE ORTHOPEDIC SURGERY AND UROLOGY?
Q9: HOW LONG DO YOU FEEL GENERAL SURGERY CORE ROTATION REQUIREMENTS SHOULD BE FOR VASCULAR SURGERY INTEGRATED RESIDENTS?

- 24 Months (current...)
- 18 Months
- 12 Months
- Other (please specify how...)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Q10: SHOULD GENERAL SURGERY CORE ROTATIONS FOR VASCULAR SURGERY INTEGRATED RESIDENTS BE INSTITUTION SPECIFIC?
Q11: SHOULD THERE BE A MINIMUM NUMBER OF GENERAL SURGERY CASES FOR VASCULAR SURGERY INTEGRATED RESIDENTS?
Q12: RANK THE FOLLOWING TEACHING/EDUCATIONAL OBJECTIVES THAT VASCULAR SURGERY INTEGRATED RESIDENTS SHOULD GAIN FROM THEIR GENERAL SURGERY ROTATIONS

- Acute care surgery
- Critical care
- How to perform exploratory...
- Trauma
- Work up acute abdomen

0 1 2 3 4 5 6 7 8 9 10
SUMMARY

1- Majority feel we should add venous and dialysis categories
   Case range 10-20, 20-30 respectively
   Can some of these cases roll over from GS?

2- Leave the CEA and CAS separately, as well as the 100 Diagnostic

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

4- Billing for complex endo AAA planning

5- 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
### SUMMARY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
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<tbody>
<tr>
<td>Open aortic surgery...</td>
<td>18</td>
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<tr>
<td>Extremity open arterial byp...</td>
<td>28</td>
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<tr>
<td>Extremity endovascular...</td>
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</tbody>
</table>

About the same
Separate some of them?
• We should specify that this all includes cognitive training and the ability to distinguish when to do open and when to do endovascular.

• Suggest minimum GS cases at 100. There is a wide variance of opinion within our own group so these numbers somewhat reflect that input - but mostly these are my own bias.

• As most institutions require 25 cases for CAS for credentialing purposes, it would be a disservice to our trainees not to have them prepared for employment and do less than the required number for credentialing.
• Age old problem and is difficult because each trainee has a different level of skills. Some need more, some less. The good ones will get theirs and the average ones need to have targets.

• I think endovascular aortic cases should be a single category rather than separate EVAR and TEVAR. Branched and more complex cases go into endovascular complex which should stay separate.

• Minimums if adopted should be different for 5+2 and 0-5 programs; in general do not favor the concept of minimum numbers in categories.
It would be of value to provide the current minimum case requirements to individuals completing this form. Open abdominal vascular surgery is going to continue to decline and consequently the requirement that graduates have extensive experience in performing those surgeries will diminish. In other words, they will become less and less likely to perform those procedures in practice. As a result it would seem that emphasizing open aortic surgery in training and creating free-standing training programs for aortic surgery may not be necessary or advisable.
• Diagnostic angiography has been replaced by CTA or MRA and should be removed from a requirement. Open Aortic surgery may require an additional sub specialty experience to allow for true competence.

• This was a bad survey - I had to fill in numbers to submit the survey when for some questions, I didn't think there should be a minimum number.
THANK YOU
• We have a problem with open exposure
  – Abd exploration/LOA
  – Open AAA repair
• What is the solution?
  – Simulation
  – Courses
  – Electives at high volume centers
  – Outside the US
• Role of APDVS
• Credentialing
• Rollover cases from GS?