

Required/Elective Procedures of Several Institutions, Compiled by SVS Members

As of March 25, 2020

Sean Lyden	Cleveland Clinic	AAA >6cm	Done w/in 2 weeks vs or wait up to 8 weeks
		AAA 5-6cm	Can wait >=8 weeks
		AAA symptomatic	Urgent or Inpatient
		ALIF exposure per Spine team decision	Per Spine team decision
		Amputations	Urgent or Inpatient vs done w/in 2 weeks
		AVMs	Can wait >=8 weeks
		Carotid asymptomatic >80 for CEA or CAS	Needs done 2-8 weeks
		Carotid symptomatic for (CEA/CAS)	Needs done <2 weeks
		Carotid-SC Transposition/bypass follow TBAD and TAAA guidelines	Follow TBAD and TAAA guidelines
		Claudication	Can wait >=8 weeks
		Endoleak, Type 2	Can wait >=8 weeks
		Femoral or Popliteal aneurysm, Asymptomatic	Can wait >=8 weeks
		Femoral or Popliteal aneurysm, Symptomatic	Urgent or Inpatient vs done w in 2 weeks
		Fistula Creation, not on HD	Can wait >=8 weeks
		Fistula Creation, on HD	Needs done 2-8 weeks
		Fistula Declot	Urgent or Inpatient
		Fistula Revision for Malfunction/steal	Needs done <2 weeks
		Fistula Revision for Ulceration	Urgent or Inpatient
		Fistulagram for malfunction	Needs done <2 weeks
		Gangrene/Significant Ulcer >2cm	Needs done <2 weeks
		IVC filter placement	Urgent or Inpatient vs done w in 2 weeks
		IVC filter removal	Can wait >=8 weeks
		Lysis, Arterial and venous	Urgent or Inpatient
		May Thurner without thrombus	Can wait >=8 weeks
		MediPort for immediate infusion needs	Needs done <2 weeks
		Mesenteric angio/bypass	Urgent or Inpatient
		Popliteal entrapment syndrome, anatomic with clot	Done w in 2 weeks vs or wait up to 8 weeks
		Popliteal entrapment syndrome, physiologic	Can wait >=8 weeks
		Procedure for Rest Pain	needs done 2-8 weeks
		Skin Graft	can wait >=8 weeks
		TAAA >7cm	Done w in 2 weeks vs or wait up to 8 weeks
		TAAA 6-7cm	Can wait >=8 weeks
		TBAD with high risk features	Can wait >=8 weeks
		TBAD with malperfusion	Urgent or Inpatient
		Thoracic Outlet Syndrome, Arterial with thrombosis	Urgent or Inpatient vs done w in 2 weeks
		Thoracic Outlet Syndrome, Neurogenic	Can wait >=8 weeks
		Thoracic Outlet Syndrome, Venous otherwise	2-8 weeks vs >8 weeks
		Thoracic Outlet Syndrome, Venous with thrombosis	Urgent or Inpatient vs done w in 2 weeks
		Tunneled Dialysis Catheter	Urgent or Inpatient
		Vein ablations	Can wait >=8 weeks
		Vein excision/phlebectomy	Can wait >=8 weeks
		Vein sclerotherapy	Can wait >=8 weeks

		Wound Debridements	Urgent or Inpatient vs done w in 2 weeks
Dawn Coleman		Ruptured aortic aneurysm	Urgent
		Acute aortic dissection with malperfusion	Urgent
		Vascular injury with bleeding	Urgent
		≥ Grade IIB severe acute limb ischemia (ie, amputations)	Urgent
		Stroke in evolution/Crescendo TIA	Urgent
		Acute mesenteric ischemia	Urgent
		Fasciotomies	Urgent
		AAA: Symptomatic AAA, Ruptured AAA, Asymptomatic AAA 8 cm or	Not Urgent
		Symptomatic non-aortic intra-abdominal aneurysm	Not Urgent
		Cerebrovascular: Symptomatic with lateralizing symptomatology	Not Urgent
		Limb Ischemia: Progressive tissue loss, acute limb ischemia, wet gangrene, ascending cellulitis	Not Urgent
		Prosthetic graft infection with sepsis	Not Urgent
		Mesenteric Ischemia: Acute or Acute-on-Chronic	Not Urgent
		Fasciotomies	Not Urgent
		Vascular Trauma	Not Urgent
		Pseudoaneurysm Repair: Not candidate for thrombin injection or compression, rapidly expanding, complex	Not Urgent
		Intraoperative Consults	Not Urgent
Joseph Mills	Baylor College of Medicine	AAA Rupture	Emergent (within hours)
		Traumatic injury with hemorrhage and/or ischemia	Emergent (within hours)
		Bleeding from access, bypass or fistula/graft	Emergent (within hours)
		Type B dissection with rupture and/or severe malperfusion	Emergent (within hours)
		AEF with septic/hemorrhagic shock, or signs of impending rupture	Emergent (within hours)
		Acute mesenteric ischemia	Emergent (within hours)
		Symptomatic carotid artery stenosis	Urgent (within 1-14 days)
		Large AAA > 7 cm	Urgent (within 1-14 days)
		Acute limb ischemia (Rutherford 1, 2a, 2b)	Urgent (within 1-14 days)
		Infected arterial prosthesis without overt sepsis, or hemorrhagic shock	Urgent (within 1-14 days)
		Chronic mesenteric ischemia	Urgent (within 1-14 days)
		Symptomatic renovascular hypertension/renal failure	Urgent (within 1-14 days)
		Massive symptomatic iliofemoral DVT in low risk patient	Urgent (within 1-14 days)
		Symptomatic venous TOS with acute occlusion and marked swelling	Urgent (within 1-14 days)
		Revascularization for chronic limb-threatening ischemia, depending u	Yes (but use judgement and be selective): Semi-urgent, within 30 days
		Revascularization for high grade re-stenosis of previous intervention	Yes (but use judgement and be selective): Semi-urgent, within 30 days
		Acute iliofemoral DVT, in low risk patient	Yes (but use judgement and be selective): Semi-urgent, within 30 days
		Large, asymptomatic visceral artery aneurysms	Yes (but use judgement and be selective): Semi-urgent, within 30 days
		Claudication	No, Elective: generally defer until Corvid situatin resolved/controlled
		Asymptomatic carotid stenosis	No, Elective: generally defer until Corvid situatin resolved/controlled
		Varicose veins, GSV ablations	No, Elective: generally defer until Corvid situatin resolved/controlled
		Dialysis access creation in patient	No, Elective: generally defer until Corvid situatin resolved/controlled
		AAA < 6 cm	No, Elective: generally defer until Corvid situatin resolved/controlled
		Asymptomatic May Thurner syndrome	No, Elective: generally defer until Corvid situatin resolved/controlled

		TOS for chronic neuro symptoms (exception acute arm swelling, Page	No, Elective: generally defer until Corvid situatin resolved/controlled
Bradley Thomas		Acute limb ischemia	Tier 1
		Ruptured and symptomatic aneurysms (thoracic, abdominal aortic, m	Tier 1
		Aortic dissection with malperfusion	Tier 1
		Surgery/Embolization for uncontrolled bleeding in unstable patients	Tier 1
		AV fistula and graft placement for dialysis (ESRD, CK4, and CK5 only)	Tier 2
		Dialysis maintenance surgery if required for successful HD	Tier 2
		Aneurysmal disease: Asymptomatic and/or aneurysm >5.5 cm men 5	Tier 2
		Mesenteric and Peripheral Aneurysms large enough to be a risk of ru	Tier 2
		Peripheral Vascular Disease: Chronic limb threatening ischemia - rest	Tier 2
		Symptomatic Carotid Stenosis: CEA and TCAR	Tier 2
		Asymptomatic but severe Carotid Artery Stenosis (>80%)	Tier 2
		Tunneled HD Catheters	Tier 2
		Surgery/Embolization for bleeding in stable patients	Tier 2
		IVC Filters (placement and removal)	Tier 2
		Deep vein interventions with acute ileofemoral DVT and/or PE	Tier 2
		Amputations for infection/necrosis (toes, TMA, BKA, AKA)	Tier 2
		Port placement for cancer, Removal for complication	Tier 2
		Routine Angio	Tier 3
		Superficial Vein Procedures	Tier 3
		PAD for claudication (open and endo)	Tier 3
		Port Removal (not infected)	Tier 3
Cheong Lee	Northshore University Health Systems	Peripheral Angiograms for Claudication	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		AAA < 6.5 cm unless extenuating circumstances are present	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		TAA < 6.5 cm unless extenuating circumstances are present	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		Asymptomatic Carotid artery intervention	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		Fistulograms unless bleeding or risk of thrombosis	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		Vein procedures	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		TOS unless arterial	Postponed or cancelled cases out to 60 (will likely extend to 90) days
		Dialysis access creation (case by case basis)	Postponed or cancelled cases out to 60 (will likely extend to 90) days
Judith Lin	Henry Ford	Symptomatic Carotid	Urgent (should not be delayed)
		Symptomatic upper and lower extremity occlusive disease patients w	Urgent (should not be delayed)
		Lower extremity disease with non-salvageable limb (amputation)	Urgent (should not be delayed)
		All symptomatic abdominal aortic aneurysm or thoracic or thoracoab	Urgent (should not be delayed)
		Asymptomatic abdominal aortic aneurysm or thoracic or thoracoabd	Urgent (should not be delayed)
		Aneurysm associated w/infection or Prosthetic graft infection	Urgent (should not be delayed)
		Saccular thoracic or abdominal aortic aneurysm	Urgent (should not be delayed)
		Symptomatic femoral/popliteal/subclavian aneurysm	Urgent (should not be delayed)
		Renail failure with need for dialysis access	Urgent (should not be delayed)
		Infected dialysis access	Urgent (should not be delayed)
		Symptomatic mesenteric occlusive disease	Urgent (should not be delayed)
		Surgical wound infection or necrosis	Urgent (should not be delayed)
		Foot owund soft tissue infection (diabetic wound infection)	Urgent (should not be delayed)
		Wounds requiring amputation	Urgent (should not be delayed)
		Complications related to compartment syndrome	Urgent (should not be delayed)

		Venous thrombosis related to TOD	Urgent (should not be delayed)
		Arterial aneurysm related to TOD	Urgent (should not be delayed)
		Asymptomatic carotid artery	Can be delayed
		Asymptomatic upper and lower extremity occlusive dz	Can be delayed
		Lower extremity occlusive disease manifested by claudication alone	Can be delayed
		Upper extremity occlusive disease manifested by exercise fatigue alone	Can be delayed
		Asymptomatic bypass graft restenosis/stent restenosis	Can be delayed
		Abdominal aortic aneurysm or thoracic aneurysm or thoracoabdominal aortic aneurysm	Can be delayed
		Non-infected asymptomatic popliteal femoral subclavian aneurysms	Can be delayed
		Dialysis access graft stenosis/low flow	Can be delayed
		Impending or anticipated renal failure	Can be delayed
		Asymptomatic mesenteric occlusive disease	Can be delayed
		Wounds requiring skin grafts	Can be delayed
		Ulcerations secondary to venous disease	Can be delayed
Michael Conte	University of California	Symptomatic/rapidly enlarging or very large/unstable aneurysms	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Complicated type B aortic dissection	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Acute limb or visceral ischemia	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Symptomatic carotid stenosis	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Chronic limb threatening ischemia with gangrene/major ulcer (WIFI)	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Suspected graft infection/mycotic process, any location	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Threatened bypass graft (impending failure)	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Severe renal artery disease with pulmonary edema or malignant HTN	Urgent - diagnoses/cases that should be done within 7 days or the patient will potentially suffer adverse consequences
		Asymptomatic, stable, larger aneurysms (e.g. > 6 or 6.5 cm)	Non-urgent but priority; diagnoses/cases that should be done within 1 month or the patient will potentially suffer adverse consequences
		High grade/critical asymptomatic carotid stenosis (>80%)	Non-urgent but priority; diagnoses/cases that should be done within 1 month or the patient will potentially suffer adverse consequences
		Chronic or subacute limb threatening ischemia with rest pain/minor ulcers	Non-urgent but priority; diagnoses/cases that should be done within 1 month or the patient will potentially suffer adverse consequences
		Chronic mesenteric insufficiency with severe, episodic symptoms	Non-urgent but priority; diagnoses/cases that should be done within 1 month or the patient will potentially suffer adverse consequences
		Asymptomatic, stable aneurysms that meet size guidelines	Elective
		Asymptomatic carotid stenosis	Elective
		Claudication	Elective
		New dialysis access creation	Elective
		Venous interventions	Elective