

VIVA TODAY

MAINTENANCE OF CERTIFICATION OPPORTUNITIES AT VIVA: MEDICINE, RADIOLOGY, AND SURGERY

By John A. Kaufman, MD | Portland, Oregon



Physicians are constantly adjusting to new demands on their time, including an increase in requirements for maintenance of certification (MOC). All specialty boards participate in MOC, and many state licensing boards and some local hospital credentials committees are also requiring participation. As part of MOC, it is no longer sufficient to just earn Category I credits. Many physicians must now document a certain quantity of active learning by completing tests based on participation in an educational activity. These are termed MOC points by the American Board of Internal Medicine (ABIM), or self-assessment CME (SA-CME) by the American Boards of Radiology (ABR) and Surgery (ABS). In other words, simply attending a meeting is not enough to meet the Part 2 MOC ("Lifelong Learning") requirements. New at VIVA this year, physicians will have the opportunity to earn MOC points towards the ABIM MOC program, or SA-CME credits that can be applied to the MOC programs of the ABR and the ABS.

Today, Drs. Josh Beckman and John Laird will be moderating two ABIM MOC knowledge modules: the 2014 Update in Cardiovascular Disease and the 2014 Update in Interventional Cardiology. These will be offered for a total of 10 ABIM MOC points each. In order to earn credits, you must be enrolled in the ABIM MOC program and submit 30 completed question modules for scoring.

Radiologists and surgeons can also earn SA-CME at VIVA. The approved sessions for these specialties were the Acute Pulmonary

SEE IT LIVE

Opportunity to earn credit at the following sessions:

2014 UPDATE IN CARDIOVASCULAR DISEASE

Today, 9:00 AM – 12:00 PM

2014 UPDATE IN INTERVENTIONAL CARDIOLOGY

Today, 1:20 PM – 4:20 PM

CAROTID ROUNDTABLE SESSIONS

Tomorrow, 2:15 PM – 3:15 PM; 3:20 PM – 4:20 PM

ACUTE STROKE ROUNDTABLE SESSION

Tomorrow, 4:25 PM – 5:30 PM

Embolism pre-symposium on Monday (4.5 SA-CME), the Carotid I and II Roundtable sessions on Wednesday (1 SA-CME each), and the Acute Stroke Roundtable session on Wednesday (1 SA-CME). To earn credits, you must attend the session and successfully complete an online question/answer module with a score of 75% or higher.

VIVA is constantly working to make the educational experience at the meeting as relevant as possible to attendees. We will continue to monitor the changes in MOC requirements and modify the meeting to ensure that attendees receive a complete vascular educational experience.

The BEST-CLI Trial: A Multidisciplinary Effort to Identify What's BEST for Patients With Critical Limb Ischemia

BY ALIK FARBER, MD; MATTHEW MENARD, MD; AND KENNETH ROSENFELD, MD

The burden of critical limb ischemia (CLI) is staggering—for the individual patient, for providers, on the health care system, and on society as a whole. Individuals with CLI represent the most challenging patients for those clinicians who treat peripheral arterial disease (PAD). Yet, these patients also stand to benefit the most from proper and effective management. CLI is characterized by intractable foot or ankle pain at rest and/or the presence of ischemic ulcerations or gangrene. Without successful revascularization, up to 40% of patients will require limb amputation. The annual incidence of CLI in the United States is 500 to 1,000 per million and is expected to grow due to the impact of diabetes, dietary indiscretion, tobacco abuse, and the aging population.

Medical therapy is generally ineffective in CLI; resolution of rest pain or tissue loss requires successful revascularization to improve limb perfusion. Over the last 2 decades, the widespread adoption of endovascular techniques for PAD has extended to patients with CLI, in whom reduced periprocedural morbidity and mortality compared to open surgery has created a paradigm shift away from surgical bypass towards an endo-first approach. Yet, evidence regarding effectiveness, durability,

cost, and appropriate case selection for initial treatment with endovascular intervention versus open surgery is lacking. There is general agreement that poor surgical candidates are appropriate for endo-first, but in patients who are candidates for both open and endovascular treatment, it remains to be defined which therapy is most effective (and cost-effective).

BEST-CLI is a prospective, randomized, multicenter (and multispecialty), controlled trial comparing Best Endovascular versus Best Surgical Therapy in patients with Critical Limb Ischemia, designed to evaluate these issues. Funded by the National Institutes of Health (NIH), it will enroll 2,100 patients with CLI at 120 North American sites over the course of 4 years. The aim of BEST-CLI is to compare treatment efficacy, functional outcomes, and cost in patients who are candidates for both infrainguinal open surgical and endovascular revascularization. The design is pragmatic: once randomized, the definition of best endovascular or surgical therapy is left to the individual investigator. Investigators may use virtually any commercially available endovascular therapy, as well as all surgical bypass techniques and types of conduit.

The national Principal Investigators

are Drs. Alik Farber, Matthew Menard, and Kenneth Rosenfield. The Executive Committee and investigators represent all disciplines involved with CLI; collaboration among specialties will be mandated.

BEST-CLI will examine two cohorts of patients: 1,620 patients with adequate single segment great saphenous vein (SSGSV) and 480 patients without adequate SSGSV. Within each group, patients will be randomized 1:1 between open surgical bypass and endovascular therapy. Groups will also be stratified based on clinical presentation and anatomy.

The BEST-CLI trial incorporates novel endpoints and a robust cost-effectiveness component. The primary endpoint is major adverse limb event (MALE)-free survival. This aggregate measure captures the main goals of treatment, namely, survival with an intact, functional limb without a major reintervention (eg, repeat bypass graft, thrombectomy or thrombolysis, major surgical graft revision) that might significantly impact quality of life (QoL). Minor reinterventions (eg, surgical patch angioplasty or percutaneous intervention without lysis) are captured as secondary endpoints, as are amputation-free survival, reintervention- and amputation-free survival, freedom from

MALE perioperative death, and freedom from myocardial infarction or stroke. BEST-CLI will also provide a comprehensive assessment of patient functional status, QoL, and cost-effectiveness, capturing resource utilization throughout the continuum of care.

The BEST-CLI trial and NIH leadership acknowledgement of the importance of participation of all relevant specialties at each trial site is promoting the concept of CLI teams. CLI teams are intended to promote enrollment of all eligible patients, ensure standard-of-care treatment for each patient, and create a collaborative environment with ongoing communication, collegiality, and information exchange among investigators.

BEST-CLI promises to answer many questions that remain regarding the management of patients with CLI and infrainguinal PAD, and to help define best practice in these challenging patients.

SEE IT LIVE

For more on CLI, attend Thursday's session:

CRITICAL LIMB ISCHEMIA / FUNCTIONAL LIMB PRESERVATION

Thursday, 1:20 PM – 3:28 PM
Lafite Ballroom