

Message from the President

What is the President for?



New President Michael Gough

Why do we have a President? Is it an accolade handed out to one of Will Carling's "old farts" as surgeons approach the end of their career, or is it to facilitate and progress the development of vascular surgery? Most Presidents would prefer the second job description. If true, then what can be achieved in a single year? The important issues currently facing the Society (new training curriculum, specialty status, implementation of aneurysm screening etc) requires input from agencies such as the Department of Health, PMETB, the

Royal Colleges and the JCST/SAC. None of these organisations moves quickly! Success also depends upon learning how these bodies and their committees work and on establishing relationships with them. Because of this the President of most specialist surgical societies now serves for 2-3 years. Only we and the Association of Coloproctology limit this to 1 year. John Wolfe suggested that this should change and I agree with him - what does the membership think? Views to president@vascularsociety.org.uk please.

Status and Training

There was much debate at the 2007 AGM about the "status" of vascular surgery. Should it remain part of general surgery, formally become a sub-specialty of general surgery or be a specialty in its own right? The latter prevails in 21 EEC states so the precedent is set. Specialty status would require Department of Health approval (they prefer the concept of PMETB-approved sub-specialties), Royal College agreement, a separate vascular SAC, specific criteria for a CCT and an exit exam. Overcoming these hurdles will not be quick. Equally, I believe that a significant proportion of existing vascular surgeons and trainees would be reluctant to sever all links with general surgery.

“A designated sub-specialty of general surgery ... provides the optimum solution”

The option of becoming a designated sub-specialty of general surgery (combined with interventional vascular radiology) was suggested by Peter Rubin, chair of PMETB when the new curriculum for combined vascular and interventional therapy was presented to him in October 2007.

continued on page 2

Aneurysm screening promised at last

The Prime Minister finally announced a national aneurysm screening programme as part of a wide ranging government initiative to screen the population, rather than simply treating diseases as they occur. It appears there will be funding to start the programme with first wave sites (generally those already screening, or ready to go), together with administration and a training programme for scanning technicians.

Details are emerging slowly and will be passed on to the Society as soon as possible. The Council initiative on Network development will form a central part of the Society response. The Executive is working with Robert Sherriff who co-ordinates the programme to deliver it effectively. Roll-out is likely to take five years. Members should be discussing with colleagues whether they are able to offer to be a second wave network next year.

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President's message *continued from page 1*

Although support from the Royal Colleges of Surgery, Royal College of Radiology, and the JCST is required, discussions with these groups suggest that this is achievable with fewer obstacles. This would allow continued development of an integrated vascular surgery and interventional radiology curriculum as well as providing the core competencies of general surgery. From a training perspective I believe that this provides the optimum solution, although it may not raise the profile of vascular surgery to the same degree as separate specialty status. Does this matter?

New Curriculum

A response to the outline submitted to PMETB in October has been slow and progress is required if it is to be implemented by 2009. However, our proposals are in line with the changes suggested in the final Tooke report. Core training (CT1-3) will replace FY2 and ST1-2. CT1 is likely to be broad based (A&E, ITU, general surgery etc), CT2 is likely to be more surgically orientated and CT3 could include six months each of vascular surgery and interventional radiology. With sub-specialty status, two years would then be spent attaining the core competencies in general/emergency surgery followed by four years modular training in vascular surgery and radiology. Tooke appears to support this concept, recommending that training programmes should be fine-tuned to recognise NHS needs and evolving technical advances. Further, if additional training is required, then both out-of-programme experience and post-CCT fellowships also feature amongst his recommendations. The Society must decide whether this or pure vascular training (i.e. an entirely separate specialty) will produce clinicians who are best equipped to deal with vascular patients.

Revalidation

This is coming but the GMC is taking advice on its format from the Royal College of Surgeons of England who, in turn, enrolled the ASGBI to canvas opinion from the specialist societies. This was discussed by society Presidents when they met (on a Saturday!) recently. For vascular surgeons, a major component of revalidation will almost certainly be submission (and analysis) of data from the NVD and I would urge everyone to start using the new web-based system as soon as possible. Tim Lees describes this in more detail elsewhere in the Newsletter.

So, there is more to being President than hosting a memorable AGM. Nevertheless we can look forward to meeting in Bournemouth. Remember, it is earlier than normal this year (12-14 November) so I will only be President for 50 weeks!

AAA Screening

You will have heard that AAA screening is to be rolled out as part of the latest NHS reforms announced by the Prime Minister on 7 January. The screening programme will require the further development of vascular networks throughout the UK and more importantly "compulsory" submission to the National Vascular Database for those treating screen-detected aneurysms. As I tell the trainees – "no audit no operating"! Importantly the DoH has recognised the important contribution that the Society can make to this initiative and through the NVD we will facilitate governance of the programme.

"No audit - no operating"!

Feedback

Feedback on the following issues would be welcome:

1. **Duration of Presidency**
2. **Specialty or sub-specialty status?**
3. **Training issues**
4. **Revalidation**

Please send your comments via email to president@vascularsociety.org.uk



Outgoing President Professor George Hamilton, hands over to incoming President Michael Gough

New

National Vascular Database is live

The new webtool for the National Vascular Database is now available for VSGBI members.

Following the AGM we registered a few surgeons so that they could help us test the webtool and allow changes to be made before the majority of users joined. At the time of writing we have 80 individual users signed up with a log-in for data entry and there are already 198 cases on the database. Sara Baker is currently working her way through all the NVD contributors and will be providing everyone with a log-in. If you wish to push forward with contribution in the meantime you are welcome to contact her to get your log-in (sara.baker@rbch.nhs.uk). Those centres with helpers are also able to have an administrator log-in allowing one person to enter data for all the surgeons at their site. Some of the changes required to the system are being noted and will be done in a batch together so please be patient when you use the system initially. If there are particular problems you discover, however, please feed these back to Sara or me.

I would like to express my thanks to Sara for the considerable time and effort she is putting into the database development at present.

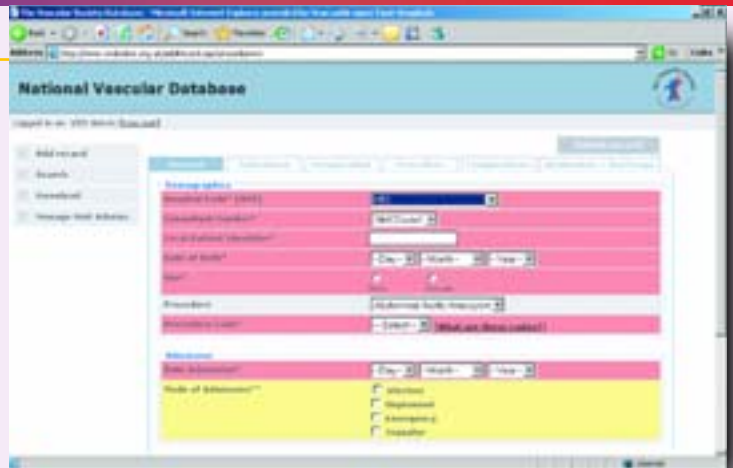
You will note that the upload facility is not yet available on the system. The Dr Foster team will provide this once we have confirmed that we are fully satisfied with the fields and functioning of the database. It is important for us to be quite sure that the database conforms to our requirements before doing this. Nevertheless this facility will be available shortly, and we will also be adding some facilities for analysis. Enhancements planned for the future include HES comparison and risk adjustment of mortality rates, subject to funding.

Aneurysm Screening and NVD

The Government has recently announced their support for aneurysm screening. It seems likely that the NVD will be used to provide the data required for quality assurance of this programme in relation to surgical mortality rates. Further discussions are being held with the DoH.

Carotid Endarterectomy Audit

The current audit includes all patients operated on up until 31st December 2007 but you should continue to put all your patients into the existing web tool, and I would like to encourage you to complete the follow up data on all the patients



you have entered so far. There are currently 5129 cases on the system, with follow up data complete in 3918. We have applied to the Healthcare Commission for funding to continue this audit and if successful we will take the opportunity of improving some of the questions and mechanisms for data entry.

Tim Lees (tim.lees@nuth.nhs.uk)

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Urgent Carotid Intervention

The Need for Service Redesign

Peter Lamont, Bristol Royal Infirmary

The Department of Health's National Stroke Strategy, published in December 2007 (www.dh.gov.uk/stroke) recognises that there is an indirect but compelling case for urgent carotid intervention within 48 hours in fit patients with >50% internal carotid stenosis who suffer a transient ischaemic attack (TIA) or minor stroke.

Of the 15% or so of such patients who will go on to have a major stroke within the next 3 months, half will have their stroke within a week, the majority within the first couple of days. The time frame for carotid intervention to achieve the maximum benefit in stroke prevention is therefore very short.

The National Stroke Strategy recognises that to meet this tight 48 hour timeframe will present a significant clinical challenge.

To meet that challenge, a number of things need to be put in place. Public and GP awareness needs to be raised, along the lines of recent acute chest pain initiatives, so that patients might think of a TIA as a "brain attack", needing immediate medical attention. Stroke physicians, experienced in the diagnostic dilemmas which some TIAs present, need to see the patients within 24 hours in a dedicated, immediate access TIA clinic to assess their early stroke risk. This can be done using simple clinical risk scoring systems, such as the ABCD2 (see below) which is based on age, blood pressure, clinical features, diabetes and duration of symptoms and which can be used to stratify patients with the highest risk of stroke in the next 7 days. Patients then need to be investigated for the presence of carotid stenosis on the

same day, either by duplex ultrasound, CT or magnetic resonance angiography. Patients with a high risk of stroke on clinical scoring, who are fit for surgery (ASA I or II) and have an internal carotid stenosis >50% using NASCET criteria need to be admitted as an emergency for carotid intervention within the next 48 hours. The intervention needs to be performed in a high volume centre with an experienced team in order to minimise the procedural stroke risk. To achieve this would require intervention on the next available daytime list rather than using inexperienced staff in the middle of the night.

Although challenging, these goals are attainable

This novel approach to stroke prevention therefore needs development co-ordination, involving

stroke physicians, vascular scientists, vascular radiologists and vascular surgeons. Although challenging, these goals are attainable. Peter Rothwell has recently demonstrated in the Oxford EXPRESS study, published in the *Lancet* (2007 Oct 20; 370: 1432-42), that reducing the interval to 1 day from first TIA/minor stroke to assessment and prescription of best medical therapy in a dedicated clinic reduced the risk of subsequent stroke by 80% compared to historical controls. Challenges remain, particularly with regard to weekend cover and the availability of theatre/radiology slots, but the vascular community is nothing if not dedicated and

innovative and will certainly be up to the challenge. Indeed some have already moved a long way down this route. Those worried by any financial implications will be encouraged to hear that if surgery is required, then under payment by results the non-elective tariff is £3,966 compared to only £2,812 for elective surgery. The first step is to start talking with your stroke physician colleagues about how the service could best be set up locally and then to establish appropriate pathways of care to reduce the risk of stroke in line with the National Stroke Strategy.

The ABCD2 Scoring System

Age	Over 60 Years	1 point
Blood pressure	Systolic > 140 mm Hg	1 point
	Diastolic > 90 mm Hg	1 point
Clinical features	Unilateral Weakness	2 points
	Speech impairment with no weakness	1 point
Duration of TIA symptoms	Longer than 59 minutes	2 points
	10 to 59 minutes	1 point
Diabetes	Diabetic patient	1 point

Maximum score on ABCD2 is 7 points. The risk of stroke within 48 hours of a TIA is 1% in low risk patients (score 0-3), 4.1% in moderate risk patients (score 4-5) and 8.1% in high risk patients (score 6-7). See Johnston SC, Rothwell PM, et al., *Lancet* 2007; 369: 283-292.

See also Lamont PM. Urgent carotid surgery. *Br J Surg* 2007; 94: 921-2.

AGM 2007 - Endovascular Highlights

Geoff Gilling-Smith, Royal Liverpool University Hospital

The trend towards minimally invasive endovascular treatment of all forms of vascular disease was underlined by the number and quality of endovascular papers presented at the AGM. In addition to a keynote lecture by Dr Roy Greenberg and a symposium on the complexities of EVAR, chaired by the President, there were two sessions devoted to papers on endovascular topics. These included presentations on aspects of endovascular repair of thoracic, abdominal and thoraco-abdominal aortic aneurysm, papers on the endovascular treatment of superficial venous insufficiency as well as papers on the endovascular management of lower limb and gastrointestinal ischaemia. Truly a feast for the endovascular enthusiast!

It is not possible to comment in depth on all the presentations but two topics deserve discussion if only because they are areas in which endovascular therapy is under-utilised, and yet has the potential to make a significant impact on patient survival.

Three presentations focused on the endovascular management of ruptured and symptomatic AAA. A meta-analysis of papers comparing the outcomes of endovascular and open surgical treatment of ruptured AAA in selected patients (Sadat and colleagues, Cambridge) underlined the potential advantages of the

“intra-operative angiography may be an acceptable alternative to CT to assess the suitability of the infra-renal neck for EVAR.”

endovascular approach: less blood loss, lower mortality, decreased requirement for ITU, shorter hospital stay etc. The Nottingham group (Richards et al) sounded a note of caution, however. In reporting the results of emergency EVAR in 142 patients (51 ruptured and 91 symptomatic), they noted a 30 day mortality of only 29% for ruptured AAA and 24% for symptomatic AAA but drew attention to the number of early deaths attributable to failure of the endovascular repair. They concluded that the results of emergency EVAR could be improved by eliminating procedural errors.

One of the criticisms of the endovascular approach is the need to perform a CT to evaluate anatomical suitability for EVAR. This delays transfer to the operating theatre and may compromise outcomes in those found not to be suitable. Badger and colleagues (Belfast) compared the findings on pre-operative CT with those on intra-operative angiography in patients undergoing both elective and emergency EVAR. Their findings suggest that intra-operative angiography may be an acceptable alternative to CT to assess the suitability of the infra-renal neck for EVAR.

EVAR has the potential to impact significantly on outcome in patients with ruptured AAA but it is clear that further study is required in this area. It is not sufficient to report the results in those who are stable enough to undergo CT and anatomically suitable for

EVAR. We need to know if an endovascular programme is logistically feasible and perhaps more importantly whether it alters overall mortality from ruptured AAA.

Another area in which endovascular therapy has the potential to make an important contribution is in the management of aortic transection following blunt trauma. Speaking on behalf of the Barts and London Hospitals, Brent reported the results of TEVAR in 15 patients with contained rupture of the thoracic aorta: no deaths, paraplegia or stroke. Others have reported similar results. How can we continue to justify transferring multiply injured patients to cardiothoracic units

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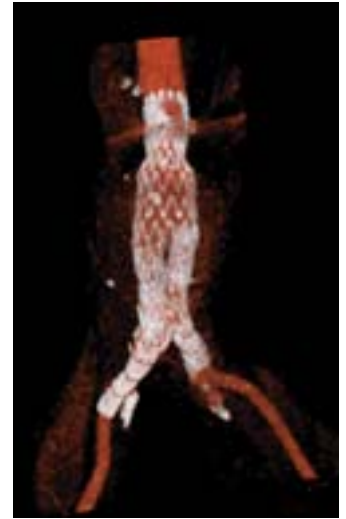



Image of a reconstruction and a cross sectional CT of stentgraft in place at 48 hours, with associated retroperitoneal haematoma in obese male treated at the Royal Liverpool University Hospital.



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where the results of open surgery are inevitably worse and where there are often inadequate facilities for treatment of abdominal, pelvic and orthopaedic injuries? Members of the Society are encouraged to ensure that their general surgical, orthopaedic and accident and emergency colleagues are made aware of the endovascular option for these patients.

The highlight of the meeting was perhaps the extra-ordinary lecture by Roy Greenberg of the Cleveland Clinic on endovascular treatment of the aorta from the aortic valve to the bifurcation. Speaking quietly with both humour and humility, Roy gave an authoritative insight into what can, and is being achieved. Yesterday's dreams are now a reality, today's dreams are being realised.

EVAR Questionnaire

A questionnaire is enclosed seeking a response on resource use in EVAR or open surgery for AAA. We would be grateful if Members could please complete and return to the Academic Vascular Unit at the Northern General Hospital, Sheffield, in the enclosed envelope.

Major deficits in training – survey from the Rouleaux Club

The Rouleaux Club represents the views of trainees in vascular surgery in Great Britain and Ireland. Membership is free, details can be found at www.rouleauxclub.com.

The results of our annual survey were reported at the VSGBI. A summary of the main findings follows:

There will be 10 CCT expiries in 2008, 7 in 2009 and 16 in 2010. Training posts are split equally between general surgery and specialist vascular, with 63% covering emergency general surgery and only 23% pure vascular. The majority are working night shifts (69%) in order to comply with EWTD. A total of 85% of trainees work in units with formally organised vascular emergency cover. With respect to consultant practice, 61% intend to be pure vascular and 37% general surgeons; 73% thought that the part 3 FRCS should be a specialist vascular exam.

Although most trainees are getting some interventional radiological experience, it is limited to less than one session per week for 77%, with 5% engaged in a dedicated fellowship. Some 51% wanted shared training for vascular surgeons and radiologists and nobody wanted the two specialties to remain separate. Some 70% thought vascular and general surgery should separate, 47% thought centralization of vascular units was inevitable but 48% thought vascular services should be provided across networks.

Only 32% of trainees have had experience of EVAR graft deployment, although an additional 36% are involved in access via the femoral artery. Of some concern is the high percentage of trainees who, in the last year, have done fewer than one case per month of; abdominal aortic aneurysm (78%), carotid endarterectomy (70%), peripheral bypass (73%), AV fistula (70%), lower limb amputation (61%). Those with lower numbers were generally in the first 4 years of training, but not exclusively.

In conclusion, this survey has shown that there are major deficits in training for the majority of current vascular surgery trainees in both endovascular and index open vascular surgery procedures. These deficiencies are certain to be further compounded by shift patterns of work. It is vital that the delivery of training to vascular trainees is urgently addressed, with targeted training and better use of current training opportunities and resources, to enable standards of consultant practice to be maintained.

Leith Williams, Affiliate Representative, Vascular Society Council



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The Circulation Foundation



Fundraising with per una:

The Circulation Foundation is being supported by per una, a part of Marks and Spencer. On the 9th January, a casual collection of fitness wear was launched, in aid of the Foundation. **The CF receives 20% from all sales of this collection, which will help to raise valuable funds and, also, raise awareness of vascular disease.** The collection is the idea of George Davies, per una's designer:



“The Circulation Foundation cares about our blood vessels and is very close to my heart. 10 years ago, my mother suffered from bad circulation problems that lead to her leg being amputated. From this sad experience, I came in contact with Professor Sir Peter Bell who really inspired me to support the Foundation. I feel very passionately about the cause and I think it's important that we all know about this organisation and hopefully support them. Not only do they care for people who are suffering from this condition but they also fund research in how we can begin to conquer the disease.”

The range is now available in stores and online at www.marksandspencer.com and there will be further fundraising initiatives with per una announced later in the year.

Circulation Foundation Grants Programme:

The 2008 Circulation Foundation grants programme will be launched soon.

There are 4 grants available:

- The Circulation Foundation Research Fellowship worth £15,000;
- The Mary Davies Research Fellowship worth £25,000
- Two travel grants to learn endovascular techniques, each worth £5000.

Further details of the grants will appear on the Foundation's website in the next few weeks.

If you have any questions about the work of the Foundation or any ideas for future events or fundraising initiatives, please contact Terrie McCann on terrie@vascularsociety.org.uk or telephone: 020 7304 4779.

www.circulationfoundation.org.uk



Recipients of 2007 awards (clockwise from top):
 Professor Annie Anderson
 Mr Paul Flora
 Mr T K Ho
 Mr Matthew Bown





Annual Scientific Meeting

MANCHESTER CENTRAL CONVENTION COMPLEX
28-30 November 2007



PUBLICATION OF ABSTRACTS

The abstracts from the AGM in Manchester are again to be published via the British Journal of Surgery. Twelve abstracts which were presented in the BJS Prize and Sol Cohen (Founders) Prize sessions will be published in full at the back of the February issue of the BJS. The remaining abstracts will be published on the BJS website.



To access the abstracts, click on the link (vascular society abstracts on BJS) at the bottom of the Vascular Society's home page (www.vascularsociety.org.uk).

At the bottom of the blue box on the left of the screen, click on "view full text of this article >PDF (255k). Just below 'Save Article to My Profile' you will see a line starting 'Abstract Full Text: PDF (255k)'.



Click on PDF and you will get to the site.

The abstracts are fully citeable and can be used as a reference, either in the conventional way using the supplement number applied to the web page and available on the first page of the BJS link from our web site (for this issue it will be Supplement 1) as Br J Surg 2008; 95 (S1): page number or, alternatively, using the DOI (digital object identifier) reference, which is also given on the website.

ANNUAL BUSINESS MEETING

The minutes of the Annual Business Meeting, held on 29 November 2007, are enclosed.

MAJOR SPONSORS

I would like to express the thanks of the Society to our Major Sponsors for their continuing support.

THE YEARBOOK

The Society's Yearbook was distributed to all delegates who attended the AGM and also sent to those unable to attend. If Members require a further copy, please contact the Society's Secretariat. Many thanks to our publisher, Nikki Bramhill of tfm Publishing Ltd, for all of her help with the Yearbook.

Photography

Simon Parvin very kindly took photographs of delegates at the meeting and the Annual Dinner. These can be viewed at



www.vascularsociety.org.uk/Annualmeeting/photos

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Annual Scientific Meeting
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28-30 November 2007



PRIZE WINNERS

Congratulations to the winners of the following prizes at the AGM:

DVD Prize

sponsored by Cook Medical Ltd

Best Video

R Bulbulia, M Whyman, L Emerson, L Visser,
F Slim, K Poskitt,
Cheltenham General Hospital

Laparoscopic Aortic Aneurysm Repair

Best Educational/Training Video

J Tsui, R De Souza, G Hamilton,
Royal Free Hospital, London

Carotid Endarterectomy: Retro-Jugular
Approach and Eversion Technique

Poster Prize

G Atturu, S Brouillette, M Bown, NJ Samani,
NJM London, R Sayers,
University Of Leicester

Leucocyte Telomere Length is Reduced in
Patients with Abdominal Aortic Aneurysm

SARS Prize

T K Ho¹ (S Zu², P Leoni², N Aden², C Disalvo³,
R Walesby³, CM Black², DM Abraham², G
Hamilton¹, DM Baker¹, Department Of
Surgery¹ And Department Of Rheumatology²,
The Royal Free And University College
Medical School, The Royal Free Hospital,
London, And Department Of Cardiothoracic
Surgery³, The Heart Hospital, London)

Increased Sdf-1 Alpha and Cxcr4 But Not
Sdf-1 Beta Expression in Human Critical
Limb Ischaemia



Prize winners AGM 2007

Venous Forum Prize

R Winterborn, C Foy, JJ Earnshaw,
Gloucestershire Royal Hospital

No Advantage in Performing Flush Saphenofemoral Ligation:
Results of a Randomised Trial

Richard Wood Memorial Prize

P Bourke, C D Bicknell, S Maxwell, J Mayet, J Wolfe, RGJ Gibbs,
NJW Cheshire, M P Jenkins,
Regional Vascular Unit, St Mary's Hospital, London

The Proposed 18 Week Target - Is There Time For Investigations?

BJS Prize

A Thompson, J A Cooper, S Druce, H Ashton, H Hafez,
S E Humphries

Cardiovascular Genetics Departments, University College London,
And The Vascular Department, Royal West Sussex NHS Trust,
Chichester

TGF3 And LTBP4 are Associated with Altered AAA Growth: A
Candidate Gene Study

Sol Cohen (Founder's) Prize

R A Weerakkody, S R Walsh, A Noorani, T Tang, U Sadat,
ME Gaunt,
Cambridge Vascular Unit

An Evaluation of Radiation Exposure in Endovascular Abdominal
Aortic Aneurysm Repairs

Future Events

CAROTID MEETING, DUBLIN: 7 MARCH 2008

A one day meeting focusing on Intervention for Carotid Artery Disease will be held at the Royal College of Surgeons of Ireland, Dublin from 10am-4pm on Friday 7th March. The programme for this meeting has been e-mailed to all Members; it can also be downloaded from the Society's website - www.vascularsociety.org.uk

ASGBI AGM 2008: 14-16 MAY 2008

The ASGBI AGM is also being held in Bournemouth this year. Whilst the Society has previously hosted a dedicated vascular symposium at this meeting, the focus this year is to concentrate on more generic issues to meet broader educational needs. The main 'VSGBI Symposium' on Friday 16 May is entitled Bleeding and Clotting and some excellent speakers will cover DVT, PE, surgery on anticoagulated patients, surgical and radiological control of haemorrhage, and monitoring and treatment of coagulopathy.

The Society is also contributing to a medico-legal symposium on the same day.

Further details are available on the ASGBI website – www.asgbi.org.uk

SVS

The Society for Vascular Surgery would like to invite the members of the Vascular Society of Great Britain to become members of the Society for Vascular Surgery. The Society for Vascular Surgery seeks to advance excellence and innovation in vascular health through education, advocacy, research, and public awareness. Membership consists of 2,400 professionals actively participating in the treatment of vascular disease.

For more information about membership with the Society for Vascular Surgery email membership@vascularsociety.org, or to download a membership form visit http://www.vascularweb.org/_CONTRIBUTION_PAGES/SVS_Membership/Categories_Membership/international_membership.html

OTHER EVENTS THIS YEAR:

5th March 2008

Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) Theoretical Training for Clinicians

The Radiological Protection Centre, London

Contact: Kathryn.StJohn-Mosse@stgeorges.nhs.uk for further details

T: 020 8725 1050 F: 020 8417 1338

April 9th - 10th 2008

Vascular Ultrasound Course

The Thistle Birmingham City Hotel, UK.

This is an intensive 2-day course/workshop on the application of duplex, pulsed wave, colour and power Doppler techniques in the investigation of the abdominal, extra and intra-cranial and peripheral vasculature. The course is a combination of lectures, demonstrations and workshop sessions with normal volunteers, and is designed to cover both the basic principles of these techniques and a review of the current state of ultrasound arteriography and venography. For programme and registration forms contact: The Secretariat, secretariat@med-ultrasound.org; fax: 01384 350132.

2nd May 2008

Thoracic Aortic Masterclass 2008

Guy's Hospital, London

Organisers: John Reidy and Peter Taylor
Contact Information: Janet Williamson
Phone 020 7403 3893

E-mail: taylorvasc@aol.com

20-21 June 2008

Endovascular Forum

Holiday Inn, Stratford upon Avon

Further details from office@vascularsociety.org.uk

9-11 July 2008

The March Course - An Introduction to Endovascular Procedures and Techniques

Coombe Abbey, Coventry

A three day workshop for senior trainees in vascular surgery and trainees in radiology who are interested in interventional techniques

Contact Mr. Gilling-Smith: gigs@btinternet.com

VSGBI Membership

The AGM approved an increase in subscriptions from 1 January 2008.

The Ordinary Member rate has increased to £175 pa, and the Affiliate, Associate and Overseas rate £100 pa. Members joining the Society during the year will pay an initial subscription pro rata by cheque, and will be requested to set up a direct debit mandate from the following January.

Any Members currently not paying by Direct Debit should complete a mandate as soon as possible to ensure there is no interruption to your subscription. Forms are available from the Secretariat.

A number of members have allowed their membership to lapse, and their details have now been removed from the Society's database.

Welcome to the following new members of the society

Ordinary

Mr Salem Al-Hamali, Kettering General Hospital

Mr Arindam Chaudhuri, Wirral University Teaching Hospitals

Ms Bridget Egan, The Adelaide and Meath Hospital, Dublin

Mr Gary Hicken, Chesterfield Royal Hospital

Dr David Kessel, St James's University Hospital, Leeds

Mr Ciaran McDonnell, Mater Misericordiae University Hospital, Dublin

Mr Kevin Mercer, Bradford Royal Infirmary

Mr Ferdinand Serracino-Inglott, Manchester Royal Infirmary

Mr Jawaharlal Senaratne, Kent and Canterbury Hospital

Dr David West, University Hospital, North Staffordshire

Mr Christopher Wood, James Cook University Hospital

Affiliate

Mr Kumar Abayasekara, Norfolk and Norwich University Hospital

Miss Nung Rudarakanchana, The Royal Free Hospital, London

Associate

Mr Orwa Falah, Hairmyres Hospital, Glasgow

COUNCIL APPOINTMENTS

The following were elected to the Council from November 2007-2010:

- Mr Daryll Baker
- Mr Richard Holdsworth
- Professor Gerard Stansby



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