

## President's Message

Peter Lamont



**Times are busy for the Vascular Society, with many initiatives coming together as we move steadily towards separate specialty status. Our second stage application is currently with the Department of Health, who have sent it out for consultation.**

The majority of the second stage process is an examination of the proposed curriculum, to ensure that it is both deliverable and that it meets the standards of the regulator, who is the GMC. The timeframe quoted to us is that, if the consultation process raises no serious problems, then the DH will ask the Secretary of State to sign off the application hopefully by May.

A statute is then prepared which goes to Parliament for approval before being entered on the statute books, at which stage the specialty is formally recognised. Things don't end there though, as the GMC will then require us to resubmit the curriculum for formal regulator approval and Deaneries will also need to submit training programmes to GMC for approval. The Training Committee, under Jonathan Beard's chairmanship, have been working hard on this and are currently revising the Society's previous guidance on standards for training which we hope will inform the Deaneries as they develop specific vascular training programmes. In the meantime, we have also been in discussion with Medical Specialty Training (England) over a potential national selection process for entry into training at ST3, with the SAC in General Surgery and the JCST over potential training numbers, with the Intercollegiate Exam Board over the development of a vascular specialty exit exam and with the College Presidents over the initiation of a vascular SAC. All these initiatives are at various stages of progress but hopefully a comprehensive package will be in place to report to you at the AGM in Edinburgh on the 24th November.

Many of you will be aware of vascular service commissioning reviews taking place in many SHAs around the country. Various members of Council have been involved in giving advice on service reconfiguration and a number of issues have arisen as a result. Council debated the implications recently and came to the unanimous view that the published advice from the Society in its Provision of Services document needed early revision. There are a number of drivers for this: the NHS AAA screening programme has raised the profile of vascular surgery amongst public health physicians and SHA medical directors but has also brought home to them that larger volume hospitals achieve better patient outcomes.

*continued on page 2*

### CONTENTS

Vascular Society and Royal College of Radiologists joint statement	3	AGM Brighton 2010 Prizewinners	8
The Importance of Vascular MDT	3	Future Meetings	9
A Year in the life of a President	4	Circulation Foundation	10
Quality Improvement and the NVD	5	The IMPROVE Trial	12
Vascular Society/Cook Endovascular Fellowships 2011	6	EVAR - Producing an Optimal Service	12
Vascular Disease Awareness Week	7	Editorial Assistant Bursary	13
		Coress Vascular Cases	13
		New Members	15

## The Circulation Foundation

I think anyone visiting the AGM or reading the Newsletters this year will have noticed the vastly increased profile of the Circulation Foundation. Last year alone it gave over £160,000 in grants supporting research into vascular disease and also supported the first President's Early Career award to Mr Matt Bown, a consultant/senior lecturer from Leicester.

All this has largely come about due to the enthusiasm of Andrew May who has been Chairman for the past 2 years. He has kept the charity going through a difficult time and has organised a number of charity events, including the famous dinners and auctions, raising funds and widening support. The Vascular Society is very grateful to Andrew for all his hard work for the Circulation Foundation.

We are delighted to inform you that your Council has elected Mr Ian Franklin as the new Chair of the Circulation Foundation. Ian has supported the Foundation for a number of years with fundraising initiatives, and has served on the CF Committee for the past year. With Ian's leadership it is hoped that the CF will develop into a much larger charity and provide even more money for essential vascular research.



## President's Message continued from page 1

A new specialty would alter our inter-relationship with general surgery, particularly with regard to emergency middle grade cover, and the EWTR and New Deal requirements mean that if vascular emergencies were also concentrated on larger volume hospitals then it would allow for sustainable on call rotas (for both consultants and trainees) and a sufficient volume of cases to allow the best possible training opportunities. Some of our members in smaller volume hospitals (although by no means all) have advised that they feel vulnerable and unsupported when on call and would prefer to undertake emergency duties on less onerous rotas in a larger volume unit where 24/7 vascular interventional radiology cover should also be a requirement. A major flaw in emergency clinical networks utilising separate sites can be that vascular patients do not have on site cover at the weekend if their hospital is not on call. Care must be taken though, not to remove vascular consultation, out-patient and non-invasive diagnostic services from adjacent hospitals in a network as these provide an essential portal of local access. Patient outcomes are

worse when such local access is not available because patients are not then referred for intervention. Council has suggested that existing clinical networks should start to consider moving all major elective and emergency vascular interventions onto one site in the network, whilst maintaining a local presence in each unit and an equal partnership amongst the consultants involved. Different solutions will need to be found, according to local circumstances. Clearly the need for such major upheavals needs to be widely discussed and debated amongst the membership of the Society. Mike Wyatt, our new Honorary Secretary, has been tasked with revising the Provision of Vascular Services document and would be very grateful to hear your views. We clearly will also need a major debate on this issue at the AGM in November.

Some members have expressed concern about rumours that interventional radiology is no longer interested in collaboration over training, following a presentation at the Brighton meeting last year. In fact, nothing could be further from the truth and the Royal College of Radiology has been supporting our specialty bid, as we supported their successful IR sub-specialty application. A joint statement has been issued by myself and Tony Nicholson, Vice-President and Dean of the Faculty of Clinical Radiology at the RCR, which is printed opposite.

To finish with good news, out of a very strong field of 20 applicants, the Society has appointed 3 Cook Endovascular Fellowships. As more and more members undertake endovascular interventions and start to train in them, hopefully the need for these Fellowships will decline but at the moment they clearly fulfil an unmet need. Welcome also to Ian Franklin as the new Chairman of the Circulation Foundation Committee, where he hopefully will build on the current success of the charity and increase the amount of money available to support vascular research, an aim for which he has very clear views on how to achieve. Shervanthi Homer-Vanniasinkam, who chairs our Research Committee, has already identified CF funds to support a one year Surgeon Scientist Award of £55,000 for a vascular surgical trainee and also to repeat last year's President's Early Career Award. David Mitchell and the Audit and QI Committee have been working tirelessly and with great enthusiasm to drive forward the AAA Quality Improvement Framework around the country and hopefully will be rewarded by seeing a reduction in AAA mortality as a result. The QIF is scheduled for review this year and Council has already agreed in the light of published data on volume/outcome relationships to increase the recommendation on the minimum number of elective AAA per unit to over 30 per year or around 100 every 3 years.

**INNOVATION, EDUCATION  
AND RESEARCH**

**MAQUET**

CARDIOVASCULAR



**Innovation** - new addition to the graft range for complex hybrid cases  
**Education** - ten bursaries for RCS Surgical Skills Courses in 2011  
**Research** - 'Small Vessel Registry' launched

**MAQUET - The Gold Standard**

MAQUET LIMITED  
 14 - 15 Burford Way, Boldon Business Park, Sunderland,  
 Tyne and Wear NE35 9PZ  
 tel: 0191 519 6200 · fax: 0191 519 6201  
 email: info@maquet.co.uk · www.maquet.co.uk

MEMBER OF THE  
GETINGE GROUP

## Vascular Society and Royal College of Radiologists joint statement

“Members will be aware that the VS have been engaged in talks regarding joint training in vascular surgery and interventional radiology for many years with the Royal College of Radiologists. These talks started in 2003 and repeatedly stumbled on the simple issue that a large part of IR does not involve vascular disease and that VS could not offer clinical training in those non-vascular surgical areas. Agreement was eventually reached in 2008 by those who wanted to make joint training a reality. It was based on the needs of the patient not on the needs of the organisations involved nor of any pressure group. For pragmatic reasons, the establishment of a new joint specialty was ruled out, particularly as the creation of such a specialty would have run foul of European Union rules on new specialties and would also have created difficulties in running one specialty through two different Colleges. What did become clear though, was that IR and VS wanted very

much to collaborate in two mutually beneficial areas. VS could offer IR trainees the opportunity to learn patient management skills in their clinics and on their wards, consistent with the desire of IR to offer service delivery rather than service support. IR could offer VS trainees the opportunity to learn endovascular skills to equip them to offer a modern vascular service. As a result, the RCR offered to support the VS separate specialty bid and VS offered to support the RCR sub-specialty bid on the basis that subsequent training would become mutually beneficial in the way out-lined above. The VS and RCR remain committed to this agreement and will re-establish talks on mechanisms to bring it about once the new vascular specialty is approved. We hope that this joint statement will reassure members that talks between the two specialties on joint training initiatives have not broken down but have simply taken a pause while specialty status is resolved.”

**Peter Lamont**  
President, The Vascular Society

**Tony Nicholson**  
Dean & Vice-President, The Royal College of Radiologists


## The importance of Vascular MDT

Multidisciplinary team meetings (MDT) are well established in the management of patients with cancer. We have written a paper for the bulletin of the Annals of the Royal College of Surgeons which emphasises the importance of MDT in a modern vascular practice. A full text version is available free on <http://www.rcseng.ac.uk/publications/bulletin>.

In the face of increasing vascular technology and shared working with radiology, MDT has become the cornerstone of vascular practice. In particular, for abdominal aortic aneurysm, where the options between open and endovascular surgery are complicated, shared decision-making is vital. MDT could even include anaesthetic input. Carotid endarterectomy may also be best managed through an MDT, although this may need to be more frequent than weekly, because of the 48h target for intervention. Peripheral arterial disease, diabetic foot disease and any complex or unusual condition that requires intervention merit discussion among colleagues. The vascular MDT should be formalised into a process that is supported by employers and recognised into direct clinical care via job plans.

Jonathan J Earnshaw, Jonathan D Beard

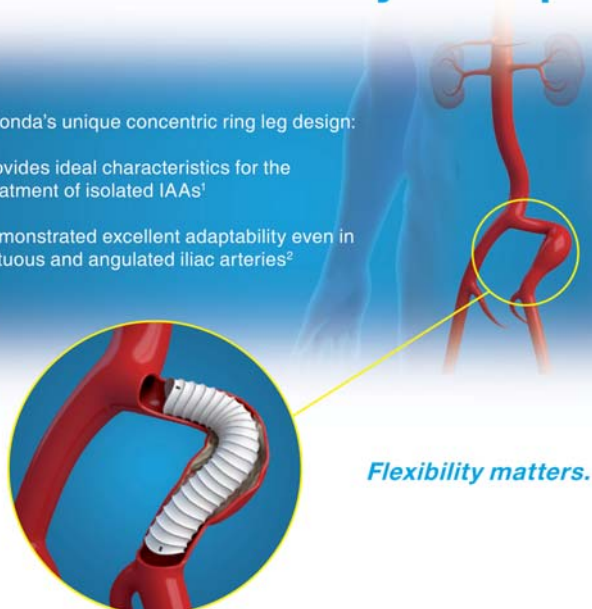
**NEW indication\***



AAA Stent Graft System

Anaconda™ legs are now indicated for

### Isolated Iliac Aneurysm Repair\*




Anaconda's unique concentric ring leg design:

- Provides ideal characteristics for the treatment of isolated IAAs<sup>1</sup>
- Demonstrated excellent adaptability even in tortuous and angulated iliac arteries<sup>2</sup>

*Flexibility matters.*

References:  
<sup>1</sup> Alvarado, J. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms  
<sup>2</sup> Puri, S. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms  
<sup>3</sup> Alvarado, J. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms  
<sup>4</sup> Alvarado, J. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms  
<sup>5</sup> Alvarado, J. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms  
<sup>6</sup> Alvarado, J. Endovascular (EV) for the Treatment of Isolated Iliac Aneurysms



VASCUTEK, a TERUMO Company  
 Newmans Avenue, Incheon  
 Renfrewshire PA4 5RR  
 Scotland, UK  
 Tel: (+44) 141 812 5555  
 Fax: (+44) 141 812 7170  
 www.vascutek.com

**\*All products and indication are subject to local regulatory approval.**

**"CAUTION - Investigational device.  
 Limited by Federal (or United States) law to investigational use."**

# A year in the life of a President

## Cliff Shearman

I was asked by our Honorary Secretary, Mike Wyatt, to write a short article on what I felt I had achieved during my year as President of the Vascular Society. This actually proved more difficult than I had thought. It was a very busy year and I seemed to be involved with a number of issues. However, the nature of the President's role is to promote and progress matters relating to vascular surgery, many of which have been launched by Presidents and Councils past. In that respect it is really hard to think of anything which is entirely unique to me! Having said that, I think the real strength of the Vascular Society Council is its ability to function as a team with a long term plan to develop vascular surgery.

I hope my main achievement was to use the opportunities that came up to promote the cause of vascular surgery. The need to separate from general surgery to allow our trainees time to develop the skills they will need to become vascular and endovascular surgeons has been brewing for a long time. It was really good to get through the First Stage of the Department of Health process based on the work of Mike Gough and Peter Taylor for recognition of a new specialty, despite being sidelined for a while by the general election! For me it was a pleasure to at last see the curriculum that was started by Julian Scott, worked on by me and the Training Committee, and now being finalised by Jonathan Beard and his team, being used to determine the shape of our new specialty.

However, perhaps the biggest opportunity came with the concerns of

outcomes of aortic surgery from the Vascunet data. At first this appeared a very dismal story for British vascular surgery, but in fact it has been the biggest catalyst for change I have ever seen and has brought vascular surgery into the forefront of the political and public arena. This is an opportunity not to be missed if we are to set vascular surgery on a pathway fit for the next decade.

The need for good data and the National Vascular Database was painfully realised when we featured in the Guardian, but equally this proved an opportunity to bring the challenges of providing vascular services into the popular media with follow-up stories in the press and on the BBC. These all helped raise interest not only amongst the public but also in the Department of Health. Perhaps not co-incidentally, this year NICE has commissioned a number of Health Technology appraisals and Clinical Guidelines in areas of treatment of vascular disease which are now close to publication. This again is not only likely to improve the quality of vascular care, but will raise its profile in a wide range of professional and patient groups.

**Perhaps the biggest opportunity came with the concerns of outcomes of aortic surgery from the Vascunet data**

The Strategic Health Authority reviews that have been launched, largely to ensure high quality outcomes for patients, together with the need for cost effective vascular units, have been painful for some units, but is necessary if we are really going to have a specialty fit for the future. We cannot continue with over a 110 vascular provider units. It is also essential that we plan units that will cope with the changing roles of consultants in delivering services with fewer trainees. This means units with greater numbers of consultants working together in a team. In the current financial climate we are not going to see large numbers of new jobs created and the way forward must be to form bigger units and consolidate the current consultants together.

Last year the Vascular Society worked with the NHS Employer's Confederation and a number of other specialties to address many of the issues of delivering service in the future. At the national launch of this project I was really proud to see that vascular surgery was easily the most advanced specialty in addressing the future in a realistic manner and I hope this will continue. Many of these ideas were presented in the opening session of the Annual Scientific Meeting and introduced by Sir Bruce Keogh. He made it very clear that we, as a Society, have a fantastic opportunity to lead vascular surgery into the future, but, equally, if we ignore the difficult issues, we will fail.

The Vascular Society has had several attempts to promote research in the area of vascular disease, but has never really got it off the ground. Last year the newly formed Research Committee got off to a lightening start, largely due to the skills and enthusiasm of the Chair, Shervanthi Homer-Vanniasinkam. Supported by the Circulation Foundation, a number of awards including the President's Early Career Award were made and look set to continue.

I guess if there is one thing I am particularly involved with and keen to promote it is the role of vascular surgeons in reducing amputation in people with diabetes. The Vascular Society has lobbied in the Houses of Parliament, had two Spring meetings (and a third due on the 10th March) dedicated to reducing amputations, and has contributed to National Guidelines (Putting Feet First and NICE) aimed at improving care for patients with diabetes. It is not unrealistic to aspire to see a 50% reduction in amputation and if, as a Society, we could contribute to that it would be a fantastic achievement.

I really enjoyed my year as President and met and learnt much from many of you during that time. I miss working with the Council and Executive team at the Vascular Society, but I am confident that it will meet the challenges posed to us by Sir Bruce Keogh. The future of vascular surgery has never looked better.



# Quality improvement and the NVD

*David Mitchell, Chair, Audit and Quality Improvement Committee*

## AAA QIP

The AAA QIP continues to gather momentum. The team in the North East of England has developed a care pathway for patients needing abdominal aortic aneurysm surgery. This pathway contains surgical, radiological, and anaesthetic components, and the standards contained within the quality improvement framework. It needs development of nursing and PAM documentation to make it complete. This work is being taken forward with the help of the SVN who are planning to review and refine it before approving it for use.

Preparing documentation is only a small part of the quality improvement process and the central team is working to run more regional action/implementation days this year. We ran our first one in January in the East of England. There was representation from patients, surgeons, radiologists, anaesthetists, nurses, cardiac and stroke networks and the SHA. Animated discussions of the key components of the pathway led to an agreement to adopt it throughout the East SHA. In addition, each Trust gave a commitment to test an aspect of the care pathway. We will be meeting with them to find out what has been learnt in May. We will feedback in future letters and through our website [www.aaaqip.com](http://www.aaaqip.com). We are grateful to Kevin Varty for all his work in organising the day and making it a success.

Future planned events include Yorkshire and the Humber on 11th February in Doncaster, the South West, South Central and Wales on 17th March in Cardiff, and East Midlands on 4th April in Northampton. We are looking to host one in Belfast in late May and hope to do the same in other regions. If you would like to help set up and run a regional day in your region please contact the team in Bristol using the contact details on our website.

## Upcoming reports


The QIP team will be producing an interim report in the spring describing the progress of the programme and to spread the learning that has resulted. This report will be one of two appearing in the spring, the other being the round 3 report from the Carotid Intervention Audit.

Both reports will publish data contributions from NHS Trusts by name and will be circulated widely to clinicians, NHS trusts and commissioners. I am pleased to inform you that the Society Members have yet again increased contribution rates to round 3 of the carotid audit. The time from symptoms to treatment continues to fall, but we have yet to achieve the published NICE standard.

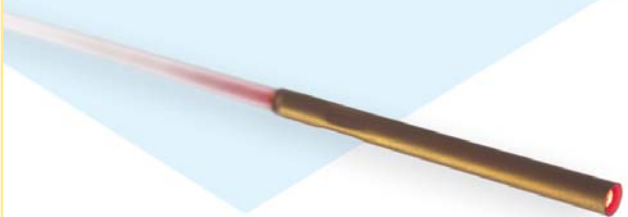
Whilst it is not possible to modify the data in the carotid audit, the data for the AAA QIP report is not yet finalised for analysis. Vascular units will have received the fourth quarterly (plus annual summary) report of NVD data contributions for AAA surgery compared to their Trust's HES data. We would encourage you to study the reports carefully as there is an opportunity to update contributions for AAA, for the period 1/10/09 to 30/09/10, before the final analysis is made and reported. **We will be locking the data for reporting purposes on Friday 11th March 2011 (i.e. any changes after that date will not be included in the report).**

Please use this opportunity to validate your contribution (and your Trust's HES data if you feel the numbers are inaccurate). If you find inaccuracies, please contact us for discussion and corrections as required. There is likely to be significant public interest in our data quality, so it is important that we present the best data that we can. We are happy to provide advice to units, but we

continued on page 6



**NeverTouch® Gold-Tip Fiber**  
The Gold Standard in Endovenous Laser Treatment



**The NeverTouch Gold-Tip Fiber for Less Pain and Bruising**

The NeverTouch® gold-tip laser fiber establishes a new standard for patient comfort, visibility and ease of use. The gold-tip fiber eliminates laser tip contact with the vein wall, which in turn minimises perforations of the vein wall that typically result in pain and bruising as compared to traditional bare-tip fibers. The gold-tip also maximises ultrasonic visibility, making it easier for physicians to use.

For more information about the science behind NeverTouch laser fibers visit [www.VenaCure-EVLT.co.uk](http://www.VenaCure-EVLT.co.uk), call +44 1223 729300 or email [enquiries@angiodynamics.com](mailto:enquiries@angiodynamics.com).

**ANGIODYNAMICS®**

## Quality Improvement *continued*

cannot undertake validation of data that is generated locally within NHS trusts.

### Review of the NVD dataset

There have been a lot of changes to the dataset, particularly the aneurysm data, with the advent of the NHS AAA screening programme and our agreements to host datasets for the BSIR and Vascular Anaesthetists. As announced at the AGM last November, your Council has agreed that no further changes will be made to the NVD until the datasets are formally reviewed. This process commenced recently with an email shot to Members asking for suggestions for changes. We propose a 3 month consultation period followed by a review and publication of the findings. A final proposal will go before Council for approval in September. The revisions will form part of a tendering process for a new contract to run the NVD in its new form, for several years.

The AKI audit will continue to run this year until the autumn. Please

continue to contribute cases. We are particularly keen to recruit high risk patients undergoing both open and endovascular repair.

### Funding of the NVD

As you will be aware, the Carotid Intervention Audit is funded by HQIP, providing us with staff and statistical input to allow us to produce reports on carotid interventions nationally. We are hoping to secure longer term funding when our current contract ends in 2012. We will be making representation to try and extend the funding scope for the NVD and to allow us to produce more feedback to Members about their practice. We will also use any funding to report national outcomes for our major index cases.

### Future plans

We plan to analyse mortality rates for AAA once the spring report is published. These will be reported back to vascular teams in each unit, with anonymised comparison data made available. Council has commenced a dialogue with the Society about how we move to open

data publication as part of our QI programmes in the future. It is important for us as a Society to place this data in the public domain to demonstrate that we are providing high quality care to our patients with a focus on patient safety. There are now national guidelines about acceptable mortality ranges for participation in the NHS AAA screening programme and for carotid surgery. Coupled with the national QIPs for AAA and amputation, we have many standards against which to measure our service.

### QI awards

Finally I am delighted to announce that the Society has approved an inaugural QI award. Those with projects are invited to submit them using the abstract process, to the AGM. Papers and posters will be selected in the usual way for inclusion in the meeting and then judged for quality. The award(s) will be made at the annual dinner and participating teams will be encouraged to attend. Further details will be available to Members later in the year.

## Vascular Society/Cook Endovascular Fellowships 2011

The interviews for the 2011 Vascular Society/Cook Endovascular Fellowships were held in London at the beginning of February. There were 20 applicants for the three six-month Fellowships and, from a very strong field, seven high-calibre candidates were shortlisted for interview. Most of the applicants were in their penultimate or last year of training and generally had an adequate experience of open vascular surgery. Most of them also had experience of basic duplex ultrasound, workstation planning and arterial and venous puncture/wire/catheter skills. They had also had some involvement with peripheral arterial angioplasty and stenting, as well as endovascular aneurysm repair, but required more 'first operator' experience of these techniques. A few applicants already had extensive experience of straightforward endovascular interventions and wanted further experience of complex interventions, such as embolisation and branched/fenestrated stents.

We were also fortunate in being able to collaborate with our Irish colleagues in re-appointing an existing Cook

Endovascular Fellowship in Dublin. I am pleased to report that the following four candidates were appointed: **Nick Matharu, Duncan Drury, Manj Gohel and Stephen Badger (Dublin).**

Congratulations to the successful candidates and commiserations to those who were unsuccessful, despite having strong CVs and interviewing well.

The three BSET Endovascular Fellowships were appointed the week before the VS/Cook Fellowships. Several of the successful applicants were disappointed that their first choice of Training Unit had already been taken. I hope that this problem can be resolved next year by creating a joint BSET/Vascular Society Appointments Committee. These Fellowships have proved to be extremely successful. They are clearly meeting an unmet training need and we are grateful to Cook for their continued support.

**Jonathan D Beard ChM MEd FRCS**

Chair, Education & Training Committee

## Vascular Disease Awareness Week: 7 - 13th March 2011

The Circulation Foundation is holding its second Vascular Disease Awareness Week from 7th-13th March focusing on lower limb vascular disease entitled "**Are your legs killing you?**" The Foundation will be relaunching its patient information handbook which will provide disease specific information alongside easy to follow exercise and diet advice to help guard against vascular disease. This handbook will be distributed to all vascular units. The Foundation is aiming to raise awareness not only with the public but also with primary healthcare to help diagnosis and improve referral pathways.

Across the UK, events will be held at public venues and health centres to raise

awareness of vascular disease, in particular peripheral arterial disease (PAD). Vascular nurse specialists will be on hand to offer advice and information on vascular disease and to highlight the need for early diagnosis and referral.

We need your help to promote the awareness week and the Circulation Foundation in and around your hospital and department. If you would like more information, please contact [info@circulationfoundation.org.uk](mailto:info@circulationfoundation.org.uk)



## The Vascular Society Spring Meeting: 10th March 2011

As part of the Circulation Foundation Vascular Disease Awareness week, the Society's spring meeting "Best Foot Forward" will be held on Thursday, March 10th at the Kings Fund in London.



The meeting will focus on the increasing burden of lower limb disease and diabetes on the NHS and the importance of a multidisciplinary approach to limb health. There will be a

wide range of topics covered throughout the day and we are honoured to have so many distinguished speakers on the programme.

A parallel session will be held for allied healthcare professionals involved in the care of patients with diabetes and lower limb related complications. This session will run in the morning and delegates are invited to join the main meeting for the afternoon sessions.

**Register for the meeting at <http://vascularsociety.eventhq.co.uk/springmeeting2011>**

## Varicose Vein Referral

*Professor Alun Davies, President, Venous Forum*

The referral for varicose veins is influenced significantly by local guidelines/practice in the UK. The Venous Forum at the Royal Society of Medicine have put together a recommendation document that we hope clinicians and those allocating NHS resource will find helpful. This can be found at: [http://www.rsm.ac.uk/academ/downloads/venous\\_referral\\_guidelines\\_jan11.pdf](http://www.rsm.ac.uk/academ/downloads/venous_referral_guidelines_jan11.pdf) or if you require further information please contact Venous Forum Academic Department, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE Tel: 020 7290 2984 Fax: 020 7290 2989 Email: [venous@rsm.ac.uk](mailto:venous@rsm.ac.uk)



# AGM, Brighton 2010 Prizewinners

Congratulations to the following AGM Prizewinners:

## Venous Forum Prize

**Modelling the effect of venous disease upon quality of life**

**D Carradice**, Academic Vascular Surgical Unit, University Of Hull/Hull York Medical School, Hull

## Brighton Prize for The Best Poster

**Prediction of the impact of AAA screening programme in reducing ruptured aneurysm events after a decade**

**A Jibawi**, Brighton and Sussex University Hospitals, Brighton

### Runners Up:

**Senior vascular trainee experience of assessment and management of patients undergoing endovascular repair of abdominal aortic aneurysm (EVAR). Results of a survey of UK vascular trainees**

**CD Marron**, Vascular Surgical Unit, Belfast City Hospital, Belfast

**Can EVAR be performed safely; abandoning a policy of routine cross-matching of blood products**

**KS Mann**, Frimley Park Hospital NHS Foundation Trust, Frimley

## Richard Wood Memorial Prize

**Modifying the illness and treatment beliefs of patients with intermittent claudication increases daily walking and reduces demand for vascular intervention - Results from a randomised controlled trial**

**M Cunningham**, University Of Stirling

## Sol Cohen (Founder's) Prize

**Flow-sensitised dynamic magnetic resonance imaging (MRI) can identify dominant false lumen flow and secondary entry tiers in type B aortic dissection: implications for endovascular treatment**

**RE Clough**, NIHR Comprehensive Biomedical Research Centre of Guy's And St Thomas' NHS Foundation Trust and King's College London, London



## BJS Prize

**Imaging of the vulnerable carotid plaque: biological targeting of inflammation using Ultrasmall Superparamagnetic Particles of Iron Oxide (USPIO) and MRI**

**J Chan**, Vascular Surgery Unit, St Mary's Hospital, Imperial College Health Care NHS Trust London; Cytokine Biology Of Atherosclerosis, Kennedy Institute Of Rheumatology, Imperial College London; Translational Molecular Imaging Group, Singapore Biomedicine Consortium, Agency for Science, Technology and Research (A\*Star), Singapore

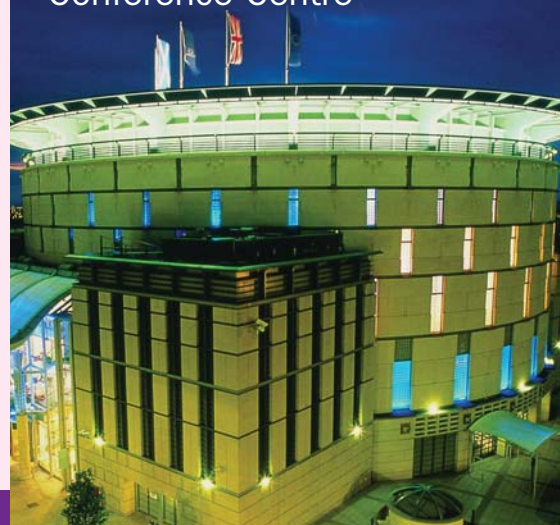


*Rachel Clough being presented with Sol Cohen (Founder's) Prize*

**23-25 November 2011**

## Vascular Society AGM

Edinburgh International Conference Centre



## THE YEARBOOK

The Society's Yearbook was distributed to all delegates who attended the AGM. Copies are available from the Society's Secretariat. Many thanks to our publisher, Nikki Bramhill of tfm Publishing Ltd, for all of her help with the Yearbook.

## MAJOR SPONSORS

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

## Future Meetings

### 17th March 2011

**Title:** AAA QIP South West Regional Action Plan Event

**Venue:** Cardiff

**Contact:** [www.aaaqip.com](http://www.aaaqip.com)

### 24th and 25th March 2011

**Title:** Laparoscopic Abdominal Aortic Surgical Course

**Venue:** Colchester Hospital

**Contact:** 07920 546207

[Naomi.hill@colchesterhospital.nhs.uk](mailto:Naomi.hill@colchesterhospital.nhs.uk)

### 24th and 25th March 2011

**Title:** General and Emergency Ultrasound Course

**Venue:** Suttie Centre, Royal Infirmary, Aberdeen, Scotland.

**Contact:** [secretariat@med-ultrasound.org](mailto:secretariat@med-ultrasound.org) or

[www.wessexscientific.com](http://www.wessexscientific.com)

### 9-12 April 2011

**Title:** 33rd Charing Cross International Symposium: Vascular & Endovascular Consensus Update

**Venue:** Imperial College, London, UK

**Contact:** [www.cxsymposium.com](http://www.cxsymposium.com)

[info@cxsymposium.com](mailto:info@cxsymposium.com)

### 27th/28th April 2011

**Title:** Venous Forum Spring meeting

**Venue:** RSM, London

**Contact:** Louisa Mason on 020 7290 3935 or email

[venous@rsm.ac.uk](mailto:venous@rsm.ac.uk)

### 10th/11th May 2011

**Title:** Vascular Ultrasound Course

**Venue:** Strathallan Hotel, Birmingham, U.K.

**Contact:** [secretariat@med-ultrasound.org](mailto:secretariat@med-ultrasound.org); Fax: 01384 350132

### 13-14 May 2011

**Title:** 15th Symposium in Endovascular Aortic Grafting

**Venue:** The Victoria Gallery and Museum Liverpool

**Contact:** +44 (0) 141 942 8104

[info@criticalissues.uk.com](mailto:info@criticalissues.uk.com)

<http://www.criticalissues.uk.com/>

### 13 May 2011

**Title:** Critical Appraisal of clinical trials and Systematic Review: One-Day Course for Surgeons. In Collaboration with the Cochrane

**Venue:** Collaboration Education Centre, Freeman Hospital, Newcastle

**Contact:** [Julie.winship@nuth.nhs.uk](mailto:Julie.winship@nuth.nhs.uk)

### 9th – 10th June 2011

Liverpool Aortic Symposium IV

New Frontiers – Bi-annual event

**Venue:** Hosted by Liverpool Heart and Chest Hospital Arena and Convention Centre, Liverpool

**Contact:** L.R. Associates – Ms. L. Richardson

Tel: 01296 733823 Fax: 01296 733823

Mobile: 077111 32946

Email: [lorrainerichardson1@btinternet.com](mailto:lorrainerichardson1@btinternet.com)

### 13th and 14th June 2011

**Title:** RCS(Eng) Vascular Course: Specialist skills in vascular surgery

This new, cadaveric skills course is designed to cover the proficiencies that trainees are expected to learn during the

early years of specialist training. By the end of the course you will have seen all the procedures covered in the early and intermediate stages of vascular training. The course is for levels ST 1 - 4.

**Contact:** <http://www.rcseng.ac.uk/education/courses/specialty-skills-in-vascular-surgery>

### 14th June 2011

**Title:** Hull Aortic CT Study Day

**Venue:** Hull Royal Infirmary

**Contact:** [Raghuram.Lakshminarayan@hey.nhs.uk](mailto:Raghuram.Lakshminarayan@hey.nhs.uk) or

[Vivek.Shrivastava@hey.nhs.uk](mailto:Vivek.Shrivastava@hey.nhs.uk)

### 15th and 17th June 2011

**Title:** RCS(Eng) Vascular Course: Advanced skills in vascular surgery

Aimed at senior trainees and consultants, this practical, hands-on course with cadaveric dissection teaches a number of advanced and complex procedures associated with the later stages of training and vascular surgery. The course is for levels ST 5 - 8 and consultants.

**Contact:** <http://www.rcseng.ac.uk/education/courses/advanced-skills-in-vascular-surgery>

### 17th and 19th June 2011

**Title:** 9th bi-annual International Symposium on Sympathetic Surgery

**Venue:** Odense, Denmark.

**Contact:** [www.sympatektomi.dk](http://www.sympatektomi.dk)

*The next generation has arrived.*

CONFORMABILITY  
WITHOUT COMPROMISE.



[www.conformabletag.com](http://www.conformabletag.com)

W. L. Gore & Associates, Inc.  
Flagstaff, AZ 86004  
[goremedical.com](http://goremedical.com)

Products listed may not be available in all markets.  
GORE, PERFORMANCE BY DESIGN, TAG®, and designs are trademarks of W. L. Gore & Associates.  
©2010 W. L. Gore & Associates, Inc.  
AP0088-EN1 FEBRUARY 2010



PERFORMANCE  
by design

# The Circulation Foundation

## Research Awards

**Matthew Bown is the winner of the President's Early Career Award, a brand new award launched in 2010.**

Matthew, a Senior Lecturer in Vascular Surgery at Leicester University will receive £100,000 over a 2 year period. Matthew's research is focused on the genetics of abdominal aortic aneurysms and their growth. The project is a prospective cohort study of patients with small abdominal aortic aneurysms (AAA) and a group of healthy controls. Ten-thousand males with AAA and ten-thousand healthy controls attending the NHS AAA screening programme will be recruited over 5 years. Biochemical samples will be obtained from each participant and all participants will be followed up through the UK Medical Research Information Service. Those participants with small AAA will be followed up with yearly biochemical sampling and clinical data collection. This approach will generate an unprecedented resource to enable the study of the natural history of AAA alongside genomic, transcriptomic and proteomic experiments that will determine biological markers and pathways associated with AAA and AAA growth.

We wish Matthew all the best with his research in helping to stamp out vascular disease.



## New for 2011: The 'Surgeon-Scientist' Award

The Circulation Foundation is delighted to announce the launch of a brand new "Surgeon-Scientist Award" for 2011.

This one year award will support young surgeons during the transition between their academic clinical fellow years into full time research. As a result, it is hoped applications for future clinical lecturer posts will be boosted.

The Surgeon-Scientist Award will provide one-year funding of around £45,000 - £55,000 including a £10,000 bench fee.

### Who is eligible?

Junior surgeons, who are members of the VS, who are in an academic clinic fellow [ACF] post or post-CT2

### Criteria

- The applicant must be committed to a career in vascular surgery with a strong research interest.
- MRCS essential.
- The applicant must demonstrate a commitment to active vascular research which may include vascular biology, translational research or clinical research and have a long-term goal to seek a senior lecturer award.
- Applicants should note that they will be responsible for providing a CRB check prior to interview or evidence that they have applied for one.
- A full list of terms and conditions, and application forms, can be found by visiting [http://www.circulationfoundation.org.uk/news/surgeon\\_scientist\\_award](http://www.circulationfoundation.org.uk/news/surgeon_scientist_award)

Application deadline is 5pm, 25th February 2011



## Icicle Bicycle

Congratulations to VS Council members David Mitchell and Jonathan Beard, along with vascular surgeon Richard Harvey and vascular scientist Tom Hopkins, who raised over £1000 for the Foundation on a London to Brighton bike ride. They completed the gruelling 54 mile ride on a cold November afternoon, starting from the Royal College of Surgeons.

This is a brilliant example of Members of the Society helping raise funds and awareness of the Circulation Foundation. If you are inspired by our riders and would like to raise funds for the Foundation, please get in touch.



## Brighton Fun Run

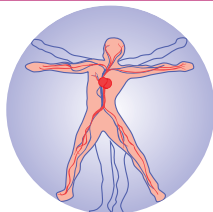
We are grateful to those Vascular Society AGM delegates who braved the early morning cold in Brighton on Friday 26th November for a 5km run along the promenade to raise awareness of the Circulation Foundation.



## London Marathon

7 runners will be taking part in the London Marathon on Sunday 17th April to raise money for the Circulation Foundation, and we would like to thank them and wish them all the best for the day.

The Circulation Foundation  
 35-43 Lincoln's Inn Fields  
 London WC2A 3PE  
 T: 020 7304 4779  
 F: 020 7430 9235  
 E: [info@circulationfoundation.org.uk](mailto:info@circulationfoundation.org.uk)  
[www.circulationfoundation.org.uk](http://www.circulationfoundation.org.uk)



NEW

LeMaitre®

VASCULAR

Your Peripheral Vision™

Now offering a full range of  
ePTFE and Polyester Vascular Grafts

LifeSpan®

ePTFE Vascular Graft

AlboGraft™

Polyester  
Vascular Graft

Contact us for more information:

<p><b>United Kingdom</b>                  Tel. UK Lo-Call 0870 240 66 40                  Fax UK Lo-Call 0870 240 66 41  <a href="mailto:csuk@lemaitre.com">csuk@lemaitre.com</a></p>	<p><b>Ireland</b>                  Tel. IRE Toll Free 01 800 557 200                  Fax IRE Toll Free 0818 423 112  <a href="mailto:infogmbh@lemaitre.com">infogmbh@lemaitre.com</a></p>
---	--

[www.lemaitre.com](http://www.lemaitre.com)

LeMaitre and LifeSpan are registered trademarks, and AlboGraft is a trademark of LeMaitre Vascular, Inc. or one of its affiliates. ©2010 LeMaitre Vascular, Inc. All rights reserved.

## Endovascular Aneurysm Repair (EVAR) Service - What do we need to produce and optimal service?

The Medicines and Healthcare products Regulatory Agency (MHRA), the Department of Health Regulatory Authority for medical devices, became increasingly concerned by the number of adverse events reported to its Adverse Incident Centre in relationship to placement of stent grafts. Investigation of these reports revealed that a substantial number were associated with inadequate imaging facilities for fluoroscopy and that this factor, at least partially, was a contributory factor to a number of the adverse events reported, resulting in a failure to recognise and act appropriately to problems of device positioning or deployment. As a result of the MHRA approaching the Royal College of Radiologists about their concerns, an Expert Advisory Group was set up by MHRA representing The Royal College of Radiologists, The British Society of Interventional Radiology, The Vascular Society of Great Britain and Ireland, and The Vascular Anaesthesia Society of Great Britain and Ireland was set up to provide guidance for existing

centres and for centres setting up EVAR services with regard to facilities, staffing and standards of equipment necessary in order to set up and deliver a safe and effective service for patients and satisfactory user working conditions. This document contains guidance on: equipment, location, anaesthetics and radiology equipment, post procedural care, protection principles and staffing requirements. The resources detailed in this document are considered essential to provide a safe EVAR service. In the meantime, all Trusts where EVAR is being undertaken should review their existing facilities and take action to ensure that adequate resources as described are available in order to allow for optimal patient outcome, staff protection and working environment and especially that adequate backup imaging is available.

A copy of this document is available on the MHRA website ([www.mhra.gov.uk](http://www.mhra.gov.uk)) or hard copies available from Dr Susanne Ludgate ([susanne.ludgate@mhra.gsi.gov.uk](mailto:susanne.ludgate@mhra.gsi.gov.uk))

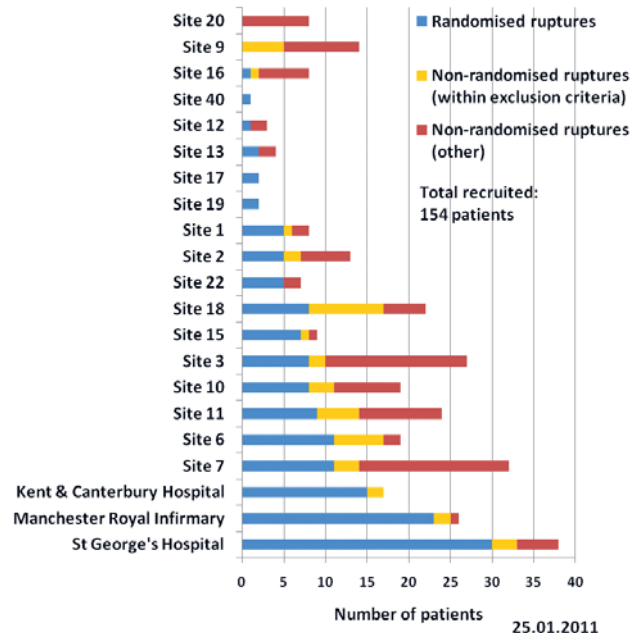
## The IMPROVE Aneurysm Trial (Immediate Management of the Patient with Rupture: Open Versus Endovascular Repair)

Emergency vascular surgical patients require treatment by vascular specialists, but for those with ruptured aneurysm does this need to be taken one step further, with patients requiring treatment by endovascular specialists? The IMPROVE trial aims to show that operative mortality from ruptured abdominal aortic aneurysm can be reduced from 45% to 30% when a strategy of endovascular rather than open repair is used to exclude the aneurysm. Our target is a recruitment of 600 patients, as fast as possible. By now we have recruited more than 25% of the number needed and are the largest ruptured aneurysm trial. After review of the first 50 patients the Data Monitoring Committee had no safety concerns and the next review will be this summer when they review the first 200 patients. We need all potential patients, including the haemodynamically unstable patients, where the benefits of endovascular repair may be greatest. There are good reasons why not all patients have been randomised. Not all centres can offer emergency endovascular repair 24/7 and approximately one third of the non-randomised patients meet the exclusion conditions e.g. prior aneurysm repair or Marfan syndrome.

We hope to have the main trial results available for the Vascular Society in November 2013.

Contact: [www.improvetrial.org](http://www.improvetrial.org) Dr Pinar Ulug, Trial manager, email: [improvetrial@imperial.ac.uk](mailto:improvetrial@imperial.ac.uk)

IMPROVE trial patient recruitment & exclusions by centre



## Editor Assistant Bursary 2011

The BJS wishes to encourage young surgeons to take an interest in medical publishing. To this end the BJS Society has established Editor Assistant bursaries. It is envisaged that suitable applicants will be at or near the end of higher surgical training, or recently appointed to a substantive post. Although no previous publishing experience is expected, the successful candidate will have scientific curiosity, write well and have a facility for constructive criticism.

The role will require

- Attending monthly editorial meetings in London

- Assisting the editors in the handling of papers, from submission to publication
- Contributing to BJS scientific writing courses
- Completing a research project relating to surgical publishing

Tenure will be for a period of 12 months. Necessary travel and accommodation expenses will be reimbursed, and the successful candidate will receive an honorarium of £1000.

Applications should be made in writing to the Managing Editor, Alison Cherrie, at [alison.cherrie@wiley.com](mailto:alison.cherrie@wiley.com), and should be received no later than 6th May 2011. Please include a full CV plus covering letter explaining your interest in the position.

## CORESS Vascular Cases

Frank CT Smith, CORESS Programme Director



### Limb ischaemia as a complication of vascular closure device<sup>1</sup>

A 64 year old man with claudication was admitted for proximal right superficial femoral angioplasty. A retrograde contralateral approach was used from the left groin to undertake proximal and mid-superficial femoral angioplasty on the right leg. A percutaneous closure device was used to seal the arterial puncture site in the left groin. The same night, the patient developed an acutely ischaemic left leg. There was a short occlusion at the site of the puncture in the common femoral artery, due to luminal thrombosis in association with arterial wall damage caused by the closure device. The artery was explored and thrombectomy with patch repair of the common femoral artery undertaken. The patient subsequently required additional revision surgery of the common femoral artery in the groin, due to recurrent stenoses.

#### Reporter's Comments:

Patients require very careful assessment after any percutaneous procedure. Closure devices are associated with specific complications. When there is any evidence of ischaemia after interventional radiology using arterial closure devices, appropriate imaging should be undertaken.

#### CORESS Comments:

Most arterial puncture sites undertaken in association with peripheral angioplasty can be controlled by a period of conscientious sustained pressure on the artery. Control is more difficult where the puncture site is above the inguinal ligament, inadvertently involves the profunda femoris artery or in the obese patient.

Use of large bore catheters and anticoagulation may influence the decision to deploy a closure device. Numerous complications have been associated with use of closure devices including early and late thrombosis, arterial damage and infection<sup>1</sup>. Such devices should only be deployed after careful consideration of the individual patient's circumstances.

Records of complications should be discussed between surgeons and radiologists in multidisciplinary meetings, so that a realistic overview of potential complications associated with use of such devices can be appreciated by those who deploy them.

#### Reference

1. Biancari F, D'Andrea V, Di Marco C et al. Meta-analysis of randomized trials on the efficacy of vascular closure devices after diagnostic angiography and angioplasty. *Am Heart J*. 2010 Apr;159(4):518-31.

### Limb ischaemia as a complication of vascular closure device<sup>2</sup>

A 72 year old lady, warfarinised for a prosthetic mitral valve replacement, presented with established gangrene of her left forefoot. CT angiography confirmed a tightly stenosed left common iliac artery, and a 2cm stenosis of the distal left superficial femoral artery. Angioplasty had to be delayed until 3.00pm on a Friday afternoon to allow reversal of anticoagulation. The iliac stenosis was dilated and a stent inserted. Following intervention there was some bleeding from the groin (anticoagulation not having been fully reversed) and to

avoid a second downstream puncture it was felt that having dealt with the proximal stenosis, the more distal stenosis could wait till after the weekend. Due to the bleeding from the groin, a percutaneous closure device was inserted in the left common femoral artery. In the recovery area, the limb appeared cool and pale, but a duplex ultrasound was undertaken, which showed the closure device to be in a good position with flow below this.

The patient was transferred back to the ward for observation and commenced on heparin. One hour post-procedure the limb was still cool, although the patient denied pain and had full movement and sensation.

The vascular Consultant took the locum Consultant covering for the weekend to see the patient and explained that he thought that further intervention may eventually be required but that it was too early to see if the limb was going to improve. The vascular Consultant returned on Monday morning. The locum stated that the patient had remained comfortable although the limb still looked slightly "blotchy".

When the vascular Consultant reviewed the limb, it was

instantly apparent that the leg was irreversibly ischaemic with fixed contractures of the calf muscles and mottling to the groin. Imaging showed that the common femoral artery was occluded. The closure device had caused dissection of an atherosclerotic plaque, occluding the artery. The common femoral artery was reconstructed with a graft to the profunda femoris artery, to salvage an above-knee amputation which was performed at the same time. The original bleeding in the groin was found to have been from a transected vein at the puncture site.

**Reporter's Comments:**

The percutaneous closure device was associated with arterial injury. Inadequate follow-up cover by someone inexperienced in assessment of vascular deterioration was arranged, despite a formal handover. Where specialist assessment is required, this must be formally arranged, ideally between the responsible surgeon and the Consultant surgeon on-call.

**CORESS Comments:**

It is essential in cases such as this, that a named and appropriately qualified clinician assumes responsibility for clinical care. Whilst the onus here may appear to rest with the vascular surgeon, in the modern health service appropriate provision should be made for continuity of specialist care. Rotas for emergency vascular cover should be in place if an institute is to undertake vascular intervention. In this case, formal reassessment by an on-call vascular surgeon, as part of a covering on-call vascular rota, recommended by Vascular Society guidelines<sup>2</sup>, should have been put in place.

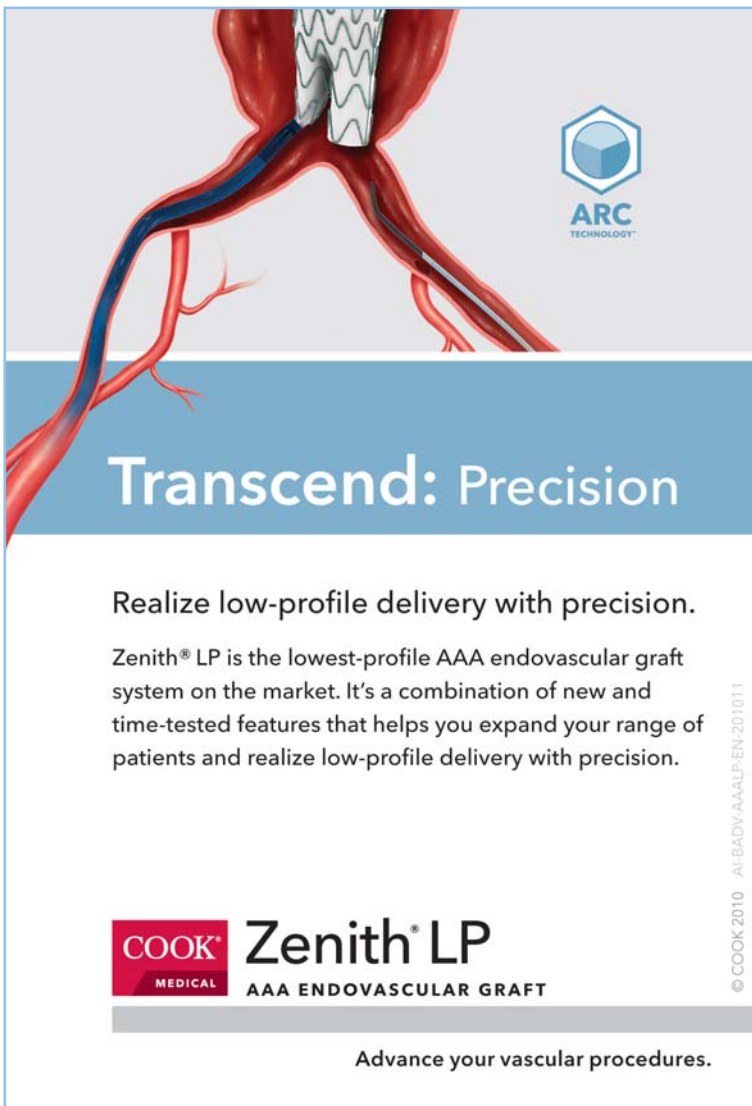
**Reference**

2. [http://www.vascularsociety.org.uk/library/vascular-society-publications/doc\\_download/65-the-provision-of-services-for-patients-with-vascular-disease-2009.html](http://www.vascularsociety.org.uk/library/vascular-society-publications/doc_download/65-the-provision-of-services-for-patients-with-vascular-disease-2009.html)

Several other cases of problems with vascular closure devices have been reported to CORESS. Readers may be interested to know that MRHA have issued a useful poster providing guidance on the use of these devices, which covers:

- \* pre-deployment imaging
- \* angle of insertion
- \* wound healing
- \* existing haematomas
- \* instructions for use

The poster can be found at:  
<http://www.mhra.gov.uk/Publications/Postersandleaflets/CON076415>



**Transcend: Precision**

Realize low-profile delivery with precision.

Zenith® LP is the lowest-profile AAA endovascular graft system on the market. It's a combination of new and time-tested features that helps you expand your range of patients and realize low-profile delivery with precision.

**COOK MEDICAL Zenith® LP**  
 AAA ENDOVASCULAR GRAFT

© COOK 2010 AI-BADV-AAALP-EN-201011

Advance your vascular procedures.

## Welcome to the following new members of the Vascular Society

### Ordinary

<b>Irfan Akhtar</b>	Kings Mill Hospital
<b>Karim El Sakka</b>	Royal Sussex County Hospital
<b>Sumaira Khan</b>	Kings Mill Hospital
<b>Lucy Wales</b>	Freeman Hospital

### Affiliate

<b>Islam Mohamed Ahmed</b>	Royal Sussex County Hospital, Brighton
<b>Paul Bevis</b>	Gloucestershire Royal Hospital
<b>Pauline Buxton</b>	Queen Elizabeth Hospital
<b>Edward Choke</b>	Leicester Royal Infirmary
<b>Robert Davies</b>	Queen Elizabeth Hospital, Birmingham
<b>Upeksha De Silva</b>	Royal Infirmary of Edinburgh
<b>Colin Forman</b>	Guy's Hospital, London
<b>Teik K Ho</b>	The Royal Free Hospital
<b>Keith Hussey</b>	Ayr Hospital, NHS Ayrshire and Arran
<b>Eyad Issa</b>	Leicester Royal Infirmary
<b>Greta Jass</b>	Royal Derby Hospital
<b>Pankaj K Jha</b>	Norfolk & Norwich University Hospital
<b>Muhammad Kabeer</b>	Dumfries and Galloway
<b>Rakesh Kapur</b>	Queens Medical Centre Nottingham
<b>Jo Krysa</b>	St Thomas' Hospital, London
<b>Steven Jones</b>	Leighton Hospital
<b>Tristan Lane</b>	Charing Cross Hospital, London
<b>Christos Lioupis</b>	Jewish General Hospital, Quebec
<b>Kulbir Mann</b>	Frimley Park Hospital
<b>Nick Matharu</b>	Coventry & Warwickshire Hospitals
<b>Connor Marron</b>	Belfast City Hospital
<b>Linda Parsons</b>	Torbay Hospital
<b>Hemanshu Patel</b>	Royal Free Hospital, London
<b>George Peach</b>	St George's Vascular Institute
<b>Mark Portou</b>	Chase Farm Hospital
<b>Sriram Rajagopalan</b>	Aberdeen Royal Infirmary
<b>Adriano Sala Tenna</b>	Sunderland Royal Hospital
<b>Sandip Sarkar</b>	Southend University Hospital
<b>Hani Slim</b>	Kings College Hospital
<b>James Thorpe</b>	Ayr Hospital
<b>Michael Wall</b>	New Cross Hospital, Wolverhampton
<b>Alasdair Wilson</b>	Aberdeen Royal Infirmary

### Associate

<b>Syed Andrabi</b>	The Royal Derby Hospital
<b>Devan Thavarajan</b>	Royal United Hospital
<b>Barnabas Green</b>	James Cook University Hospital
<b>Devinder Gupta</b>	Mid Yorkshire Hospitals NHS Trust
<b>Muhammad Junaid Sultan</b>	University Hospital of South Manchester

## MEMBERSHIP SUBSCRIPTIONS

Rates for 2011:

**Ordinary Member - £195**

**Affiliate, Associate & Overseas - £105**

**Senior - £35**

## Council Appointments

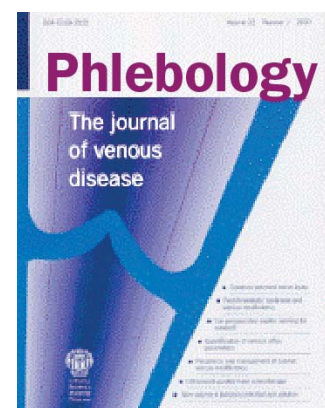
The following were elected to Council from November 2010-2013:

**Professor Alison Halliday,  
Mr Ian Loftus and  
Mr John Thompson**

## Phlebology Journal

To reflect the increase in the quality and quantity of submissions, The Royal Society of Medicine Press and the editors of Phlebology have decided to increase the number of issues due to be published from 2011 from 6 to 8. The 2011 price for a subscription will be £116 for members of the Vascular Society (standard prices are: £145 / €203 / \$245).

Visit <http://phleb.rsmjournals.com/misc/vascularsoc.dtl>





# The Vascular Society of Great Britain and Ireland

## CONTACTS

The Vascular Society of Great Britain  
and Ireland  
At The Royal College of Surgeons  
35-43 Lincoln's Inn Fields  
London WC2A 3PE

Tel: 020 7973 0306  
Fax: 020 7430 9235  
E-mail: [office@vascularsociety.org.uk](mailto:office@vascularsociety.org.uk)  
Website: [www.vascularsociety.org.uk](http://www.vascularsociety.org.uk)

Registered in England, limited by guarantee  
Registered Company No 5060866  
Registered Charity No 1102769

## OFFICERS

President: **Mr Peter Lamont**  
President Elect: **Professor Ross Naylor**  
Vice-President Elect: **Professor Julian Scott**  
Honorary Secretary: **Mr Michael Wyatt**  
Honorary Treasurer: **Mr Simon Parvin**  
Chairman Training & Education Committee:  
**Professor Jonathan Beard**  
Chairman, Audit and Quality Improvement:  
**Mr David Mitchell**  
Chairman, Research Committee:  
**Professor Shervanthi Homer-Vanniasinkam**  
Chairman, Circulation Foundation Committee:  
**Mr Ian Franklin**  
Chairman, Professional Standards Committee:  
**Professor Michael Gough**  
Chief Executive: **Ms Jeanette Robey**

## SOCIETY MAJOR SPONSORS

