



## National Vascular Database Online The First 1,000 Cases

*Report from Sara Baker, NVD Co-ordinator*

After a very busy year we now have a robust, secure and flexible audit tool providing real time data, with live reporting due imminently. We have retained the four index procedures: aortic aneurysm (which now includes EVAR and laparoscopic repair), infrainguinal bypass and amputation. Carotid endarterectomy is still managed through the shared audit with the Royal College of Physicians; the aim is for this to continue, but for the dataset to be refined and incorporated into the same NVD online website later this year.

Those of you who have already adopted NVD online will be familiar with the flexibility of adding data at various points along the patient admission. Some of you who are lucky enough to have data coordinators are able to choose to enter a complete record retrospectively at the time of discharge.



The new NVD online system allows for each surgeon to add their own data and view their results at all times from any web-enabled computer. A local administrator can also be

allocated privileges to view the whole centre's records and to add data items for several local surgeons. They can also manage the introduction and account verification of a newly appointed consultant colleague without having to wait for this to be done centrally. The use of a website tool adds considerable security advantages in that the data are encrypted in a way that non-members who gain access can see the numbers, but cannot interpret them without the electronic data key.

The acquisition of data in the last 6 months has been excellent and at the time of writing there are over 1000 complete aortic aneurysm records, 300 infrainguinal bypasses and similar numbers in the amputation database. By the time you read this we will have completed the upload facility for the historical data, and will be live testing the centre upload for acquiring data from bespoke and commercial systems. This means that vascular centres with established audit departments and databases will be able to upload their data to NVD online in batches.

*continued on page 2*

## New Secretariat

The Society has recently appointed two new members of staff within the Secretariat. Ms Neelam Daswani (top right in picture) is Executive Assistant to Jeanette Robey, and will assist with the organisation of the Society's Annual Conference.

Neelam also undertakes administration for the Society for Vascular Technology, running their membership database and supporting their Executive Committee.



Ms Rebecca Wilkinson has been appointed as Fundraising and Events Co-ordinator for the Circulation Foundation and is responsible for promoting the Foundation amongst Members and the public, and co-ordinating the regular grant-giving programme and fundraising events.

### CONTENTS

President's Message	2	2008 AGM, Bournemouth	7
Clinical Excellence Awards	3	Circulation Foundation Grant	8
Carotid Meeting, Dublin	4	Circulation Foundation	9
Carotid Endarterectomy Audit	5	Council Membership Nominations	10
Aneurysm Screening	6	VSGBI Membership	11

## National Vascular Database

*continued from page 1*

Once this is in place the Vascular Society can provide a national overview at regular intervals through the year without the need to transfer large inadequately secured data through the email systems or wait many months for data analysis. Alternatively, it is anticipated that members will be able to do real time analysis of their own results and download them from NVD online at their convenience.

During the next 12 months we will be developing the reporting tool further to allow for both national and local data reporting so that a surgeon can see their own figures locally against the national figures. Local data extraction will also be of benefit to centres for morbidity and mortality analysis e.g. surgical site infection.

In the future we plan to use NVD data to make comparisons against each hospital's own HES reporting, as well as to use the system as the quality assurance tool for patients screened within the new UK AAA screening programme. The reporting tool online will provide real time data analysis which will be a much more robust system of reporting than we have had previously.

The current NVD online tool reflects the vision not only of the Audit and Research Committee, but also the input from all of you who have used this tool and been kind enough to take the time and trouble to comment on the function, content, future amendments and clinician needs at a local level. Thank you.

[www.nvdonline.org.uk](http://www.nvdonline.org.uk)

## President's message

The focus of the last newsletter was training and the changes in curriculum and specialty/sub-specialty status that are being pursued. Members were invited to e-mail me with their opinions on this (President@vascularsociety.org.uk), though few of you did. Does this mean you are all happy or does it mean that you don't read the newsletter? Nevertheless there were one or two interesting replies, varying from satisfaction with the path that the Society was following, to suggestions that the President might consider resignation!

To recap, there are many barriers to vascular surgery becoming a separate specialty from general surgery, the most important of which is a total lack of support from PMETB, the Royal Colleges, and almost certainly the Department of Health. For those that wish to bang their heads against a brick wall, we could do this for a number of years whilst training developments, arguably the most important facet of either partial or complete separation from general surgery, remain in limbo. Further, the Royal College of Radiologists, who are central to curriculum developments, are more comfortable with an application for sub-specialty status.

Central to an application to PMETB for formal sub-specialty status is an agreement with the SAC, JCST and the College Presidents on the time that vascular trainees should spend learning general/abdominal surgery before commencing specialist vascular/interventional training. In the recently published ASGBI Consensus Statement (Emergency General Surgery: The Future, 2007) it was recognised that vascular surgery is undergoing major changes and that it is unlikely to be involved in providing emergency general surgical cover in the future. If this is the case then some would argue that 12 months of general surgical experience would be sufficient. Conversely, the ISCP curriculum states that the core competencies of general surgery should be obtained during the first 2

years of specialist training. If such experience would allow vascular trainees to open a hostile abdomen with confidence and deal with the potential complications of abdominal vascular surgery then this would seem to be a more suitable period of training. Finally, the report also stated that *"It is clear from trends within the specialty and training that separation of vascular surgery from general surgical practice in the UK is inevitable"*.

**“To recap, there are many barriers to vascular surgery becoming a separate specialty from general surgery, the most important of which is a total lack of support from PMETB, the Royal Colleges and almost certainly the Department of Health.”**

The good news is that the SAC in general surgery has agreed to debate, and hopefully decide this issue in July. Given this, an application to PMETB for sub-specialty status should follow shortly thereafter.

If you have strong views on the duration of exposure to general/abdominal surgery please let me know. If it is 2 years, this will leave 4 years for specialist vascular/interventional training. Similarly, I would like to hear your suggestions for a new name for the sub-specialty which has to be different from a medical specialty listed by the European Union (i.e. not vascular surgery). Will the sub-specialty be called vascular intervention, vascular therapy (ugh!), vascular disease management?

## Post-CCT Fellowships

In the meantime we still have the opportunity to improve our training programmes. This is because the Department of Health has provided funding for post-CCT fellowships. These are aimed at trainees who are within 6 months of their CCT date. At very short notice the Society successfully bid for 7 posts that will allow trainees to spend a year in interventional radiology. The job plans for these posts are currently being written but it is anticipated that they will involve modules taken from the new curriculum. This will allow testing of both the curriculum and the assessment tools required for quality assurance.

The fellowships will be advertised nationally in the near future and will commence over the next 6 months or so, depending on the CCT date of the appointee. It is envisaged that both the appointments process and quality assurance will be overseen by the joint RCR/Vascular Society working group to ensure that both the trainees and ourselves derive as much benefit and information as possible from these posts. In a simultaneous bid, the RCR was successful in obtaining 4 posts for radiology trainees to gain experience in the clinical aspects of vascular disease, which again should expose the appointees to parts of the joint curriculum.

The issue of providing trainees with experience in interventional radiology has been a source of anxiety to the Society and our trainees for some time. The recently advertised BSET (British Society for Endovascular Therapy) fellowships, or similar posts overseas may have appeared attractive. Although a year in Australia (for example) may offer other benefits, it must be stressed that the DoH-funded posts are the only ones that have a written curriculum, and mechanisms for appropriate appraisal and assessment. Further, the commercially funded fellowships have not been scrutinized by PMETB which is a requirement even for out-of-programme experience for pre-CCT trainees.

In addition to the 7 post-CCT fellowships there is also the opportunity to undertake funded, PMETB approved interventional posts in at least 2 other UK centres. These posts should meet the current demand given the number of year 5/6 trainees and the anticipated number of consultant vacancies.

## The Future

We are committed to having approval for the new curriculum in advance of the 2009 applications for specialist training. There will therefore be an interim between its implementation and the output of fully trained vascular specialists. During this time it is vital that we are able to offer continuing experience in interventional procedures to our trainees and this is the subject of ongoing discussions with NHS management.

**Mr Michael Gough**

## Clinical Excellence Awards



Any member wishing to seek support from the Society's Clinical Excellence award committee for a National Bronze, Silver or Gold award needs to submit an ACCEA form to the Secretariat by **Friday 22nd August**. You do not need to attach an employer's citation. The awards committee, which includes the President, the Vice-President and the Honorary Secretary, objectively score and rank the applications. Those considered for support by this committee are submitted directly to the ACCEA in ranked order, accompanied by a citation from the Society. The ranked list is also sent to the ASGBI awards committee, who then make recommendations to the College of Surgeons awards committee and both of these committees also make direct submission to the ACCEA with their own ranked lists and citations. The process is meant to be as open as possible, so if you have any questions about it, please contact the Honorary Secretary for clarification.

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# Carotid meeting in Dublin

**Prakash Madhavan hosted a meeting on behalf of the Irish Association of Vascular Surgeons at the Royal College of Surgeons in Ireland to update and inform the audience on the management of carotid disease.**

The roles of both carotid endarterectomy and carotid stenting were discussed in detail. In asymptomatic patients with carotid stenosis, Ross Naylor reviewed the evidence critically and pointed out that the risk of stroke seemed to be reducing, presumably as a result of more effective medical treatment. Further research is needed to find which stenoses are higher risk in asymptomatic patients that may benefit from intervention.

Results of carotid intervention were presented from Ireland and also from the UK National Vascular



Database. Peri-procedural death and stroke rates of approximately 2% were seen in both series, much better than the 12% historically reported in 1979. These studies, however, were criticized by neurologists present at the meeting as possibly missing some minor strokes. The results, of carotid stenting in Ireland were as shown to be as good as those for carotid surgery.

The major debate was around delivery of carotid service. The biggest gains were agreed to be had from improving education and access; this means educating both patients and general practitioners about the risks of stroke after transient ischaemic attack. An improved pathway for symptomatic patients that includes prompt best medical therapy, speedy investigation and the delivery of effective and timely intervention will make the biggest difference to reducing stroke risk. Carotid stenting is clearly growing and much work needs to be done on training which could include the use of simulators.

The meeting was educational and challenging and the organisers were congratulated for an excellent conference.

“ **The biggest gains were agreed to be had from improving education and access** ”



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# Carotid Endarterectomy Audit of UK and Ireland

Report from Tim Lees, Chairman of the Audit and Research Committee

**There is firm evidence supporting the role of CEA and its urgency in the prevention of stroke. In early 2005 a 2 year audit was designed as a collaborative project between the VSGBI and the RCP. This was led by a multidisciplinary steering group and the audit was funded by the Healthcare Commission.**

The audit commenced in December 2005 and patients having carotid endarterectomy between December 2005 and December 2007 were included. The audit has examined patient pathways, surgical outcomes and post-operative follow up. Two organisational surveys have been published examining the way in which carotid endarterectomy services are currently provided and the final report on the clinical data will be published in August this year.

The audit includes over 5000 cases and as such it will be one of the largest published audits of carotid endarterectomy. This is a tribute to the hard work of all the surgeons and data coordinators who have submitted data and I would like to extend a personal thank you to all those who contributed. There will be some clear messages arising from the audit and alongside the forthcoming guidelines from the Department of Health National Stroke Strategy and NICE I believe there will be major changes in the provision of CEA in the future.

The Healthcare Commission has funded the audit to continue for a further 2 years and so I would like to encourage contributing surgeons to keep sending in your data. For those who are not contributing I would ask you to join the audit. I firmly believe that it is better that we collect accurate reliable data ourselves prospectively rather than relying on the publication of retrospective data that many of us have no confidence in.

If you would like to join please contact [ceaaudit@rcplondon.ac.uk](mailto:ceaaudit@rcplondon.ac.uk)



# Implementation of the National AAA Screening Programme from scratch: The North East approach.

**On 7 January 2008, the Prime Minister announced the establishment of a National Screening Programme for abdominal aortic aneurysm (AAA). Roll out is expected to take 5 years and some national funding will be provided with an allocation per head of population screened.**

The UK National Screening Committee has indicated that during 2008/09 a small number of early implementer sites will be identified; these will be where formalised, funded, population based screening programmes are already operating. From April 2009 onwards, it is intended that there will be approximately equal waves of new sites starting to screen in each of the following four years. The Department of Health will not accept sites for implementation without Strategic Health Authority (SHA) approval. SHAs will want to ensure that any sites starting to screen patients have full support from commissioners, and that they fit into a strategic approach for the development of AAA screening across the region.

**“ At present, ultrasound capacity is limited and it is recognised that a programme of training will be required prior to the “rolling out” of AAA screening.**

To date, there have been no formal AAA screening programmes in the North East (NE). In order to prepare for the introduction of the national programme, an early decision was made to engage directly with the SHA and to guide the commissioners in their preparation for implementation from April 2009 onwards. This process has been driven by the formation of the North East AAA Screening Advisory Group, consisting of Consultant Vascular Surgeons representing each of the provider Trusts, Public Health North East, regional medical physics and screening leads and commissioners from the PCTs.

The recommendation of this group is that a single NE AAA screening programme can be established, with up

to three screening units operating within the programme. The programme would have a sessionally funded Programme Director, regional medical physics support, and would have responsibility for quality assurance and reporting at national level. Details regarding the final screening unit groupings are yet to be finalised, but it is envisaged that they will be organised over clinically relevant geography, and will provide a local base for screening staff.

The advisory group has identified several difficulties in implementation. At present, ultrasound capacity is limited and it is recognised that a programme of training will be required prior to the “rolling out” of AAA screening. In addition, although there are some strong clinical links between vascular services in the NE, not all are working within recognised vascular networks. Commitment has now been secured to work towards a single vascular network for the NE, mapped onto the single AAA screening programme, but further work will be required to develop this network prior to implementation. Perhaps more importantly however is the potential risk to the viability of any vascular service that is not selected to host a screening unit. This has been mitigated through the adoption of the single programme model, which sees the screening units as merely a local base for staff working in the NE programme. This will ensure that referrals from the screening programme can follow the same routes as symptomatic referrals, and that screening can be provided in the most appropriate way for the people of the NE.

The next stage will be for the commissioners to develop a service specification and options for provision. Hopefully this will be in time for consideration of the NE for inclusion as a first wave programme to be activated in April 2009. This process is time consuming and we would encourage other regions to engage early to prepare for implementation within the specified 5 year time frame.

## **Mike Wyatt**

Northern Regional Vascular Advisor  
*Chair, North East AAA Screening Advisory Group*

## **Madeleine Johnson**

Acting Locality Director of Public Health Hartlepool Borough Council/Hartlepool PCT  
*Chair, North East Regional Screening Group*

## 2008 AGM

### Bournemouth: 12 - 14 November 2008

The provisional programme for this year's meeting will be sent to Members in the next few weeks. Registration and hotel booking will also soon be available on-line on the Society's website - [www.vascularsociety.org.uk](http://www.vascularsociety.org.uk)

The Annual Dinner will be held at the Bournemouth International Centre on Thursday 13th November.

**Are you a star in the making?! Do you want to show off your talent at the Society's X-Factor evening at the Annual Dinner? We are looking for an act from the Society to take on the SVN, SVT and Rouleaux Club. For further details, contact Jeanette in the Society's office.**

#### Abstract Submission

Abstract submission is now available on the Society's website. The deadline is midnight on Sunday 10th August. Full details are available on the Society's website: [www.vascularsociety.org.uk](http://www.vascularsociety.org.uk)

A summary of the guidelines follows:

- The abstract must consist of four paragraphs, entitled: Objective, Methods, Results, Conclusions
- The abstracts are to be submitted as text only.
- The text should be no longer than 250 words and fit comfortably on a single page of A4 using 12 font.
- Since the abstract will be judged anonymously, the text may not reveal the institutional affiliation
- The category which best describes the subject of your work should be indicated
- If the paper is to be considered for a prize or a poster, the relevant box should be marked

The Vascular Society takes a serious view of Research Governance. Please ensure that the abstract has been seen and agreed by all of the named authors before submission. All of the authors have a responsibility to ensure that the data submitted is accurate, is not extrapolated and fairly represents the presentation to be given at the Scientific Meeting.

Once selected, the abstracts will be available on the Society's website for Members' information prior to the meeting. They will also be published in the Society's Yearbook, which will be available at the AGM, and later by post to those Members who do not attend the AGM.

The abstracts from the meeting will be published electronically via the BJS website.

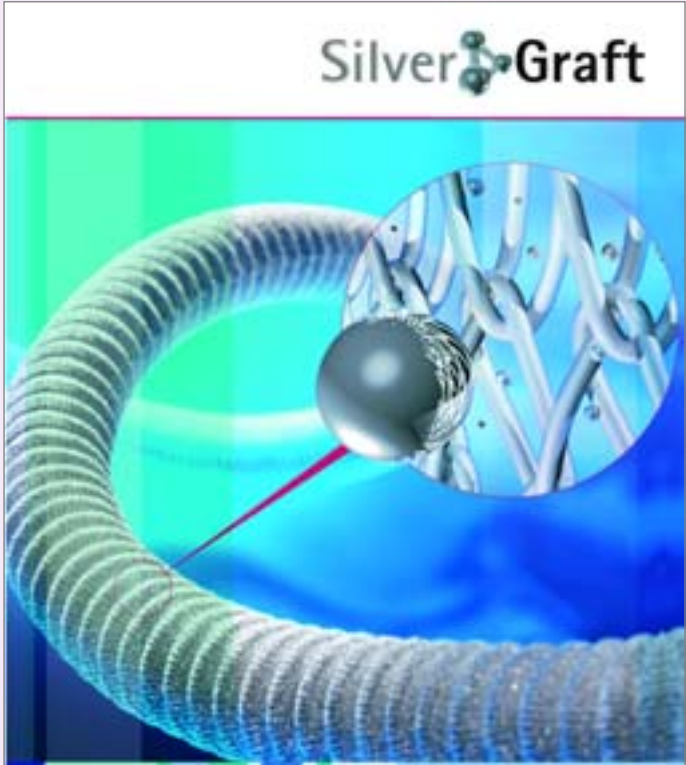
#### Posters

Abstracts not selected for presentation at the meeting will be considered for poster display, and these will be displayed throughout the meeting at the conference centre.

#### Introduction to Endovascular Interventions

Bournemouth International Centre: 11 November 2008

This course is aimed at ST3-8 and radiology trainees. It will cover the basic principles of endovascular techniques, including angioplasty and stenting as well as endovascular aortic aneurysm repair. It will include an opportunity to practise skills on the latest virtual reality simulators. The faculty comprises highly experienced interventional radiologists and endovascular surgeons. For further information contact [vascular@rcseng.ac.uk](mailto:vascular@rcseng.ac.uk)



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# Circulation Foundation:

This is a report from Graham Roche-Nagle who received a grant from the Circulation Foundation in 2007 to visit Canada to further his endovascular training. Toronto General Hospital is a 950-bed, Level 1 trauma centre and is the tertiary referral centre for the entire province of Ontario. Of the approximately 50,000 emergency room visits each year, more than 2,500 are vascular related.

## 6 Months Clinical

During the year as a vascular fellow, I was given the autonomy of overseeing the vascular service, with appropriate guidance from the attending consultants. The clinical attachment provided an intensive experience in the diagnosis and treatment of a wide variety of vascular disorders. It included experience in operative treatment, patient management, angiography, angioscopy and non-invasive vascular diagnosis. The fellowship provided access to the full range of vascular cases performed by the departmental surgeons (more than 1,100 procedures per year) including complex aortic reconstructions, thoraco-abdominal aneurysms, complicated cerebrovascular problems and mesenteric reconstructions. The operative experience in vascular surgery was extensive and varied in the elective and emergency setting. In addition, the Fellow was assigned to the outpatient clinic one day a week, and had opportunity to participate in the preoperative evaluation and postoperative follow-up of patients with the attending surgeons.

**During the fellowship I was also able to rotate through sub-programmes:**

### 3-months interventional radiology suite

The programme provided exposure to a full range of endovascular interventional radiology that included nearly 6000 procedures. There were a number of formal and interactive lectures, and Fellows conducted daily case review sessions.

### 3-months vascular diagnostic laboratory

This allowed me to acquire experience in the vascular diagnostic laboratory. It gave me the opportunity

to learn skills and gain knowledge for certification as a Registered Vascular Technologist and to take the Physician Interpretation Exam while observing and performing diagnostic vascular examinations.

### Teaching

Teaching activities included seminars for medical students, rounds with medical staff members and residents and there were bi-weekly teaching sessions which were a combination of didactic and interactive lectures. Fellows ran a monthly journal club as well as participating in weekly endovascular conferences. Fellows were also involved in vascular surgery, round table case, and morbidity and mortality conferences. In addition I had the opportunity to attend a number of meetings.

### Northwestern vascular symposium: Chicago 2008

The course spanned two and a half days, covering open surgery involving carotid artery, the abdominal aorta,

thoracic aorta, peripheral arteries and venous systems. In addition, there were debates where experts discussed the relative merits of open and endovascular treatments for a variety of common vascular diseases.

### 25th Annual UCLA symposium *What's New in Vascular Surgery*

This five-day course provided an in-depth review of the specialty of vascular surgery. An internationally recognized faculty presented a comprehensive survey of generally accepted views, including basic science, pathogenesis, diagnosis, and management of the broad spectrum of vascular disorders. In addition, each speaker reviewed the important new developments, as related to their topic, that have taken place within the last year. As such, this course was a complete didactic review of the specialty of vascular surgery, together with an update of new material.

## Conclusion

Vascular surgery has evolved to become quite distinct from general surgery both in terms of clinical practice and service delivery. The most striking change has been the rapid adoption of endovascular techniques. Although endovascular aneurysm repair (EVAR) sub-intimal angioplasty and carotid stenting are more recent developments, basic angioplasty techniques have already replaced conventional surgical techniques in many areas. Open surgery, when it is undertaken is now more complex and challenging in patients unsuitable for endovascular treatment. Emergency work forms a major component of vascular service workload. This includes ruptured aneurysms, ischaemic limbs, trauma and the vascular complications of diabetes. It is likely that many of these conditions will be treated by endovascular methods in the future.

The service needs of the future will be for a Vascular specialist who can provide open and endovascular treatment as well as medical care for patients with Vascular disease. This fellowship has equipped me with the expertise and experience to meet these needs.



## Fundraising with per una - over £100,000 donated

As you may be aware, per una founder George Davies has designed a range of fitness wear with 20% of the profits donated to The Circulation Foundation.

The range was launched on 9th of January this year in Marks and Spencer stores nationwide and has been a resounding success with stocks selling out. To date the range has raised over £110,000 for the Circulation Foundation, our most successful campaign to date.

**per una** and **Marks and Spencer** stores up and down the country really embraced the Circulation Foundation and, alongside the clothing line, held charity events to help raise money and awareness. The Teeside branch raised £1,300 pounds by organising a charity raffle, this amount was then kindly matched by Marks and Spencer. The range of clothing also received some really positive press coverage with the range being reported in many regional newspapers and Sunday supplement magazines.

At the present time the CF are in talks with George Davies and per una about a second range of fitness clothes for Spring 2009. We would like to sincerely thank Sir Peter Bell for introducing George Davies to the Circulation Foundation. This relationship has proved invaluable to us, as not only has it generated a significant income but it has also helped raise awareness locally of vascular disease.

### Donor Drinks Reception Evening September 11th 2008

We are pleased to announce that we will be holding a drinks reception for all major donors to the Circulation Foundation, members of the Committee and previous grant recipients. This event will give donors the opportunity to meet with grant recipients and be able to talk to them about their research, and more importantly for us to say "thank you" for giving generously over the last year. If you donate to the Foundation and would like to attend, or would like any further information, please contact Rebecca Wilkinson at [rebecca@vascularsociety.org.uk](mailto:rebecca@vascularsociety.org.uk) or call on 020 7304 4779.

### Goodbye and Hello

The Society said farewell in April to Terrie McCann, who had worked for the Circulation Foundation for two and a half years. Terrie left to pursue her career with a fundraising consultancy company, and we wish her well in her endeavours. Rebecca Wilkinson has now taken on this role and would be pleased to meet with Members to discuss fundraising initiatives.



### NHS Regatta

Andrew McIrvine and his crew took to the waves again this year for the NHS Regatta. They came 7th out of 59 boats and raised £700 for the Circulation Foundation. Thanks also to VNUS Medical Technologies for providing help with sustenance for the sailors and the nautical fleeces modelled in the photo.

### Vascular Disease Awareness and Patient Support Groups

In association with the Society of Vascular Nurses, the Circulation Foundation is in the process of creating Vascular Disease Awareness and Patient Groups to give support to patients and their families, and also to raise awareness of vascular disease locally. These Groups will be formed initially in London, and include patients from the five London hospitals. Once these groups have proved successful we will be launching them nationwide. If you would like to be involved or have any suggestions or ideas, please email [Rebecca@vascularsociety.org.uk](mailto:Rebecca@vascularsociety.org.uk) or call 020 7304 4779.

### VNUS

The Foundation is very grateful to Mr Ian Franklin, Consultant Vascular Surgeon, Charing Cross Hospital for arranging with VNUS Medical Technologies Ltd to provide a monthly donation in return for the collaboration they have with the hospital for providing their VNUS closure procedure for training purposes.

## Nominations for Membership of Council

There will be three vacancies on Council in November this year, due to the completion of the terms of office of Mr Rod Chalmers, Professor Jonathan Michaels and Mr David Mitchell. A nomination form is enclosed which should be returned to the Secretariat by Monday 1st September 2008.

Members elected to Council become Trustees of the Charity, and have a responsibility to act in accordance with Charity Commission regulations in achieving the Society's objectives:

- To take part in formulating and regularly reviewing the strategic aims of the organisation

- To ensure that the policy and practices of the organisation are in keeping with its aims
- To ensure that the organisation functions within the legal and financial requirements of a charitable organisation and strives to achieve best practice.

The Council meets four times a year - February, May, September and November, and Council Members may be asked to serve on the Society's working committees - Audit and Research, and Training and Education. The Council also meets with the Vascular Advisory Committee twice a year.



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### VAC Appointments

The role of the Vascular Advisor should be to represent The Vascular Society in service, training and education matters relevant to vascular surgery within their Deanery, primarily reporting to The Vascular Society Council via the Vascular Advisory Committee (VAC). The Vascular Advisor should develop close links with the Regional Speciality Advisor in General Surgery.

The following were recently elected as VAC advisors for their region:

Mr Craig Irvine, Yorkshire

Miss Susan Hill, Wales

Mr Timothy Magee, Oxford

### Applications invited for an Operating Theatre Team Tutor

The Raven Department of Education wishes to appoint a surgeon on a sessional basis to assist the Director of Education in the development of the operating theatre team education programme. This will include using the new Eagle 2 clinical skills area which will be open by the end of 2008. One of the innovative areas in Eagle 2 is the Mock Operating Theatre and the provision of such a facility will enable cutting edge programmes to be developed to support safe theatre practice, team working and dealing with emergencies.

For a full job description, person specification and details on how to apply please follow this link:  
<http://www.rcseng.ac.uk/education/pdprojects.html>

## VSGBI Membership

### Welcome to the following new members of the society

#### Ordinary

<b>Mr Marcus Brooks</b>	Bristol Royal Infirmary
<b>Mr Francis Dix</b>	Derriford Hospital, Plymouth
<b>Mr Robert Fisher</b>	Royal Liverpool University Hospital
<b>Mr Thomas Nicholas</b>	North Cheshire Hospitals NHS Trust

#### Affiliate

<b>Mr Ahmed Assar</b>	Luton and Dunstable Hospital
<b>Miss Sarah Hulin</b>	Royal Bournemouth Hospital
<b>Mr William Neary</b>	Derriford Hospital, Plymouth
<b>Mr Mark Grannell</b>	Royal Shrewsbury NHS Trust
<b>Mr David Cooper</b>	Addenbrookes Hospital, Cambridge

### Subscription Rates for 2008

Ordinary	£175
Affiliate	£100
Associate	£100
Overseas	£100
Senior	£35

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.

### New Major Sponsor

The Society welcomes Maquet Cardiovascular as its sixth Major Sponsor. Maquet combines the vascular surgery business of Boston Scientific within its current portfolio of perfusion systems.

Maquet will be exhibiting within the Major Sponsors area at the Vascular Society's Annual Meeting in Bournemouth in November.




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## The Vascular Society of Great Britain and Ireland

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### OFFICERS

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