# South West Vascular Surgeons

## 41st Annual Meeting
## Royal Bournemouth Hospital
## Friday 15th March 2019

## Incorporating the SWVS Masterclass
## Thursday 14th March 2019

## Previous Meetings

| | | | |
|---|---|---|---|
| **1979** | **Exeter** | **2000** | **Reading** |
| **1980** | **Cheltenham** | **2001** | **Salisbury** |
| **1981** | **Plymouth** | **2002** | **Llantrisant** |
| **1982** | **Poole** | **2003** | **Bournemouth** |
| **1983** | **Swindon** | **2004** | **Treliske** |
| **1984** | **Cardiff** | **2005** | **Oxford** |
| **1985** | **Bath** | **2006** | **Bristol** |
| **1986** | **Yeovil** | **2007** | **Swansea** |
| **1987** | **Southampton** | **2008** | **Southampton** |
| **1988** | **Oxford** | **2009** | **Cheltenham** |
| **1989** | **Bristol** | **2010** | **Swindon** |
| **1990** | **Swansea** | **2011** | **Cardiff** |
| **1991** | **Gloucester** | **2012** | **Worcester** |
| **1992** | **Portsmouth** | **2013** | **Plymouth** |
| **1993** | **Torbay** | **2014** | **Taunton** |
| **1994** | **Bridgend** | **2015** | **Bristol** |
| **1995** | **Barnstaple** | **2016** | **Oxford** |
| **1996** | **Winchester** | **2017** | **Cheltenham/** |
| **1997** | **Taunton** | **Gloucester Vasc Network** | |
| **1998** | **Newport** | **2018** | **Exeter** |
| **1999** | **Exeter** | **2019** | **Bournemouth** |

## Future Meetings

| | | | |
|---|---|---|---|
| **2020** | **Swansea** | **2021** | **Truro** |

**This book contains:**

- Details of venue and directions
- Sponsors
- Programme and Abstracts
- Constitution
- SWVS members names and addresses

# Meeting Venue

**Postgraduate Centre**
**Royal Bournemouth Hospital**
**Castle Lane East**
**Bournemouth**
**BH7 7DW**

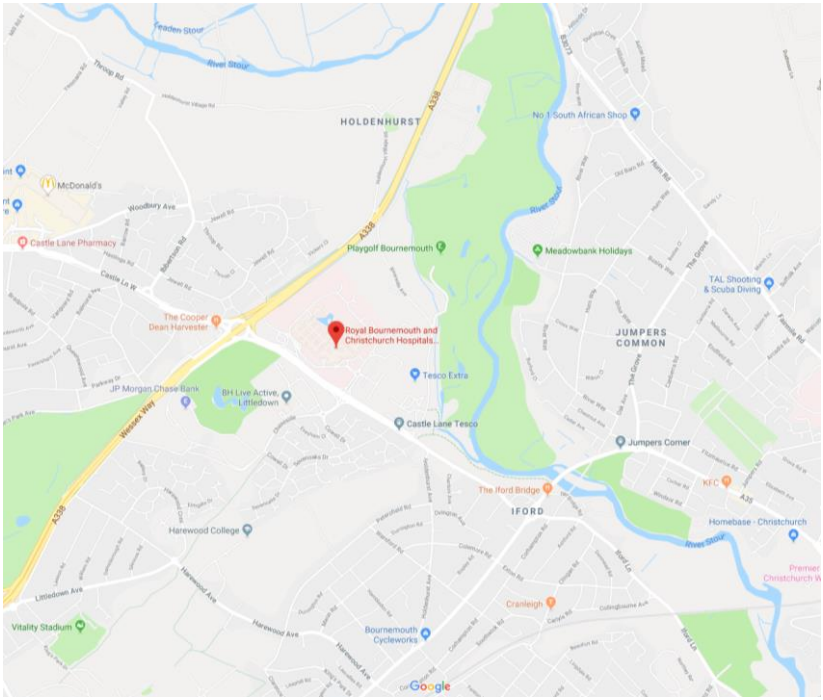
**South West Vascular Surgeons Masterclass**
**Thursday 14th March 2019**
**&**
**South West Vascular Surgeons main meeting**
**Friday 15th March 2019**

**Masterclass Dinner**
**Thursday 14th March 2019**
**(Registrants/Faculty)**
**7.00 for 7.30pm**
**The Boathouse**
**Christchurch**
**BH23 1BU**

## Directions:

## Be aware the Roadworks adds at least 30 minutes to the journey time predicted on your sat nav!

If you plan to use the A338 between Ringwood and the hospital (i.e. from the north or east) then watch out for severe delays especially during rush hour. https://www.dorsetforyou.gov.uk/travel/travel-dorset/a338-travel-updates.aspx




**Parking**

**There is pay and display in the hospital car parks. Alternatively, if you are staying at The Village Hotel there is free parking there and it is a 2 minute walk to the hospital.**

## South West Vascular Surgeons <u>Masterclass</u> meeting registration opens from 10.00 am on Thursday 14th March 2019

## Registration for the South West Vascular Surgeons main meeting will take place from 9.15 am on Friday 15th March 2019

## GENERAL INFORMATION

The local organiser Mr Lasantha Wijesinghe and colleagues from the Dorset & Wiltshire Vascular Network are pleased to welcome you to the 41st meeting of the South West Vascular Surgeons.

The meetings have been generously supported by companies, who will be exhibiting their products at the meeting.

***Please take the opportunity to visit the exhibition during the coffee and lunch breaks.***

# Presentations

**These should be no more than 7 minutes to allow 3 minutes for questions.**

Please name your file so it can be easily identified (i.e. Name of presenter, Vascular Unit and Keyword if more than one abstract).

Please note that if your presentation contains video or other content likely to cause issues, it is recommended that you use the presentation format of Powerpoint, and check that it plays after loading to the laptop.

**It is recommended that you bring your presentation with you on an USB memory stick on the day and that it is compatible with Microsoft Powerpoint.**

A computer will be available on the day to check your presentation displays correctly. Please check before 09.15 hours, or in the lunch break before your presentation session. Unfortunately it will **not** be possible for presenters to use their own computers for presentation.

**POSTERS – to be mounted before morning registration**
**Portrait - A0 size - 841 x 1189 mm 33.1 x 46.8 in**

## Educational Grants

We are extremely grateful to the following companies who have confirmed educational grants to support this year's meeting (correct as at time of printing):

Silver Sponsors:

Angiodynamics
Cook UK
Frontiere Medical
LeMaitre
Terumo Aortic/Vascutek

Bronze Sponsors:

Acelity
Aquilant
Bayer
Bentley
CR Bard
Huntleigh
Medtronic
Promed
STD Pharmaceuticals

**Vascular Masterclass**
**In Conjunction With**
**South West Vascular Surgeons**
**Thursday 14th March 2019**

**Venue: Postgraduate Centre, Royal Bournemouth Hospital**
**Registration 10.00am**
Start 10.30am

Groups and rotation through stations to be confirmed on the day.

1. Wire and catheter skills and deployment of stent graft in a glass model - Cook.
2. a) Ultrasound guided cannulation of mock GSV and endovenous laser procedure on a model leg – Angiodynamics
b) USS guided puncture & wire skills - Frontiere Medical
3. Frailty of the vascular patient. Assessment and discussion of cases.
4. Critical Care of the vascular patient. Discussion of management (viva voce style)
5. Carotid shunt insertion and removal on model neck. Pruitt, Javid and Burbank – Le Maitre
6. Tunnelling and anastomosis of femoral bypass on model leg - Le Maitre
7. Vascular cases – discussion (viva voce style)
8. Duplex ultrasound – Carotid (on a live model)
9. Duplex ultrasound – Leg (on a live model)
10. Endovascular Simulator for deployment of stent graft – Vascutek/Terumo

**Day Summary Mr. Lasantha Wijesinghe**

Masterclass Dinner (Registrants/Faculty) – 7.00pm for 7.30pm
The Boathouse, Christchurch, BH23 1BU

**Faculty:**

Lasantha Wijesinghe, Louis Fligelstone, Ashok Handa, Ian Hunter, Rebecca Winterbourne, Nandita Pal, Chris Lee, Robin Windhaber, Harun Gajraj, Rachel Barnes, Paul Bevis, Ken Woodburn, Ioannis Vlachakis. Local Vascular Scientists from Royal Bournemouth Hospital and key industry experts

# MAIN PROGRAMME – Friday 15th March 2019

**09.15 Registration, Coffee & Visit Trade Stands**

**09.45 Welcome: Lasantha Wijesinghe**

**0950 Setting up new vascular service in the Cayman Islands Robin Windhaber**

## Session 1 - Trainee Presentations
## Chairs: Mr Dean Godfrey & Paul Bevis

10.20 **Investigating Major Limb Amputation Caseload in a Post-Centralised Vascular Network**
W. Farthing[1] (Med Student), M Phillips[2], AD Godfrey[3]
[1]University of Southampton, [2]Wessex Vascular Network and 3Dorset and Wiltshire Vascular Network

10.30 **Evaluation of Performance for Major Lower Limb Amputation Surgery**
C. J. White, B. Akram, D. McLain, P. Lewis, D. R. Lewis
Aneurin Bevan University Health Board

10.40 **Return to Theatre – A Single Centre Observational Cohort Study of Vascular Amputations and Debridement in 2018**
Mr A Walsh, Dr L Jones, Dr P Hanna
Vascular Surgery, Southampton General Hospital

10.50 **Outcomes after Turndown for Elective Abdominal Aortic Aneurysm Surgery**
AD Godfrey, E Elbaz, LD Wijesinghe, J Craig
Dorset & Wiltshire Vascular Network, Royal Bournemouth Hospital

11.00 **Ruptured Aortic Aneurysms - Time to ED, CT, Intervention and Outcome. A retrospective audit**
A.Proudley, D. Rittoo, L.Wijesinghe, A.Watson, J.Metcalfe, S. Hulin, C. Lee, A. Godfrey. I, Vlachakis
Dorset & Wiltshire Vascular Network, Royal Bournemouth Hospital

**11.10 11.40 Morning Coffee – please ensure you visit the trade stands**

## Session 2 - Trainee Presentations
## Chairs: Mr Ioannis Vlachakis & Mr. Kevin Conway

11.40 **Are we complying with NICE guidelines for the medical management of critical ischaemic limb pain? A closed-loop study**
EN Kirkham, K Miller, DG Cooper
Department of Vascular Surgery, Cheltenham General Hospital

11.50 **The use of antiplatelets and anticoagulants in patients undergoing endovascular revascularisation for PAD**
Hang Long Li Medical Student, G K Ambler, C Twine, R J Hinchliffe.
The University of Bristol

12.00 **Outcomes for symptomatic carotid stenosis between 50-69% managed conservatively: a single centre experience**
N-M Goh; A Guy; R McCarthy; I Currie
Torbay and South Devon Foundation NHS Foundation Trust

12.10 **Atherectomy for peripheral arterial disease**
B G Wardle (speaker), G K Ambler, R J Hinchliffe, C P Twine
North Bristol Trust, University of Bristol

## Invited Speakers

12.20 **Pelvic vein reflux: a survey of vascular surgeons in the UK**
B Campbell [1], S Goodyear [2], K Poskitt [3], I Nyamekye [2], I Franklin [4]
Royal Devon and Exeter Hospital [1]; Worcestershire Acute Hospitals NHS Trust [2]; Cheltenham Vascular Unit [3]; London Vascular Clinic [4]

12.30 **Montgomery and me…** **Professor Ashok Handa**

**12.50 13.50 Lunch, Poster Presentation adjudication and Trade Exhibition**

**PLEASE ENSURE YOU MAKE THE MOST OF THE OPPORTUNITY DURING THE LUNCH HOUR TO VISIT THE TRADE STANDS WITHOUT THEIR SUPPORT THIS MEETING WOULD NOT RUN**

## Poster Presentations

**Antibiotic irrigation and conservative surgery in a patient with axillo-bifemoral extra anatomic bypass reconstruction**
S.Tann, S. Hulin, A.Watson, I.Vlachakis
Dorset and Wiltshire Vascular Network

**Mycotic Aneurysm of Brachial Artery Secondary to Infective Endocarditis**
Dr R. Simson, Dr T. Jacobs, Mr S. R. Kulkarni
Gloucestershire Hospitals NHS Foundation Trust, Cheltenham

**Long Posterior Flap versus Skew Flap in Below-Knee Amputation and Risk of Wound Complications: A Retrospective Cohort Study**
C. J. White, B. Akram, D. McLain, P. Lewis, D. R. Lewis
Aneurin Bevan University Health Board

**The Struthers' Conundrum**
J Manson, A Sharrock, R Allison, N Purohit, G Morris
Southampton

**Patients' Self-Reported Claudication Distance – How reliable is this?**
WMR Hamilton, CW O'Learey, C Thomson, AH Templeton, LD Wijesinghe
Dorset and Wiltshire Vascular Network

**Cerebral Hyperperfusion syndrome after carotid endarterectomy**
M Weisters, D Urriza Rodriguez, D Howard
Oxford University Hospitals

## Session 3 – Trainee Presentations
## Chairs: Mr Alex Watson & Mr. Ian Hunter

13.50 **Exploring the association between frailty and outcome in patients undergoing lower-limb revascularisation for critical ischaemia – a pilot study**
M Hewton*, I Nordon
Surgery Research Group, Department of Vascular Surgery, Faculty of Medicine, University of Southampton, Southampton General Hospital, Southampton UK - [*Undergraduate medical student]

14.00 **Bored round or board round? - Is it of any use?**
M Dewi1, R Slade1, L Fligelstone2
West Wales Vascular Unit, Morriston Hospital, ABM University Health Board, Swansea

14.10 **Surgical Frailty Services – The Expanding Multidisciplinary Team**
AH. Templeton, D. Sell, R Finn, L Wijesinghe
Dorset & Wiltshire Vascular Network

14.20 **GIRFT Reports – Are they getting it Right?**
EN Kirkham, D Windsor, DG Cooper, SR Kulkarni
Department of Vascular Surgery, Cheltenham General Hospital

14.30 **Case Ascertainment in Vascular Surgery: The importance of accurate data in clinical decision-making**
RD Slade[1],. L Fligelstone[2]. CG Davies[2]
[1] Core Surgical Trainee, [2] Consultant Vascular Surgeon
West Wales Vascular Unit, Morriston Hospital, ABM University Health Board, Swansea

14.40 **Revascularise at all costs: are the costs of revascularisation justified in avoiding amputation in a cash-strapped health service?**
D Urriza Rodriguez[1], D P J Howard[1,2]
[1] Department of Vascular Surgery, John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust
[2] Nuffield Department of Surgical Sciences, University of Oxford

14.50 **Influence of Trainer Role, Subspecialty and Hospital Status on Consultant Workplace-based Assessment Completion**
L Hopkins, A Latif, D Robinson, C Brown, T Abdelrahman, R Egan, A Iorwerth, R Egan, MJ Pollitt, WG Lewis
School of Surgery, Health Education and Improvement Wales, Nantgarw, Cardiff

15.00 **Core Surgical Trainees perspectives on a career in Vascular Surgery**
T Hardy, A Botes, D Scourfield-Evans, B Fruhstrofer
Royal Devon and Exeter Hospital

15.10 **Diagnosing Endovenous Heat Induced Thrombosis (EHIT): is it rational or relevant?**
GA Ahmed, I Nyamekye
Worcestershire Royal Hospital

## Invited Speakers

15.20 **Endothermal ablation for incompetent lower limb perforators associated with chronic venous insufficiency. Is it worth the bother?**
K.R Woodburn
Cornwall Vein Clinic, Duchy Hospital, Truro, Cornwall

15.30 **Update from Vascular Council** **Rachel Barnes**

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## 15.35 SWVS Annual General Meeting for Members

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**15.30 Afternoon tea for trainees & members**

**Please visit the trade stands**

**Session 4 – Invited Speakers**
**Chairs: Professor Ashok Handa & Mr Louis Fligelstone**

**16.05** **Paediatric Emergencies & follow up – are we getting it right?**
**Miss Meryl Davies, Royal Free Hospital**

16.25 **A new regional pathway for thoracic aortic dissection**
**Mr. Paul Bevis, on behalf of the Bristol, Bath, Weston Vascular Network**

16.35 **Announcement of Prize Winners & Meeting close**

# Notes

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10.20

## Investigating Major Limb Amputation Caseload in a Post-Centralised Vascular Network

**Mr.William Farthing[1], 4th Year Medical Student, Mr.Michael Phillips[2], Consultant Vascular Surgeon, Mr.Anthony Dean Godfrey[3] ,Consultant Vascular Surgeon**

**Institutions: [1]University of Southampton, [2]Wessex Vascular Network and [3]Dorset and Wiltshire Vascular Network**

### Introduction

In 2008, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) data demonstrated poor major limb amputation (MLA) outcomes, the majority performed by junior doctors. Ensuing NCEPOD recommendations contributed towards service reconfiguration nationwide, driving towards centralisation. We review MLA cases in a centralised vascular network, comparing with these service recommendations.

### Methods

Using hub and spoke site patient records and operative theatre logs, we identify (vascular) MLA cases over one year, ending May 2018. Operative data were cross-referenced for time, theatre location, lead surgeon and supervision, in addition to all-cause mortality. Data are compared to NCEPOD and Vascular Services Quality Improvement Programme (VSQIP) recommendations.

### Results

We identify 121 MLA (115 patients), a 26% increase on predicted case volume (pre-centralisation). Transtibial:transfemoral split of MLA was n=61:60, contrasting with national practice (n=~70:30). 92% of transtibial amputations were performed in normal hours, of these, 60% were in vascular lists. All transfemoral amputations were in-hours, 60% in vascular theatres. Transtibial MLA one year all-cause mortality was 4.9% (VSQIP in-hospital mortality 6.7%) and 10% in transfemoral (in-hospital mortality 12.4%). In designated vascular lists, consultants performed or supervised 76.5% of amputations; compared with 33.3% on non-vascular lists. Trainees performed 68.6% of 'emergency' MLA, 77.1% consultant supervised (67.2% NCEPOD [2014]).

### Conclusion

We perform this review to understand caseload in a centralised vascular service. Ultimately, we find good performance against national mortality and MLA supervision (in vascular lists) data. Supervision rates in non-vascular lists may reflect unscheduled caseload rises and hub-site capacity limitations for this. The opportunity to further optimise patient outcomes and MLA training is present in high case volume units in line with VSQIP and GIRFT recommendations.

**Evaluation of Performance for Major Lower Limb Amputation Surgery.**

**C. J. White, B. Akram, D. McLain, P. Lewis, D. R. Lewis.**
**Aneurin Bevan University Health Board.**

**Introduction**

We aim to evaluate local performance for major lower limb amputation surgery against the Vascular Society of Great Britain and Ireland Best Practice Clinical Care Pathway. Criteria (targets): National Vascular Registry submission (100%), below-knee amputation: above-knee amputation ratio (>1), consultant present in theatre (100%), admission to a recognised arterial centre (100%), multidisciplinary team assessment (100%), a pain management protocol (100%), and specialist rehabilitation referral (75%).

**Methods**

Retrospective data collection for patients undergoing major lower limb amputation surgery for vascular disease at an accredited arterial centre between 01/01/2017 and 01/01/2019.

**Results**

Below-knee amputations were performed in 55 patients and above-knee amputations were performed in 38 patients. Targets were met for below-knee amputation: above-knee amputation ratio (1.45), admission to a recognised arterial centre (100%), multidisciplinary team assessment (100%), a pain management protocol (100%), and specialist rehabilitation referral (78%). For National Vascular Registry submission (65%) and consultant present in theatre (88%) targets were not met.

**Conclusion**

Performance for major lower limb amputation surgery does not meet recognised standards. Improvements should be made to encourage delivery of a safe and effective service.

**Return to Theatre – A Single Centre Observational Cohort Study of Vascular Amputations and Debridement in 2018**

**Mr A Walsh, Dr L Jones, Dr P Hanna**

**Vascular Surgery, Southampton General Hospital**

**Introduction**

Further debridement and higher levels of amputation are a common event in Vascular Surgery, incurring longer hospital stays, repeated anaesthetic risk, and reduction in function for patients. This study sought to identify the frequency of this occurring, the reasons for this, & if there are any variables which predict it.

**Methods**

Electronic operation records were retrospectively utilized to identify amputation or debridement performed by Vascular Surgery in Southampton General Hospital in 2018. Variables recorded were age and gender of patient, emergency or elective admission, referral area (Southampton, Portsmouth, Isle of Wight, Winchester), diabetic status, if the patient required a return to theatre within 30 days of the original procedure, and why they returned to theatre. Binomial regression analysis was performed in SPSS to see which variables were statistically significant.

**Results**

404 operations were identified, performed on 323 patients. 77 patients underwent a further operation within 30 days. The most common reasons for return to theatre within 30 days were higher level of amputation (N=33), debridement (N=30), formalisation of guillotine amputation (N=7), further toe amputation (N=5), and contralateral amputation/debridement required (N=2). Statistically significant variables in predicting a return to theatre were male gender (OR 2.276, 95% CI 1.14-4.53, p=0.019) and emergency admission (OR 2.164, 95% CI 1.18-3.94)

**Conclusion**

Although emergency admission was an expected predictor for return to theatre, a patient's diabetic state and their primary referral area, an increasing concern in tertiary care, were not. The significance of male gender impacting on a return to theatre is may be secondary to a non-observed confounding factor, such as delay in presentation to medical professional or poor self-care.

**Outcomes after Turndown for Elective Abdominal Aortic Aneurysm Surgery**

**Godfrey AD, Elbaz E, Wijesinghe LD, Craig J**
**Dorset and Wiltshire Vascular Network**

**Introduction**

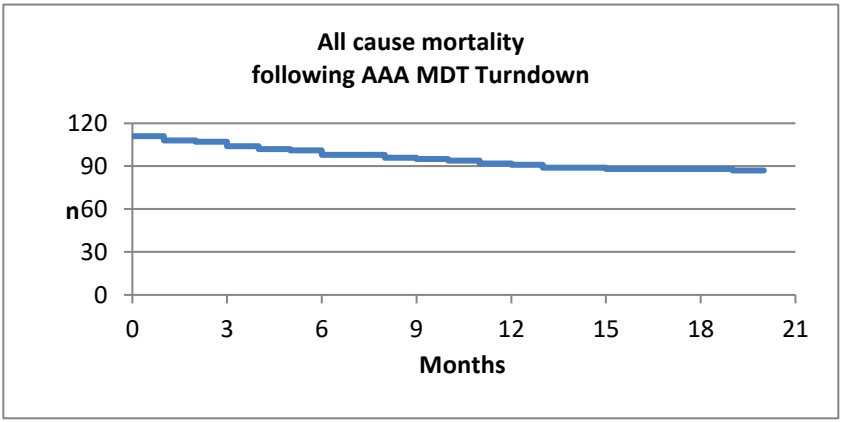
In an era of physiological assessment, risk stratification, Montgomery informed consent and a sharp focus on outcomes- AAA practice evolves. In those who 'turndown' aortic aneurysm repair, outcome is poorly understood and so counselling patients in this regard is challenging. We perform a review of AAA turndown cases.

**Methods**

Prospective collated database of MDT turndown patients (October 2016- February 2019) were analysed to identify healthcare activity or mortality outcomes.

**Results**

We identified 114 turndown patients- 2 had no registration data and were censored from further analysis. Median age was 85.1years (IQR 10.2yr); median AAA size was 60mm (IQR 8.8mm); median follow-up was 329days post MDT decision (IQR 460d).




Twenty-four patients (21.4%) were deceased with a median survival 168.5 days (IQR 236d) after MDT turndown. Patients who died had a propensity towards larger aneurysms (median 62.5mm [IQR 13.25] vs 60mm [IQR 8], p=0.21).
Of those who died, sixteen had confirmed cause of death: 31.3% rupture, 37.5% malignancy, the remnant were cardiorespiratory disease. There was a significant AAA size difference between those dying of rupture or not (70mm v 59mm, p=0.045). In the same period, 148 elective AAA repair, 47rAAA (mortality 0.03% and 0.15% respectively).

**Conclusion**

Over three quarters of turndown patients were alive at follow up- median survival 329days (range 20-834). Those with larger AAA would appear to be more likely to die from rupture than other comorbidities.

**Ruptured Aortic Aneurysms - Time to ED, CT, Intervention and Outcome. A retrospective audit.**

**A.Proudley, D. Rittoo, L.Wijesinghe, A.Watson, J.Metcalfe, S. Hulin, C. Lee, A. Godfrey. I, Vlachakis.**

**Dorset & Wiltshire Vascular Network, Royal Bournemouth Hospital**

## Introduction

NICE is currently developing guidance on the management and diagnosis of Abdominal Aortic Aneurysms.1 There's a current recommendation that transfer to a specialist unit should occur within 30 minutes of diagnosis.2 No recommendations of intra-hospital timings when arriving at specialist vascular centre are yet available. We decided to look at our timings to see if there are any areas for improvement from arrival to receiving definitive treatment.

## Methods

A retrospective audit, looking at patient electronic records. We identified 28 patients between 1/1/17 to 31/10/18 who presented and underwent intervention of a ruptured AAA. We identified timings of arrival in the Emergency Department, if they were transferred from a peripheral hospital in the vascular network, the timing of arriving in Emergency Department to getting a CT if they were stable & the time they arrived in theatres, type of intervention & 30 day outcome.

## Results

Of the 28 patients identified 20 (71%) survived greater than 30 days. 21 (75%) under went an open repair compared with 7 (25%) undergoing an EVAR. Of the 12 patients we were able to obtain ambulance data on the median time from ambulance arriving on scene to the Emergency Department was 01:30 (00:25-05:18). 17 patients (61%) were stable enough for a CT; with the median time from arrival in the Emergency Department to going to the CT scanner of 00:46 (00:10 – 04:10). The median time from arriving in the Emergency Department to getting to Theatres was 01:15 (00:32 – 05:31), with the median time of 02:51 (01:37 – 05:08) spent in the operating theatre. 11 patients were transferred from peripheral hospitals within the vascular network; we were able to identify the total time spent at a peripheral hospital for 5 patients. The median time was 01:46 (00:44 – 02:41) including travel and diagnostic time.

## Conclusion

The audit has revealed our mortality of 29% is in line of those of ruptured abdominal aortic aneurysms nationally. It has allowed us to identify areas of the patient's pathway that could be more streamlined in both Open and EVAR repairs, such as time taken to get to CT and to theatre. It's identified potential outliers and created a discussion around why things have taken that long and the potential for setting local targets to audit against in the future, as well as having data ready in preparation for the release of NICE guidelines on the management and diagnosis of AAA.

**Are we complying with NICE guidelines for the medical management of critical ischaemic limb pain? A closed-loop study.**

**EN Kirkham, K Miller, DG Cooper**
**Department of Vascular Surgery, Cheltenham General Hospital**

**Introduction:**
The National Institute for Clinical Excellence (NICE) guideline CG147 Section 1.6; 'Lower limb peripheral arterial disease: diagnosis and management', provides guidelines for the best practice management of critical limb ischaemic pain. It states, all patients should have paracetamol, and either weak or strong opioids prescribed, with laxatives and anti-emetics to manage adverse effects. We assess our compliance with these guidelines.

**Methods:**
Consecutive patients admitted with critical limb ischaemia, as classified by stage III or IV peripheral vascular disease in the Fontaine Classification, admitted to our vascular ward were recruited and their drug chart reviewed. After initial data collection and presentation, we instituted a number of quality improvement interventions to optimise our management of these patients; including education, utilisation of a surgical clerking proforma, information in the foundation-doctor handbook and use of visual displays. A further three-week data collection was completed to re-audit the effectiveness of these changes.

**Results:**
Twenty patients were analysed in each cycle. Initially, only 16 (80%) had regular paracetamol; improving by 20% to all 20 patients following education. Similarly, only 12 (60%) had any PRN analgesia prescribed; which improved to all 20 (40% improvement) upon re-audit. The availability of morphine for breakthrough pain improved by 35%, from 50% (n=10) to 85% (n=17). Only 2 (10%) had laxatives and 4 (20%) anti-emetics prescribed in the first round, which improved by 65% and 55% respectively to 15 (75%) in both groups in the second cycle.

**Conclusion:**
Targeted and appropriate education for health professionals achieves far greater compliance with NICE guidance for best practice initial pharmacological management of patients admitted to hospital with critical limb ischaemia.

**The use of antiplatelets and anticoagulants in patients undergoing endovascular revascularisation for PAD**

**Hang Long Li Medical Student, G K Ambler, C Twine, R J Hinchliffe.**
**The University of Bristol**

**Introduction**

Endovascular interventions are an effective treatment strategy for patients with symptomatic peripheral artery disease (PAD). Antiplatelet agents and anticoagulants are usually prescribed to reduce adverse events. However, no standardised guidance on the most appropriate therapeutic strategy exists.

**Methods**

A systematic review and narrative synthesis was performed, searching Medline, Embase and the Cochrane library from inception until November 2017 for randomised controlled trials (RCTs) of endovascular interventions for PAD. Peri-procedural and post-procedural antiplatelet and anticoagulant protocols were extracted and classified according to the agents used and which endovascular interventions were being trialled. For post-procedural protocols, drugs specified as being given for a period of no longer than 3 months after the intervention were considered to be given in an intensive phase. Drugs specified as being given after the procedure with no stop date were considered to be given in a maintenance phase.

**Results**

103 RCTs with 85 different antiplatelet and or anticoagulant protocols were identified, and 69% of the trials failed to specify one single protocol for all the subjects, showing that different participants may have received different drug protocols. 47% of the trials employed both antiplatelet and anticoagulant, and over 20% of the trials did not mention whether antiplatelet, or anticoagulant, or both, were used for all subjects. DAPT and heparin were the mostly used antiplatelet and anticoagulant respectively. In sub-group analysis, where the usage of each agent by each endovascular intervention were compared, and it was found that newer interventions, such as drug-eluting stent, had a higher tendency to use a more aggressive drug regimen, such as DAPT, rather than a less aggressive drug regimen, such as aspirin.

**Conclusion**

In randomised clinical trials of endovascular interventions for PAD there was a significant heterogeneity in the use and duration of antiplatelet and anticoagulant therapy. Within a significant proportion of trials subjects may have received different anti-platelet and anti-coagulant interventions. In order to estimate the effectiveness of new endovascular revascularisation techniques/technology it will be important to standardise the delivery of these drugs as co-interventions.

**Outcomes for symptomatic carotid stenosis between 50-69% managed conservatively: a single centre experience**

**Goh N-M; Guy A; McCarthy R; Currie I.**
**Torbay and South Devon Foundation NHS Foundation Trust**

**Introduction**

With the ongoing European Carotid Surgery Trial 2 (ECST – 2) and its accompanying 5-year Carotid Artery Risk (CAR) score, we sought to evaluate the outcomes for patients not having surgery due to borderline scores and other reasons.

**Methods**

All carotid duplex scans performed between January 2014 and August 2018 by Torbay and South Devon NHS Foundation Trust (TSDFT) were screened. Those with North American Symptomatic Carotid Endarterectomy Trial (NASCET) criteria stenosis between 50-69% were included. Patients who were asymptomatic or who were symptomatic and underwent carotid endarterectomy were subsequently excluded. Electronic records were then evaluated to assess for the incidence of subsequent TIAs or strokes amongst this cohort**.**

**Results**

163 scans with internal carotid stenosis between 50-69% were performed in this time period. 28 [17.2%] were asymptomatic. Of the remaining 135, 20 were offered and accepted operative management. Amongst the 115 who did not have surgery for various reasons, 17 [14.8%] had a subsequent TIA or stroke, though only 7 had symptoms related to the ipsilateral disease detected. Two of the patients who had a secondary event had a subsequent carotid endarterectomy. The remaining 98 [85.2%] had no hospital documentation suggesting further events.

The 1yr/5yr risk % calculations for the 7 patients incurring secondary events were:- N/A, >20/47.6, <5/11.4, 5.7/14.9 (11.2/28 if ulcerated), 7.3/18.9, 9.9/25.1 (19.2/44.4), <5/12.3

**Conclusion**

These results suggest a relatively high incidence of secondary events amongst patients with symptomatic carotid stenosis who did not have surgery. However, a high proportion of these events resulted from contra-lateral disease for which current guidelines do not propose operative management. As such we await the results from the ECST-2 trial to better assess whether changes to our initial evaluation of these cases could improve outcomes.

**Atherectomy for peripheral arterial disease**

**B G Wardle (speaker), G K Ambler, R J Hinchliffe, C P Twine**
**North Bristol Trust, University of Bristol**

**Introduction**

Aim: To evaluate the effectiveness of atherectomy compared to other established treatments for symptomatic peripheral arterial disease (PAD). This is important given its global use as a revascularisation option.

**Methods**

A systematic review and meta-analysis was performed in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. The Cochrane Central Register of Controlled Trials (CENTRAL) and the Cochrane Peripheral Vascular Diseases Specialised Register were searched from inception until August 2018 for randomised controlled trials comparing atherectomy and other established treatments for symptomatic PAD. Primary outcomes included primary vessel patency and all-cause mortality. Random effects models were used for meta-analysis.

**Results**

Seven trials were included comparing atherectomy vs. balloon angioplasty (BA) with or without and primary stenting. Trials were generally of poor quality, with significant risk of bias due to inadequate blinding and small trial sizes.
Six trials compared atherectomy vs. BA, including 372 patients and 425 treated lesions. Atherectomy was found to be associated with significantly lower rates of bailout stenting (RR 0.26 [0.09,0.74], P=0.01), dissection (RR 028 [0.14,0.54], P=0.0001) and balloon inflation pressures (Mean difference -3.68atm [-5.36,-2.01], P<0.0001). No significant differences were found for initial technical failure rates, patency, target vessel revascularisation, mortality, amputation, distal embolization or complication rates.

**Conclusion**

This review has identified poor quality evidence to support atherectomy as an alternative to BA. Although atherectomy reduced dissection, bailout stenting rates and balloon pressures, no difference was found in for any useful clinical indicators. Given the widespread practice, clear evidence base, and established gold standard guidelines for BA, atherectomy has no clear place in the routine treatment of people with PAD who are amenable to standard BA.

**Pelvic vein reflux: a survey of vascular surgeons in the UK**

**B Campbell [1], S Goodyear [2], K Poskitt [3], I Nyamekye [2], I Franklin [4].**

**Royal Devon and Exeter Hospital [1]; Worcestershire Acute Hospitals NHS Trust [2]; Cheltenham Vascular Unit [3]; London Vascular Clinic [4].**

**Introduction:**

Despite increasing interest in pelvic vein reflux (PVR) as a possible contribution to lower limb varicose veins (VVs) the existence, willingness to treat, and management of this condition remain variable and controversial. This survey investigated the practices of UK vascular surgeons.

**Methods:**

E mail questionnaire to 328 VSGBI members.

**Results:**

104 (32%) questionnaires were returned from all NHS regions in England, but with wide geographical variation. Of 100 respondents who treat VVs, 9% do not regard PVR (or ovarian reflux) as a pathological entity and 11% never investigate or treat it. Most frequent indications for investigation are labial (94%) and buttock/upper thigh (70%) VVs: the primary method is MR venography (46%) – only 16% use transvaginal duplex. Treatment modalities used are transcatheter coil embolization (89%), sclerotherapy via thigh VVs (47%) and transcatheter sclerotherapy (26%): for ovarian and internal iliac tributaries by 61% and ovarian veins only by 34%. Results are judged by clinical response (100%) and imaging (14%). 80% respondents treat <5 cases and only 5% treat >10 patients annually. NHS commissioners fund treatments in at least 56% areas.

**Conclusions:**

There is substantial variation in the indications and methods that UK vascular surgeons use to investigate and treat pelvic vein reflux. A minority do not recognise this condition and regard treatments as inappropriate. These results expose the need for more substantial evidence to guide practice and invite consideration of concentrating expertise in certain centres.

**Exploring the association between frailty and outcome in patients undergoing lower-limb revascularisation for critical ischaemia – a pilot study**

**M Hewton Medical Student*, I Nordon**

**Surgery Research Group, Department of Vascular Surgery, Faculty of Medicine, University of Southampton, Southampton General Hospital, Southampton UK -[*Undergraduate medical student]**

**Introduction**

Surgeons are presented with an increasingly aged and frail cohort of patients. This frail group may experience surgical success but not return to independent living. Frailty is generally assessed used walking metrics, which in the setting of severe peripheral vascular disease is useless. A tool that could assess frailty and predict outcomes would transform preoperative counselling in lower limb revascularisation. The aim of this study is to investigate the potential for hand-grip strength (HGS), in addition to other variables, to help determine outcome and discharge destination for patients undergoing lower-limb revascularisation for critical ischaemia.

**Methods**

Patients undergoing lower-limb revascularisation for critical ischaemia at University Hospital Southampton were recruited. HGS was measured using a Jamer Dynamometer. Patients also conducted the Frail Non-Disabled questionnaire as well as the Edmonton frail scale. Further data was collected from patient notes, surgical records and discharge summaries. Variables were subjected to simple descriptive and correlation statistics.

**Results**

The study recruited 10 patients with a median age of 74 years. Preliminary results indicate a negative correlation between age and HGS, meaning as you age your HGS decreases. This was expected due to both age and HGS being predictors for frailty. Patients who were discharged home to independence had a median HGS 15.3Kg higher than those who had a non-independent discharge outcome, indicating that there may be a use for HGS as an outcome predictor.

**Conclusion**

Although the results show some correlation between HGS and discharge status, it is not yet possible to infer the significance of the results due to the small number of subjects in the study. Therefore, further study is required to expand upon the current results.

**Bored round or board round? - Is it of any use?**

**M Dewi[1], R Slade[1], L Fligelstone[2]**
**[1] Core Surgical Trainee, [2] Consultant Vascular Surgeon**
**West Wales Vascular Unit, Morriston Hospital, ABM University Health Board, Swansea**

## Introduction

There is a growing pressure on inpatient surgical beds, so optimising patient discharges to avoid delays is important in vascular surgery units. One method to improve patient discharges is the use of a multidisciplinary board round before the traditional morning ward round. This multidisciplinary board round is used to highlight any patient issues and potential discharges.

## Methods

To improve the efficiency of the vascular surgery unit at Morriston Hospital, the department has worked with the management organisation KPMG. A daily board round was introduced and the number of medically fit vascular surgery patients was used as a proxy for the efficiency of the departments' discharges.

## Results

There has been a reduction in the number of medically fit vascular patients from 27% to 4%. There is also greater holistic care of vascular surgical patients with greater communication between medical, nursing and physiotherapy staff.

## Conclusion

There was initially a lack of engagement from some of the consultant body, but with increased use of the board round there was an improvement in both quantitative and qualitative outcomes for vascular patients. We advocate the use of a daily MDT board round before the morning ward round as a method to improve delays in patient discharges and improve their overall care.

**Surgical Frailty Services – The Expanding Multidisciplinary Team**

**AH. Templeton, D. Sell, R Finn, L Wijesinghe**

**Dorset & Wiltshire Vascular Network**

**Introduction**

The number of elderly and frail individuals undergoing surgery of all kinds is increasing. This group of patients are at a higher risk of post operative complications and longer hospitalisation. Models for the proactive management of the elderly surgical patient already exist with documented improvements in outcomes. These services however are not standard practice across surgical specialties. Here we aim to assess the impact of introduction of a Surgical Frailty Service within an NHS Trust.

**Methods**

In February 2018 a Surgical Frailty Service was established within a single NHS Trust. All patient reviewed by the Surgical Frailty Team from commencement to January 2019 were identified retrospectively from coded electronic data. Length of stay data was collated and compared to previous years.

**Results**

During the 11 months following introduction of the frailty service, 313 patients were reviewed across Vascular and General Surgery. Average length of stay following introduction was reduced from 5.5 to 4.4 days overall, and from 8.87 to 5.64 days in those over 85 years.

**Conclusion**

Provision of Surgical Frailty Services and comprehensive geriatric assessment significantly reduces length of stay in frail surgical patients.

**GIRFT Reports – Are they getting it Right?**

**EN Kirkham, D Windsor, DG Cooper, SR Kulkarni**
**Department of Vascular Surgery, Cheltenham General Hospital**

## Introduction

Getting it Right First Time (GIRFT) seeks to identify variations within NHS care to improve operational efficiency. The 2018 GIRFT Adult Anaesthesia and Perioperative Medicine Review of Gloucester Hospitals NHS Foundation Trust stated that our one-year mortality following elective abdominal aortic aneurysm (AAA) repair was 20% compared to 10% nationally. We report one-year mortality following all elective aneurysm repairs to compare with the GIRFT data.

## Methods

Data were collected for all patients that underwent elective AAA repair over a five-year period from November 2012 to November 2017 from the National Vascular Registry (NVR). Aneurysm repairs included open repairs, laparoscopic/laparoscopic-assisted repairs and EVARs. NVR and Hospital databases including TrakCare® and Infoflex® were used for data collection on mortality.

## Results

Some 324 elective AAA repairs were performed during the 5-year period. 50.0% (n=162) were open, 10.2% (n=33) were laparoscopic and 39.8% (n=129) were EVARs. Overall in-hospital; 30-day and one-year mortality was 0.9%; 0.9% and 3.1% respectively. Thirty-day and one-year mortality for open repairs was 1.2% and 3.1% respectively. For laparoscopic repairs, 30-day and one-year mortality was 0% and 0% respectively. For EVARs, 30-day and one-year mortality was 0.8% and 3.9% respectively. Median length of stay for open repair; laparoscopic repair and EVAR was 8; 4 and 3 days respectively.

## Conclusion

Overall in-hospital, 30-day and one-year mortality following elective aneurysm repairs are low. Our 1-year mortality is considerably lower than the 20% quoted in the GIRFT report. The apparent inaccuracies in the GIRFT data need to be explored.

**Case Ascertainment in Vascular Surgery: The importance of accurate data in clinical decision-making**

**Slade, RD[1]. Fligelstone, L[2]. Davies, CG[2]**
**[1] Core Surgical Trainee, [2] Consultant Vascular Surgeon**
**West Wales Vascular Unit, Morriston Hospital, ABM University Health Board, Swansea**

**Introduction**

Surgical databases are becoming more prevalent in surgical clinical practice as a method of research and service improvement. The National Vascular Registry (NVR) is a clinical registry that aims to compare and therefore improve the quality of UK Vascular Centres. Low case ascertainment has been highlighted on the NVR report in 2017 and 2018 as a problem. High levels of case ascertainment are vital to ensuring accurate data is being collected. If poor quality data is being collected this introduces bias to the dataset and reduces the effectiveness for comparison.

The aim was to analyse the number of major lower limb amputations carried out in each UK vascular centre and compare how these differed to their predicted numbers if each centre had 100% case ascertainment

**Methods**

The 2018 NVR annual report was analysed to collect data on the number of major lower limb amputations carried out at each vascular centre and their estimated case ascertainment. Then the numbers were adjusted to represent 100% case ascertainment, to give predicted number of lower limb amputations in each unit. Case ascertainment on the NVR is calculated between the numbers of cases recorded on the NVR compared to Hospital Episode Statistics (HES) data. As such case ascertainment data is only available for vascular centres in England. If an estimated case ascertainment was not available then the national average was used.

**Results**

The average case ascertainment for lower limb amputations is 60% across the UK. The mean number of lower limb amputations recorded on the NVR is 115, when adjusting to predicted number this increased to 205. Before adjustment . Morriston vascular unit has the second highest entries for major lower limb amputations in the UK, however the case ascertainment is 99.3%, after adjusting each unit to 100% predicted case ascertainment the rankings change and Morriston Hospital ranks 15$^{th}$.

**Conclusion**

Low levels of case ascertainment is significant source of bias within NVR reports and can lead to inappropriate interpretation of a units outcomes. As such 100% data collection is desirable however this is associated with increased workload for the vascular team. Utilising non-clinical members of staff to collect and enter data is one method to ensure that all relevant information is recorded, with the caveat that the quality of data entry is regularly audited.

**Revascularise at all costs: are the costs of revascularisation justified in avoiding amputation in a cash-strapped health service?**

**D Urriza Rodriguez[1], D P J Howard[1,2]**
**[1] Department of Vascular Surgery, John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust**
**[2] Nuffield Department of Surgical Sciences, University of Oxford**

**Introduction**
Despite peripheral arterial disease (PAD) affecting over 200 million people worldwide, there is a paucity of published data on costs of PAD on healthcare systems. This study aims to calculate the financial effect of PAD and consider if interventions to avoid major amputations are justified in cash-strapped healthcare systems.

**Methods**
The Oxford Vascular Study is a large-scale prospective population-based study (92,728 participants) of all vascular events. For this analysis, all patients with first-ever incident of acute limb ischaemia (ALI) and critical limb ischaemia (CLI) episodes were included (2002-2017). Hospital resource usage and institutional data were obtained to calculate mean 10-year healthcare costs.

**Results**
CLI is the most common acute PAD event type identified; with an incidence of 22/100,000/year compared to ALI at 10/100,000/year. CLI is the most expensive cardiovascular event with a mean 10-year healthcare cost of £44,727.
Intervention was a strong independent predictor of long-term costs. Mean 10-year costs for any PAD event was £32,971.

Performing one or more angioplasty/stent interventions or one or more bypass procedures increased the costs to £39,648 and £43,839 respectively. This was considerably less than mean costs of a below knee and above knee amputation, £59,130 and £63,150 respectively.

**Conclusion**
The study provides evidence of the impact of PAD events on healthcare systems. The results justify the approach to revascularise patients presenting with ALI or CLI, when appropriate, on grounds of overall healthcare costs when compared to a primary major amputation.

## Influence of Trainer Role, Subspecialty and Hospital Status on Consultant Workplace-based Assessment Completion

**L Hopkins, A Latif, D Robinson, C Brown, T Abdelrahman, R Egan, A Iorwerth, R Egan, MJ Pollitt, WG Lewis**

**School of Surgery, Health Education and Improvement Wales, Nantgarw, Cardiff**

### Introduction

Performance assessment is challenging to administer and validate, yet remains central to patient safety and quality of care. The aim of this study was to evaluate Consultant Surgeon trainer performance with respect to Workplace Based Assessment (WBA) completion.

### Methods

All WBAs for 60 Core Surgical Trainees (n=2,932) recorded in one academic year were analysed using the Intercollegiate Surgical Curriculum Progamme. Primary outcome measures were numbers of WBAs performed related to trainer role (Assigned Educational Supervisor [AES] vs. Clinical Supervisor [CS] vs. No Training Role [NTR]), gender, surgical sub-specialty, hospital status (teaching vs. district general), and trainer RCSEng. TrACE course accreditation.

### Results

Median WBA number performed irrespective of trainer role was 6 (range 0-51), consisting of CBD 2 (0-18), mini-CEX 2 (0-22), DOPS 2 (0-32), and PBA 0 (0-10). AES trainers were more likely to complete the full range of WBAs compared with CS and NTR assessors; WBA 17 vs. 6 vs. 3; CBD 5 vs. 2 vs. 1; mini-CEX 5 vs. 2 vs. 1; DOPS 4 vs. 2 vs. 1; and PBA 0 vs. 0 vs. 0 ($p<0.001$). WBAs completed varied by subspecialty; first quartile performance: ENT, Plastic Surgery, (median 12, interquartile range 13), compared with fourth quartile: OMFS, Urology, T&O and Cardiothoracic Surgery (median 5, interquartile range 11, $p=0.016$). Hospital status, gender and TrACE accreditation were not associated with WBA performance.

### Conclusion

Important variations in trainer WBA completion were apparent; training programme directors and trainees alike should be aware of this when agreeing educational contracts. With falling competition for surgical training programmes, specialties need to ensure that Consultant surgeon trainers remain engaged with curriculum requirements in order to attract high performing trainees.

**Core Surgical Trainees perspectives on a career in Vascular Surgery**

**T Hardy, A Botes, D Scourfield-Evans, B Fruhstrofer.**
**Royal Devon and Exeter Hospital**

## Introduction

Vascular surgery is entering a challenging time with concerns over recruitment of the future workforce. Despite increasing workloads and high levels of upcoming retirements, recruitment into higher surgical training (HST) has proved challenging with unfilled posts over the last 3 years despite reportedly high competition ratios. This study looked to investigate core surgical trainees (CSTs) considerations in career choice and perceptions of vascular surgery and how to potentially improve recruitment

## Methods

A mixed-methods study with sequential exploratory design was conducted consisting of qualitative semi-structured interviews followed by thematic analysis. This analysis was used to develop a quantitative online survey which was disseminated to CSTs across 2 deaneries in the south-west of England.

## Results

5 CSTs participated in the semi-structured interviews. Thematic analysis identified 3 major themes: influences in career choice, perceptions of vascular surgery, and exposure and applying to vascular surgery.

46 trainees returned the survey (49% response rate). Only 7 trainees (17%) were considering an application to vascular surgery. 42% of CSTs felt they were unable to make informed decision about a career in vascular surgery. However, CSTs with previous placements in vascular were significantly more likely to apply to vascular surgery ($\chi 2=4.40$, $p=0.036$). Themed trainees were also significantly more likely to apply to that specialty compared to non-themed trainees in general surgery ($p=0.01$), trauma and orthopaedics ($p=0.02$) vascular surgery ($p=0.02$) and urology ($p=0.0004$).

The 3 most important factors in career choice were type of surgery, type of team and work-life balance. The 3 most influential factors in career choice were senior role-models, variety of operating and exposure in medical school to a specialty. The most common perceptions of vascular surgery were that it is a busy, challenging, interesting specialty and covers a large geographical area for training.

## Conclusion

Patient age at time of operation, radiation dose, and post procedural cardiac complications were all factors associated with increased mortality risk. Optimising peri-operative cardiac care may therefore improve outcomes following TEVAR in the long term.

**Diagnosing Endovenous Heat Induced Thrombosis (EHIT): is it rational or relevant?**

**Goran A. Ahmed, Isaac Nyamekye**
**Worcestershire Royal Hospital**

**Introduction**:
Early duplex ultrasound (DUS) after endovenous ablation is routinely practiced in the United States but not in the UK. This is recommended in the Society for Vascular
Surgery and the American Venous Forum (SVS/AVF) guidelines (2011), but graded 2C. EHIT has not been reported to be a significant clinical problem in the UK. Our aim was to investigate whether routine duplex assessment for EHIT is rational and relevant.

**Methods:**
We assessed all publications on Radiofrequency Ablation (RFA) from 2006 to 2018. Papers referencing at Sapheno-femoral junction (SFJ) EHIT were then reviewed and data collected on EHIT and other Venous thromboembolic events (VTE). We studied the relationship between EHIT and the following factors: timing of post-procedure duplex, use of peri-procedural pharmacological thrombo-prophylaxis, junctional clearance of catheter tip from SFJ, calf vein DVT and year of individual paper publication.

**Results:** Fifty publications reported on a total number of 20519 patients. There were 63 DVTs (all calf-vein) (0.3%) and 397 EHITs (type 2-4) (1.9%). No EHITs were symptomatic and none progressed to common femoral vein DVT. EHIT incidence varied from 0 to 11.3%. 99.7% of EHITs were reported when duplex had been performed in the first 2 weeks post ablation. There was a weak negative correlation between the time of Duplex and EHIT rate. There was a moderate negative correlation between use of VTE prophylaxis and EHIT rate. There was no good correlation between junctional catheter tip clearance and EHIT. There was no correlation between Calf vein DVT and EHIT. On review of individual papers, EHIT was mostly (94%) reported after 2010.

**Conclusion:** Incidence of EHIT after RFA is highly variable. Its diagnosis is time-dependent and most likely when duplex is performed within 2 weeks. EHIT incidence is not related to calf vein DVT. All cases of EHIT reviewed were asymptomatic and not clinically relevant.
Routine diagnosis of EHIT after thermal RFA does not appear to be rational or relevant to clinical practice.

**Endothermal ablation for incompetent lower limb perforators associated with chronic venous insufficiency. Is it worth the bother?**

**K.R Woodburn**

**Cornwall Vein Clinic, Duchy Hospital, Truro, Cornwall**

**Introduction**

In addition to their truncal pathology, many patients with CEAP class 5 and 6 venous disease have clearly identifiable perforator incompetence, although historical treatments for perforator incompetence have failed to become established in routine practice. Endothermal methods may offer an effective means of treating patients with symptomatic perforator incompetence under local anaesthetic without the requirement for additional resources.

**Methods**

Retrospective review of a single surgeon endovenous practice from 2007-2018. Data were retrieved from an operative logbook and casenote review where required. All patients underwent pre-procedure duplex venous mapping and follow up scanning was undertaken between 6 and 16 weeks post-procedure to confirm closure of treated segments. For the purpose of this analysis the presence of any flow in treated segments was considered a treatment failure.

**Results**

In 72 of 185 endovenous procedures (5%), perforator ablation was attempted. 5 cases were excluded due to incomplete data. 25/67 perforators were located in the popliteal fossa, 21 at the ankle, 8 in the thigh, with the others (13) distributed in mid and upper calf. 20 radiofrequency perforator ablations were carried out in18 patients with a 55% overall perforator closure rate. 47 EVLA perforator ablations were carried out in 38 patients with a closure rate of 79%. Closure rates for truncal ablation were 95.5% - 96.1%.

**Conclusion**

The results of endothermal ablation of incompetent lower limb perforating veins are significantly poorer than the results obtained for truncal ablation by the same methods, however closure rates of 67 - 85% can be achieved. There is significant variability in outcome related to perforator location, endothermal device employed, and energy delivered. These data would suggest that EVLA using a radial firing laser is more effective than RFA in perforator treatment in most locations.

# CONSTITUTION OF THE SOUTH WEST VASCULAR SURGEONS

The South West Vascular Surgeons was founded in Exeter in 1979 by a group of vascular surgeons in the South West. It has since expanded to include surgeons throughout much of the South of England and the South of Wales.

**Title**
The Society shall be called "**The South West Vascular Surgeons**".

**Object**
The object of the Society shall be to foster the art of vascular surgery and to promote good fellowship.

**Membership**
Membership shall be open to all consultants with a major interest and regular practice in vascular surgery within the South and Western parts of the United Kingdom. Consultants appointed to posts with a special interest in vascular surgery in hospitals within the South and West of England and Wales will be invited to join on appointment. Consultants in such posts within this general geographic area may also apply for membership. Applications for membership are made to the Honorary Secretary, who will consult with members at the annual general meeting in any cases of doubt about eligibility.

**Retirement**
When they retire, members will be asked whether they wish to continue to be members of the Society.

**Meetings**
Meetings to be held annually at the hospital of one of the members by rotation and by prior agreement. Each meeting shall consist of presentations made by the members or their trainees relating to the clinical practice of vascular surgery. Abstracts for presentation are selected by the Honorary Secretary, who may enlist the advice of other members in the selection process. The Honorary Secretary organises the content and the programme for the meeting and the host makes arrangements for facilities and catering.

***Officers***
*Honorary Secretary, Honorary Treasurer. These officers are appointed following proposal and seconding by members of the Society and a vote by the other members. Each officer serves for a period of five years.*

**Finance and Accounts**
There is no membership subscription for the Society or any annual registration fee for the meeting. Most income is generated by contributions from trade exhibitors at the annual meeting.
The Honorary Treasurer is responsible for presenting the accounts to the business meeting. The accounts of the Society will be audited annually by an independent and professional accountant.

21st March, 1997 - Taunton

**South West Vascular Surgeons**

**Names and Addresses**

Please would colleagues inform the Honorary Secretary of:

- Any new Consultants who might wish to join SWVS
- Their wish to retire from SWVS
- Any amendments to this list – in particular, would newly added Consultants please write with full details, so that their entries can be expanded in next year's book.

**Honorary Secretary:**

**Mr Louis Fligelstone**
Consultant Vascular Surgeon
Department of Vascular Surgery
Morriston Hospital
Swansea
SA6 6NL

Tel: 01792 703584

**Email: louis.fligelstone@wales.nhs.uk**

**Treasurer:**

**Mr Lasantha Wijeshinghe**
Consultant Vascular Surgeon
Castle Lane East
Bournemouth
Dorset
BH7 7DW

Tel: 01202 303626

**Email: Lasantha.Wijesinghe@rbch.nhs.uk**

Mr Simon Ashley
Private Practice
Vein Clinic
Plymouth

Mr Amarjit Atwal
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Miss Rachel Barnes
Royal Cornwall Hospitals Trust
Treliske
Truro
TR1 3LJ

Mr Jamie Barwell
Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Mr Stephen Baxter
Southampton General Hosptial
Tremona Road
Southampton
SO16 6YD

Mr Tim Beckitt
Royal Shrewsbury Hospital
Mytton Oak Road
Mytton Oak Road
Shrewsbury
SY3 8XQ

Mr Paul Bevis
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Mr David Birchley
Royal Devon & Exeter Hospital
Barrack Road
Exeter
EX2 5DW

Mr Marek Blaszczynski
Morriston Hospital
ABM University Health Board
Swansea
SA6 6NL

Mr Dave Bosanquet
Royal Gwent Hospital
Newport
Newport
NP20 2UB

Mr Marcus Brooks
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Mr John Budd
Retired
Bath

Mr Richard Bulbulia
Cheltenham General Hospital
Sandford Road
Cheltenham
GL53 7AN

Professor Bruce Campbell
Retired
Exeter
EX2 4LH

Mr Harvey Chant
Royal Cornwall Hospital
Treliske
Truro
TR1 3LJ

Mr Kevin Conway
Royal Glamorgan Hospital
Ynysmaerdy
Llantrisant
CF72 8XR

Mr David Cooper
Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN

Mr James Coulston
Taunton & Somerset Hospital
Musgrove Park Hospital
Taunton
TA1 5DA

Mr Andrew Cowan
Royal Devon & Exeter Hospital
Barrack Road
Exeter
EX2 5DW

Mr Ian Currie
Torbay Hospital
Lawes Bridge
Torquay
TQ2 7AA

Mr Chris Darby
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Miss Katy Darvall
Taunton & Somerset Hospital
Musgrove Park Hospital
Taunton
TA1 5DA

Mr Chris Davies
Morriston Hospital
Swansea
SA6 6NL

Mr Francis Dix
Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Professor Richard Downing
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Mr Paul Eyers
Taunton & Somerset Hospital
Musgrove Park Hospital
Taunton
TA1 5DA

Mr Louis Fligelstone
Morriston Hospital
Heol Maes Eglwys
Swansea
SA6 6NL

me Fligelstone
attachment
Swansea

Miss Francesca Fratesi
Morriston Hospital
ABM University Health Board
Swansea
SA6 6NL

Miss Francesca Fratesi
Morriston Hospital
ABM University Health Board
Swansea
SA6 6NL

Mr Haroun Gajraj
The VeinCare Centre
The Melbury Clinic
Higher Barn, Holt Mill
DT2 0XL

Mr Perbinder Gerwal
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Mr Saboor Ghauri
Salisbury District Hospital
Salisbury
SP2 8BJ

Mr Paul Gibbs
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Mr Dean Godfrey
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Mr Stephen Goodyear
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Mr Eric Grocott
Charles Hastings Way
Worcester
WR5 1DD

Miss Alison Guy
Royal Devon & Exeter Hospital
Barrack Road
Exeter
EX2 5DW

Professor Alison Halliday
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Mr Ashok Handa
Nuffield Department of Surgery
John Radcliffe Hospital
Oxford
OX3 9DU

Mr Nicholas Hickey
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Miss Sue Hill
University Hospital of Wales
Heath Park
Cardiff
CF4 4XW

Professor Rob Hinchliffe
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Mr Neil Hopper
Royal Cornwall Hospitals Trust
Treliske
Truro
TR1 3LJ

Professor Mike Horrocks
Retired
Bath

Mr Dominic PJ Howard
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Miss Sarah Hulin
Salisbury District Hospital
Salisbury
SP2 8BJ

Mr Ian Hunter
Musgrove Park Hospital
Taunton
Taunton
TA1 5DA

Mr S R Kulkarni
Cheltenham General Hospital
Sandford Road
Cheltenham
GL53 7AN

Mr Peter Lamont
Retired
Bristol

Mr Christopher Lee
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Mr Pete Lewis
Royal Gwent Hospital
Newport
NP20 2UB

Mr Dave Lewis
Royal Gwent Hospital
Newport
NP20 2UB

Mr Patrick Lintott
Stoke Mandeville Hospital
Mandeville Road
Aylesbury
HP21 8AL

Mr Tim Magee
Royal Berkshire Hospital
London Road
Reading
RG1 5AN

Mr Rob McCarthy
Royal Devon & Exeter Hospital
Barrack Road
Exeter
EX2 5DW

Mr David McClain
Royal Gwent Hospital
Newport
NP20 2UB

Mr Ken McCune
Royal Cornwall Hospitals Trust
Treliske
Truro
TR1 3LJ

Mr Doug McWhinney
Milton Keynes General
Hospital
Milton Keynes
MK6 5LD

Mr James Metcalf
Dorset County Hospital
Dorchester
DT1 2JY

Mr David Mitchell
Retired
Bristol

Mr Gareth Morris
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Mr Bill Neary
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Mr Ian Nordon
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Mr Isaac Nyamekye
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Mr Mahesh Pai
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Miss Nandita Pal
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Mr Andreas Palffy
Queen Alexandra Hospital
Cosham
Plymouth
PO6 3LY

Mr Cris Parry
Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Mr Mark Pemberton
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Mr Jerry Perkins
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Mr Mike Phillips
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Mr Keith Poskitt
Cheltenham General Hospital
Sandford Road
Cheltenham
GL53 7AN

Mr Charles Ranaboldo
Salisbury District Hospital
Salisbury
SP2 8BJ

Mr Dynesh Rittoo
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Mr Mike Rocker
Royal Glamorgan Hospital
Ynysmaerdy
Llantrisant
CF72 8XR

Mr Angus Ruddle
Morriston Hospital
ABM University Health Board
Swansea
SA6 6NL

Mr Ahmed Shandall
Retired

Mr Anees Sharif
Morriston Hospital
Heol Aes Eglwys
Swansea
SA6 6NL

Professor Cliff Shearman
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Mr Ed Sideso
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Mr Ravi Singh-Ranger
Great Western Hospital
Marlborough Road
Swindon
SN3 6BB

Mr Frank Smith
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Ms Sabine Sonnenberg
Tremona Road
Southampton
SO16 6YD

Mr Andrew Stewart
Taunton and Somerset NHS
Foundation Trust
Musgrove Park Hospital
Taunton
TA1 5DA

Mr Graham Sutton
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Mr John Thompson
Royal Devon & Exeter Hospital
Barrack Road
Exeter
EX2 5DW

Mr Christopher Twine
North Bristol NHS Trust
Southmead Hospital
Bristol
NP20 2UB

Mr Ioannis Vlachakis
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Mr Alex Watson
Dorset County Hospital
Dorchester
DT1 2JY

Mr Andy Weale
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Ms Catherine Western
Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Mr Richard Whiston
University Hospital of Wales
Heath Park
Cardiff
CF64 2XX

Mr Mark Whyman
Cheltenham General Hospital
Sandford Road
Cheltenham
GL53 7AN

Mr Lasantha Wijesinghe
Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Mr David Williams
North Devon District Hospital
Raleigh Park
Barnstaple
EX31 4JB

Mr Ian Williams
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW

Mr Nick Wilson
Royal Hampshire County
Hospital
Romsey Road
Winchester
SO22 5DG

Miss Emma Wilton
John Radcliffe Hospital
Headington
Oxford
OX3 9DU

Mr Robin Windhaber
Royal Cornwall Hospitals Trust
Treliske
Truro
TR1 3LJ

Mr Rebecca Winterborn
North Bristol NHS Trust
Southmead Hospital
Bristol
BS10 5NB

Mr Ken Woodburn
Frontiere Medicale Europe
Vein Clinic
Truro

Mr Justin Woolgar
Morriston Hospital
Heol Aes Eglwys
Swansea
SA6 6NL

**It gives me great pleasure to share the letter I received from Roger Baird following the 40th SWVS meeting**

Mr L. Fligelstone FRCS
Consultant
Vascular Surgeon
Morriston Hospital
Swansea

36 CONTEMPORIS
10 MERCHANTS ROAD
CLIFTON
BRISTOL BS8 4HB
0117 946 6030
rnbaird@blueyonder.co.uk
affra.baird@gmail.com

10 March 2018

Dear Louis,

I greatly enjoyed my visit on Thursday and Friday to the SW Vascular Surgeons meeting at Exeter. Our society has grown from strength to strength since my day, with the advent of masterclass and simulator sessions. The dinner on Thursday was lively and caught the spirit of challenge and enjoyment of the new generation. I hope that my historical perspectives talk helped to set the scene for young people who share our values.

Yours sincerely, Roger.

# SWVS 2020

West Wales Vascular Unit, Morriston Hospital

Swansea Bay University Health Board, Swansea

**Local organisers**
**Mr. Chris Davies & Mr. Louis Fligelstone**