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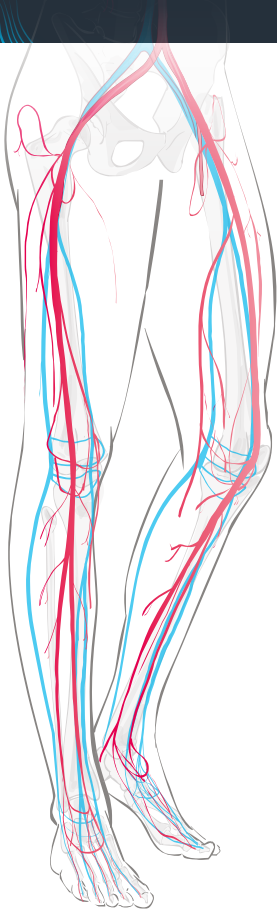
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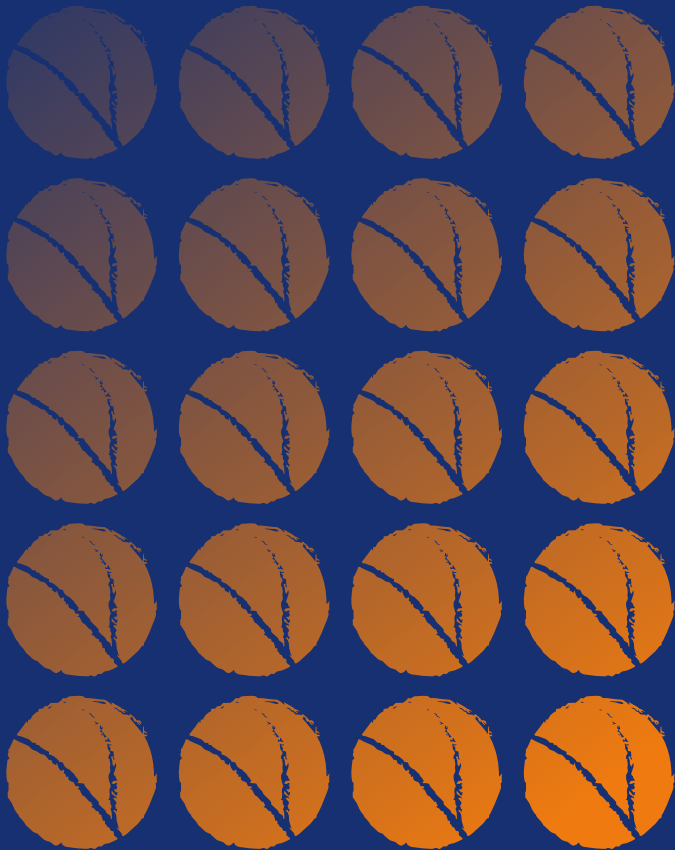
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Programme



THURSDAY 25th JUNE

09.00 – 09.05	WELCOME	
	<i>James McCaslin</i> , BSET President	
09.05 – 09.35	ROULEAUX CLUB AND BSIRT SYMPOSIUM (7 + 3 minutes)	
	<i>Chairs: James McCaslin, Alex Hardman & Nada Elzefzaf</i>	
	Rouleaux Club Endovascular Training Survey	
	<i>Nada Elzefzaf</i> , BSET Rouleaux Club Representative	
	Equality, Diversity and Inclusion – Who's problem is it?	
	<i>Kaji Sritharan</i> , Consultant Vascular Surgeon, York	
	Humanitarian work in Vascular surgery	
	<i>Simon Glasgow</i> , Consultant Vascular Surgeon, Imperial College, London	
09.35 – 09.45	BSET FELLOWSHIP REPORT	
	<i>Chairs: Paul Moxey & Emma Wilton</i>	
	BSET Training Fellowship 2025	<i>Mohamed Elkawafi</i>
	BSET Travel Fellowship 2025	<i>Bilal Azhar</i>
09.45 – 10.25	ABSTRACT SESSION 1 – (4 + 2 minutes)	
	<i>Chairs: Paul Moxey, Emma Wilton & Rachel Bell</i>	
9.45 – 9.51	Unwarranted variation in renal protection for high-risk peripheral angioplasty: A modifiable patient safety gap	
	<i>Nijat Rzayev, Abhinav Deshwal, April Herathge, Murtaza Salem</i> Nottingham University Hospitals NHS Trust, Nottingham	
9.51 – 9.57	Are we in equipoise? Open versus hybrid aorto-iliac revascularisation and implications for UK national trial recruitment	
	<i>Georgios Georgallides, Mohammed Fageer, Jae Seon Hong, Albagir Altahir, Tamer El-Sayed, Sandip Nandhra</i> Northern Vascular Centre, Freeman Hospital, Newcastle Upon Tyne	
9.57 – 10.03	Patient reported outcomes after iliofemoral deep venous thrombosis: The experience of a tertiary centre in the United Kingdom	
	<i>Youssef Ramadan, Ahamed Mohideen, Ahmed Abdel Rahim, Paul Jenkins, Devender Mittapalli</i> University Hospitals Plymouth NHS Trust, Plymouth	
10.03 – 10.09	Who and when: Real-world selection and timing for DVT recanalization	
	<i>Fernanda Binati, Zahi Qamhawi, Andrew Wigham, Emma Wilton</i> Oxford NHS Trust Hospital, Oxford	


THURSDAY 25th JUNE

10.09 – 10.15	Time between referral and angioplasty in CLTI patients and its impact on patient outcomes
	Kathryn Reid University of Glasgow, Glasgow & University Hospital Hairmyres, East Kilbride

10.15 – 10.35	GUEST LECTURE (15 + 5 minutes)
	Chairs: Ash Patel, Badri Vijaynagar & Kaji Sritharan
	Atherectomy for lower limb ischaemia – should these devices now be part of your routine practice?
	Vikram Puttaswamy, Vascular, Endovascular and Renal Transplant Surgeon, Royal North Shore Hospital, Sydney, Australia


10.35 – 11.10 COFFEE

11.10 – 11.30	DEBATE (7 + 7 + 6 minutes each)	
	Chairs: Sandip Nandhra, Emma Wilton & Rob Jones	
	All deep venous interventions should take place at high volume centres only	
	FOR	AGAINST
	Gloria Salazar, Clinical Associate Professor, Department of Radiology, University of North Carolina, USA	Baris Ozdemir, Consultant Vascular Surgeon, Bristol, Bath and Weston Vascular Network

11.30 – 11.50	SOCIETY SPONSOR:		COOK MEDICAL
	Chairs: Sandip Nandhra & Emma Wilton		
	CMD options for the Thoracoabdominal Aorta		
	Ian Loftus, Consultant Vascular Surgeon, St George's Vascular Institute		

11.50 – 12.10	GUEST LECTURE (15 + 5 minutes)	
	Chairs: Paul Bevis, Maciej Juszcak & Colin Bicknell	
	How the hybrid Thoracofoflo graft changed my practice - latest outcomes from thoracoabdominal aneurysm repair	
	Sabine Wipper, Director of the Department of Vascular Surgery, University Hospital, Innsbruck, Austria	

THURSDAY 25th JUNE


12.10 – 12.30	SOCIETY SPONSOR:		SHOCKWAVE
	<i>Chairs: Paul Bevis, Maciej Juszczyk & Colin Bicknell</i>		
	Treating the impossible - is shockwave L6 a game changer?		
<i>Dominic PJ Howard, Consultant Vascular Surgeon, Oxford University Hospitals NHS Trust</i>			

12.30 – 12.35	BSET PUMP PRIMING AWARD REPORT	
	<i>Chairs: Dave Bosanquet, Sandip Nandhra & Rob Sayers</i> 2025: Arsalan Wafi	

12.35 – 13.00	UPDATE ON ACTIVE ENDOVASCULAR TRIALS IN THE UK (3 minutes each)	
	<i>Chairs: Dave Bosanquet, Rob Sayers & Martin Claridge</i>	
	ESTABLISH	<i>Sandip Nandhra</i>
	RAF AND RAVE	<i>Athanasios Saratzis</i>
	EARNEST	<i>Colin Bicknell</i>
	WARRIORS	<i>Anna Pouncey</i>
	EVeR	<i>Baris Ozdemir</i>


13.00 – 14.15 LUNCH

14.15 – 14.35	DEBATE (7 + 7 + 6 minutes)	
	<i>Chairs: Paul Moxey, Ash Patel & Gloria Salazar</i>	
	Drug-coated technology is dead – we should stop using it in the lower limb	
	FOR	AGAINST
	<i>Lorenzo Patrone, Consultant Interventional Radiologist, San Giovanni Di Dio Hospital, Florence, Italy</i>	<i>Vikram Puttaswamy, Vascular, Endovascular and Renal Transplant Surgeon, Royal North Shore Hospital, Sydney, Australia</i>

14.35 – 14.55	SOCIETY SPONSOR:		MEDTRONIC
	<i>Chairs: Paul Moxey, Ash Patel & Gloria Salazar</i>		
	Single centre early to mid-term outcomes of primary ESAR - where it fits in our AAA treatment options		
<i>Martin Hennessy, Consultant Interventional Radiologist, Queen Elizabeth Hospital, Glasgow</i>			

THURSDAY 25th JUNE

14.55 – 15.35	ABSTRACT SESSION 2 (4 + 2 minutes) <i>Chairs: Nikesh Dattani, Becky Sandford & Sabine Wipper</i>
14.55 – 15.01	Type B aortic dissection outcomes: The time has come for a core outcome set – a systematic review Gabriel Lopez-Pena¹, Kaylee To², Matthew Machin¹, Safa Salim¹, Colin Bicknell¹ ¹ Imperial College London, London ² Department of Surgery, Amsterdam University Medical Centers, Amsterdam, Netherlands
15.01 – 15.07	Surveillance and follow-up after TEVAR for blunt traumatic thoracic aortic injury: A regional multicentre analysis from West Midlands major trauma centres Sui Wu Tee¹, Abdelrahman Farrag², Sherif Hassan¹, Liu Wing Yan¹, Virginia Summerour², Maciej Juszcak³, Tom Barker³, Ashraf El-Sharkawy¹ ¹ University Hospital Coventry and Warwickshire NHS Trust, Coventry ² University Hospitals of North Midlands NHS Trust, Stoke ³ University Hospital Birmingham NHS Trust, Birmingham
15.07 – 15.13	Bridging stent patency after inner branch endovascular aneurysm repair Athena Michaelides, Sandeep Bahia, Noaman Shaikh Kent & Canterbury Hospital, Canterbury
15.13 – 15.19	Female turnaround for AAA repair- are devices fit for purpose? Gvantsa Gamtkitsulashvili, Joseph Harker, Dean Godfrey University Hospital Dorset, Bournemouth
15.19 – 15.25	Duplex Ultrasound after Endo Revascularisation (DUSTER) feasibility randomised controlled trial Nishita Gadi¹, Alun Davies², Steven Rogers³, Hilary Engward¹, Carmel Moore¹, Jufen Zhang¹, Georgina Beetar⁴, Karen Hayden¹, Princess Gabiana⁴, Sofia Matias¹, Ankur Thapar¹ ¹ Anglia Ruskin University, Chelmsford ² Imperial College, London ³ University of Manchester, Manchester ⁴ Mid and South Essex NHS Foundation Trust, Basildon
15.25 – 15.45	GUEST LECTURE (15 + 5 minutes) <i>Chairs: Nikesh Dattani, Becky Sandford & Sabine Wipper</i> Endovascular arteriovenous fistula formation – is there any patient benefit or is this just technology looking for an indication? Rob Jones, Consultant Interventional Radiologist, University Hospital Birmingham
15.45 – 16.15	TEA

16.15 – 16.35	SOCIETY SPONSOR GORE	
	<i>Chairs: Maciej Juszcak, Simon Neequaye & Barend Mees</i>	
	Optimising Aortic Arch Treatment: Clinical Experience with the GORE® TAG® Thoracic Branch Endoprosthesis	
	<i>Mr Orwa Falah, Consultant Vascular Surgeon, Royal Infirmary of Edinburgh, Edinburgh</i>	
16.35 – 16.55	DEBATE (7 + 7 + 6)	
	<i>Chairs: Maciej Juszcak, Simon Neequaye & Barend Mees</i>	
	Endovascular repair of arch and thoracoabdominal aneurysms should be reserved for the treatment of acute cases only	
	FOR	AGAINST
	<i>Aung Oo, Consultant Cardiac Surgeon, Barts Health, London</i>	<i>Sabine Wipper, Director of the Department of Vascular Surgery, University Hospital, Innsbruck, Austria</i>
16.55 – 17.55	AORTIC PRIZE ABSTRACT SESSION (7 + 3 minutes)	
	<i>Chairs: Martin Claridge, James McCaslin & Ian Loftus</i>	
16.55 – 17.05	Morphological phenotypes are associated with early type I endoleak despite failure of conventional hostile neck and access metrics	
	<p>Michal Kawka^{1,2}, Caroline Cardou³, Ruth Scicluna⁴, Colin Bicknell⁵, Matthew Bown⁴, Manj Gohel⁶, Anna Pouncey^{1,2,5}</p> <p>¹St George's Vascular Institute, St George's Hospital, London ²School of Health & Medical Sciences, City St George's University of London, London ³Vascular Surgery Department, Bordeaux University Hospital, Bordeaux, France ⁴Department of Cardiovascular Sciences and NIHR Leicester Biomedical Research Centre, University of Leicester, Leicester ⁵Department of Surgery and Cancer, Imperial College London, London ⁶Department of Vascular Surgery, Cambridge University Hospitals, Cambridge</p>	
17.05 – 17.15	Conformable Endovascular Aneurysm Repair (EVAR) stability in hostile neck Abdominal Aortic Aneurysms: A single-centre experience	
	<i>Ayman Zyada, Mohamed Eltayeb Abdelrahman Naiem, Bryce Renwick Aberdeen Royal Infirmary, Aberdeen</i>	
17.15 - 17.25	Post-Endovascular Aneurysm Repair surveillance in the United Kingdom: A survey of current clinical practice	
	<p>Ahamed Mohideen¹, Ahmad Alhalawani², Shiva Dindyal², Devender Mittapalli¹</p> <p>¹University Hospitals Plymouth NHS Trust, Plymouth ²Mid & South Essex NHS Foundation Trust, Basildon</p>	

THURSDAY 25th JUNE

17.25 - 17.35	Reducing delays in the diagnosis and management of arterial acute mesenteric ischaemia: A five-year audit informing development of a multidisciplinary regional care pathway
	<i>Ateeqahamed Shaikh, Aseel Abudurk, Henry Mills, Alireza Rizavi, Mirjam Inchingolo</i> Norfolk and Norwich University Hospital, Norwich
17.35 - 17.45	Clinical messages from the GLOBALSTAR registry: Improving care in Fenestrated Endovascular Aneurysm Repair (FEVAR)
	<i>Aurelien Gueroult¹, BSET², GLOBALSTAR collaborators³</i> ¹ St George's Vascular Institute, London ² British Society of Endovascular Therapy, BSET ³ GLOBALSTAR, London

17.45	THE PRESIDENT'S DEBATE	
	<i>Chair: Martin Claridge</i>	
	Laughter is the best medicine – there is no benefit from endovascular treatment of infra inguinal lower limb ischaemia	
	FOR	AGAINST
	<i>Keith Jones, President, The Vascular Society</i>	<i>James McCaslin, President, BSET</i>

18.05	END OF DAY ONE
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19.15	PRE-DINNER DRINKS
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19.45	DINNER
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8.30 – 9.00	<p>ABSTRACT SESSION 3 (4 + 2 minutes)</p> <p><i>Chairs: Shiva Dindyal & Badri Vijaynagar</i></p>
8.30 – 8.36	<p>Outcomes following femoro-popliteal stenting surveillance: A three-year single-centre experience</p> <p><i>Nour Darwish, Safaa Hamid, Marcus Nicholls, Raj Gali, Andy Thompson, Kaji Sritharan</i> York & Scarborough Teaching Hospitals NHS Foundation Trust, York</p>
8.36 – 8.42	<p>When antiplatelet is not enough: Platelet function monitoring and glycaemic control predict early adverse event in peripheral arterial disease</p> <p><i>Meiling MacDonald-Nethercott¹, Hafiz Qureshi², Selvaraj Nambiah², Harjeet Rayt¹, Rob D Sayers^{1,3}, Matthew J Bown^{1,3}, Athanasios Saratzis^{1,3}, Badri Vijaynagar¹</i> ¹University Hospitals of Leicester NHS Trust, Vascular Surgery Department, Leicester ²University Hospitals of Leicester NHS Trust, Department of Transfusion Medicine & Centre for Platelet Function Studies, Leicester ³British Heart Foundation Leicester Centre for Research Excellence and National Institute for Health and Care Research Leicester Biomedical Research Centre, Division of Cardiovascular Sciences, College of Life Sciences, Leicester</p>
8.42 – 8.48	<p>Treatment decisions in peripheral artery disease: What do patients prioritise?</p> <p><i>Calvin De Louche¹, Shahd Shaltout², Colin Bicknell¹, Anna Pouncey^{1,3}</i> ¹Department of Surgery and Cancer, Imperial College London, London ²Department of Vascular Surgery, St George's University Hospitals NHS Foundation Trust, London ³School of Health and Medical Sciences, City St George's University of London, London</p>
8.48 – 8.54	<p>Utilization of Natural Language Processing (NLP) for visceral artery aneurysms identification from radiology reports</p> <p><i>Amina Amin¹, Syed Samar Ali Shah², Katarzyna Powezka³, Keith Farrell Dillon³, Arul Ganeshan², Alok Tiwari³, Martin Claridge², Donald Adam², Maciej Juszcak³</i> ¹Russell Hall Hospital, Dudley ²Heartlands Hospital, Birmingham ³University of Birmingham, Birmingham</p>
8.54 – 9.00	<p>Radiation protection training in endovascular surgery: A systematic review of educational interventions</p> <p><i>Alex Garnett¹, George Ninkovic-Hall¹, Kaji Sritharan²</i> ¹Manchester University Foundation Trust, Manchester ²York & Scarborough Teaching Hospitals NHS Trust, York</p>

FRIDAY 26th JUNE


9.00 – 9.20	VASCULAR SOCIETY SESSION		
	<i>Chairs: Shiva Dindyal & Badri Vijaynagar</i>		
	Vascular Society Update		
	<i>Keith Jones, President</i>		
	Modern Service Framework for Cardiovascular Disease		
	<i>Marcus Brooks, Vice President</i>		
	Acute Limb Ischaemia Quality Improvement Project		
<i>Colin Bicknell, Chair Audit and Quality Improvement Committee</i>			
9.20 – 9.30	GOLD SPONSOR PRESENTATION:		BENTLEY
	<i>Chairs: Rob Morgan, Kaji Sritharan & John Brennan</i>		
	Crossing the uncrossable: Contemporary aorto-iliac reconstruction and targeted re-entry		
	<i>Ash Patel, Reader in Vascular Surgery & Sciences, KCL; Consultant Vascular Surgeon, GSTT</i>		
9.30 – 9.50	GUEST LECTURE (15 + 5 minutes)		
	<i>Chairs: Rob Morgan, Kaji Sritharan & John Brennan</i>		
	What does a win look like? The Woundosome concept and markers of success in CLTI intervention		
	<i>Lorenzo Patrone, Consultant Interventional Radiologist, San Giovanni Di Dio Hospital, Florence, Italy</i>		
9.50 – 10.00	GOLD SPONSOR PRESENTATION:		ABBOTT
	<i>Chairs: Emma Wilton, Andy Wigham & Mike Jenkins</i>		
	Stealth In action: Real World Outcomes of Peripheral Orbital Atherectomy System (POAS) in patients with PAD		
	<i>Badri Vijaynagar, Consultant Vascular Surgeon, Glenfield Hospital, Leicester</i>		

FRIDAY 26th JUNE

10.00 – 10.30	TRAINING SYMPOSIUM	
	<i>Chairs: Emma Wilton, Andy Wigham & Mike Jenkins</i>	
	How to inspire the next generation of deep venous enthusiasts	
	<i>Gloria Salazar, Clinical Associate Professor, Department of Radiology, University of North Carolina, USA</i>	
	Training in open cardiothoracic surgery – does vascular surgery need dedicated aortic fellowships too?	
	<i>Aung Oo, Consultant Cardiac Surgeon, Barts Health, London</i>	
	What does the perfect lower limb fellowship look like and can Australia deliver it?	
<i>Vikram Puttaswamy, Vascular, Endovascular and Renal Transplant Surgeon, Royal North Shore Hospital, Sydney, Australia</i>		

10.30 – 11.30	CASE DISCUSSIONS IN COLLABORATION WITH THE EUROPEAN VASCULAR COURSE (EVC)	
	<i>Chairs: Barend Mees & Bijan Modarai</i>	
	Venous	<i>Baris Ozdemir, Consultant Vascular Surgeon, Bristol, Bath and Weston Vascular Network</i>
	Lower Limb	<i>Lorenzo Patrone, Consultant Interventional Radiologist, San Giovanni Di Dio Hospital, Florence, Italy</i>
	Aortic	<i>Sabine Wipper, Director of the Department of Vascular Surgery, University Hospital, Innsbruck, Austria</i>

11.30 – 12.15 BRUNCH

12.15 – 12.25	GOLD SPONSOR PRESENTATION:		PHILIPS
	<i>Chairs: Nimesh Dattani, Paul Moxey & Vikram Puttaswamy</i>		
	IVUS in PAD : Evidence, Barriers & Benefit. Why aren't you using it?		
	<i>Mark Portou, Consultant Vascular Surgeon, Royal Free Hospital, London</i>		

12.25 – 12.45	GUEST LECTURE (15 + 5 minutes)	
	<i>Chairs: Nimesh Dattani, Paul Moxey & Vikram Puttaswamy</i>	
	A balanced scorecard for deep venous intervention - what are the key outcomes that should be measured in a high volume programme?	
<i>Gloria Salazar, Clinical Associate Professor, Department of Radiology, University of North Carolina, USA</i>		

FRIDAY 26th JUNE

12.45 – 12.55	GOLD SPONSOR PRESENTATION:		TERUMO AORTIC
	<i>Chairs: Becky Sandford, Kaji Sritharan & Jon Boyle</i>		
	Precision in the Arch: The Manchester Experience with The Relay Platform <i>David Murray, Consultant Vascular Surgeon, Manchester Royal Infirmary</i>		
12.55 – 13.55	PERIPHERAL PRIZE ABSTRACT SESSION (7 + 3 minutes)		
	<i>Chairs: Becky Sandford, Kaji Sritharan & Jon Boyle</i>		
12.55 – 13.05	Revascularization Outcomes in nonagenarians in Symptomatic Elderly with Peripheral Arterial Disease – the ROSEPAD registry <i>Dimitrios Vlastos</i> On behalf of the ROSEPAD registry		
13.05 – 13.15	Contemporary experience of using intravascular ultrasound in the endovascular management of peripheral arterial disease <i>Arsalan Wafi, Vicknah Balarajah, Narayanan Thulasidasan, Ashish Patel</i> Guy's and St Thomas's, London		
13.15 – 13.25	Predictors of symptomatic improvement following endovascular treatment for pelvic congestion: The role of reflux territory <i>Zakariya Abdulazeez, David Beckett, Karen Groom, Dean Godfrey</i> University Hospitals Dorset NHS Trust, on behalf of Dorset & Wiltshire Vascular Network, Dorset		
13.25 – 13.35	Endovascular native arterial recanalisation after failed infrainguinal surgical bypass: A systematic review and meta-analysis <i>Darshan Barki, Vickna Balarajah, Harishankar Nari, Prakash Saha, Said Abisi, Hany Zayed, Junjie Ng</i> Guy's and St Thomas' NHS Foundation Trust, London		
13.35 - 13.45	Single centre experience of the Phoenix mechanical atherectomy system <i>Vickna Balarajah, Arsalan Wafi, Narayanan Thulasidasan, Mohamed Abdelhalim, Ashish Patel</i> St Thomas', London		
13.45 - 14.05	CHEE SOONG MEMORIAL LECTURE		
	<i>Introduced by James McCaslin</i>		
	Team working in aortic surgery - 20 years of innovation in open and endovascular techniques		
	<i>Rachel Bell, Consultant Vascular Surgeon, Newcastle</i>		
14.05	PRESENTATION OF PRIZES AND CLOSE		

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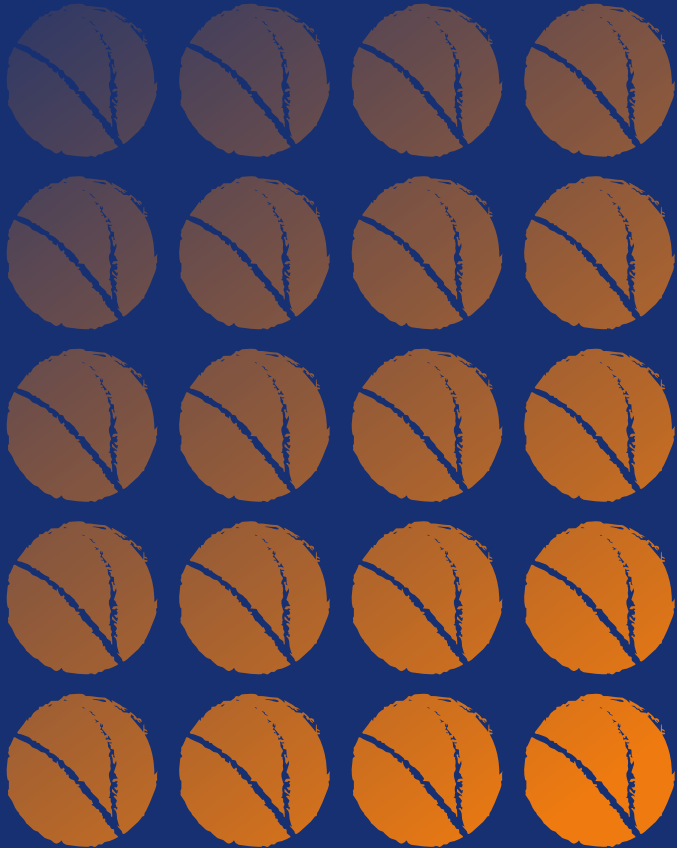
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Abstracts



Unwarranted variation in renal protection for high-risk peripheral angioplasty: A modifiable patient safety gap

Nijat Rzayev, **Abhinav Deshwal**, April Herathge, Murtaza Salem
Nottingham University Hospitals NHS Trust, Nottingham

Background

Post-contrast acute kidney injury (PC-AKI) is associated with prolonged hospitalisation, cardiovascular events, and increased mortality. Patients with chronic kidney disease (CKD) or eGFR <60 mL/min/1.73m² are at highest risk. International guidance, including KDIGO and the European Society of Urogenital Radiology, recommends structured renal risk stratification, intravenous isotonic hydration, medication optimisation, and post-procedure renal monitoring. While coronary pathways are protocolised in our institution, no equivalent vascular-specific guidance exists for peripheral angioplasty.

Method

A retrospective audit of 160 consecutive patients undergoing peripheral angioplasty over five months was performed. Forty patients (25%) had baseline eGFR <60 mL/min/1.73m² and were classified as high risk. Compliance with renal protective measures and incidence of PC-AKI (≥26 µmol/L creatinine rise within 48–72 hours) were assessed against established standards.

Results

Among high-risk patients (n=40), pre-procedure hydration was delivered in 80%, post-procedure hydration in 65%, and combined hydration in 65%. Twenty percent received no documented periprocedural hydration. Nephrotoxic medications were appropriately managed in 80% of cases. Post-procedure renal function was reassessed in 85%. PC-AKI occurred in 5% (2/40); notably, both cases occurred in patients who received neither hydration nor medication optimisation.

Conclusion

Significant variation exists in renal protective practice for high-risk peripheral angioplasty. One in five patients received no documented preventative measures, and all AKI events occurred in unprotected patients. This represents a clearly modifiable patient safety gap. Standardising vascular renal protection pathways offers a low-cost, high-impact opportunity to reduce preventable harm and improve peri-procedural equity of care.

Are we in equipoise? Open versus hybrid aorto-iliac revascularisation and implications for UK national trial recruitment

Georgios Georgallides, Mohammed Fageer, Jae Seon Hong, Albagir Altahir, Tamer El-Sayed, Sandip Nandhra

Northern Vascular Centre, Freeman Hospital, Newcastle Upon Tyne

Background

Aorto-iliac occlusive disease (AIOD) threatens limb and function. Open repair in the past was seen as preferred, yet contemporary practice increasingly favours endovascular and hybrid strategies. Whether this shift is evidence-driven or preference-driven remains unclear – a central issue for the UK EVOCC trial. Can reviewing our own real-world data restore genuine equipoise and support balanced national recruitment?

Method

A retrospective review was performed of CLTI patients who underwent aorto-iliac intervention at a single tertiary vascular centre between January 2023 and December 2024. Outcomes assessed included hospital stay, 30-day readmission, re-occlusion, re-intervention, surgical site infection, amputation, cardiovascular events, and mortality.

Results

In total, 104 patients were identified: 23 (22.1%) underwent open repair and 81 (77.9%) hybrid procedures. The hybrid cohort was older with higher ASA grades and rates of hypertension ($p < 0.05$). No statistically significant differences were observed for any 30-day outcome. Hybrid repair demonstrated a shorter hospital stay (median 5 vs 7 days), lower rates of re-admission (9 [12.3%] vs 5 [26.3%]) and re-occlusion (5 [6.4%] vs 4 [18.2%]), however not significant. Mortality was higher after open repair (3 [13%] vs 4 [4.9%]), though again not significant. Overall complication rates were similar.

Conclusion

Even accounting for selection bias, short-term outcomes were comparable between open and hybrid repair. In the context of evolving practice patterns, this reinforces genuine equipoise and highlights the responsibility to recruit into the UK EVOCC trial rather than default to preference-driven treatment.

Patient reported outcomes after iliofemoral deep venous thrombosis: The experience of a tertiary centre in the United Kingdom

Youssef Ramadan, **Ahamed Mohideen**, Ahmed Abdel Rahim, Paul Jenkins, Devender Mittapalli
University Hospitals Plymouth NHS Trust, Plymouth

Background

Post-thrombotic syndrome (PTS) after iliofemoral deep venous thrombosis (DVT) can negatively impact patients' quality of life. Intervention can mitigate that by reducing the risk of PTS. The aim of this study was to compare quality-of-life outcomes of iliofemoral DVT patients managed with intervention to those managed medically at a tertiary centre in the United Kingdom (UK).

Method

Data was collected retrospectively for iliofemoral DVT patients between January 2020 and December 2024, including demographics, diagnosis, length of stay, management, and complications. After excluding deceased and uncontactable patients, a telephone survey was administered comprising a EuroQol EQ-5D survey and Venous Disability Score (VDS). Statistical analyses were done using Mann-Whitney U-tests, Chi-squared tests, Fisher's exact tests or Student's t-tests.

Results

Of 106 iliofemoral DVT patients, 90 (84.9%) were managed medically and 16 (15.1%) underwent intervention. 34 deceased and 20 were uncontactable were excluded. 45 of the remaining 52 patients (86.5%) participated in the survey (33/45 medical management cohort; 12/45 intervention cohort). Median ages were 67 (range 28-91) and 50 (range 22-62) years in the medical and intervention cohorts, respectively. Medical management was anticoagulation and compression hosiery. Intervention patients underwent catheter directed thrombolysis, with 8/12 (75.0%) also undergoing mechanical thrombectomy. Mobility, usual activity and VDS were significantly better in the intervention cohort ($p < 0.05$, 95% Confidence Interval). Differences between self-care, pain/discomfort and anxiety were not statistically significant.

Conclusion

This study supports existing evidence that patients undergoing intervention for iliofemoral DVT experience better functional outcomes compared to those managed medically.

Who and when: Real-world selection and timing for DVT recanalization

Fernanda Binati, Zahi Qamhawi, Andrew Wigham, Emma Wilton
Oxford NHS Trust Hospital, Oxford

Background

Endovascular therapy for DVT may reduce long-term complications such as post-thrombotic syndrome by restoring venous outflow. While international guidelines support early thrombus removal in selected patients, particularly those with iliofemoral or central involvement, real-world referral patterns, access to intervention, and decision-making processes remain underreported.

Aim

To evaluate referral patterns, time to treatment, procedural types, and reasons for non-intervention in patients referred with DVT.

Method

A retrospective audit was performed on 154 patients referred to a tertiary vascular unit between April 2024 and July 2025. Data collected included demographics, thrombosis location, active malignancy, review-to-intervention interval, type of intervention, and clinician-documented reasons for conservative management. Comparative analysis was conducted between intervention and non-intervention groups.

Results

Of 154 patients, 43 (28%) underwent endovascular intervention. Treated patients were younger (median 48 vs 66 years, $p < 0.001$) and less likely to have active cancer (12% vs 36%, $p < 0.01$). IVC involvement (42%) and upper-limb DVT (41%) were associated with higher rates of intervention. Median time from specialist review to procedure was 3 days (IQR 1–7). Therapies included aspiration thrombectomy (51%), mechanical thrombectomy (47%), venous stenting (40%), and no thrombolytic infusions. Among 111 non-treated patients, common reasons included clinical improvement (16), distal clot burden (13), frailty or comorbidity (12), and minimal symptoms (9).

Conclusion

Most patients referred with DVT were treated conservatively. Treatment decisions were influenced by age, cancer status, clot location, and clinical evolution. Increased awareness of referral criteria and prompt access to vascular expertise may improve equity in endovascular treatment delivery.

Time between referral and angioplasty in CLTI patients and its impact on patient outcomes

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Background

Chronic limb threatening ischaemia (CLTI) represents the most severe form of peripheral arterial disease and carries a high risk of amputation and mortality. Timely revascularisation through angioplasty is vital for limb salvage. National guidance from the Vascular Society of Great Britain and Ireland (VSGBI) recommends angioplasty within five days of referral for inpatients and 14 days for outpatients. The aim was to evaluate compliance with national revascularisation targets and identify causes of delay in patients with CLTI at a specific hospital.

Method

A retrospective project was conducted on 120 CLTI patients referred for angioplasty between February 2025 and June 2025. Data was collected from electronic patient records and Picture Archiving and Communication System (PACS), including referral date, procedure date and inpatient/outpatient status. The interval between referral and angioplasty was calculated and compared with national standards.

Results

The median inpatient interval was 7 days (IQR 4–16), with 38% meeting the five day target. The median outpatient delay was 49 days (IQR 29.5–70.5), with only 12% achieving the 14 day standard. Primary causes of delay were likely limited interventional radiology capacity, delays in pre-procedural imaging and inconsistent referral prioritisation.

Conclusion

The hospital assessed in this project demonstrates partial compliance with national CLTI revascularisation timelines. While inpatient delays were moderate, outpatient waiting times were substantially prolonged. Service redesign, including a fast-track CLTI imaging pathway, dedicated angioplasty lists and improved referral process is recommended to reduce delays and align local practice with national standards.

Type B aortic dissection outcomes: The time has come for a core outcome set — a systematic review

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Background

Type B Aortic Dissection (TBAD) remains a complex condition with no established Core Outcome Set (COS) to standardize clinical research or support decision-making. Existing studies display significant variability in outcome definitions, reporting practices, and follow-up durations, limiting comparability and data synthesis. While optimal TBAD management remains debated, shared decision-making is essential yet patient perspectives are often underrepresented. Most studies emphasize technical success and radiological outcomes from the vascular surgeon's perspective, while overlooking patient-centered metrics. This lack of standardized outcome reporting poses a barrier to generating robust evidence and developing meaningful clinical guidelines.

Objective

To systematically review outcomes reported in TBAD studies as a foundational step toward establishing a COS.

Methods

A systematic review was conducted in accordance with PRISMA guidelines, including studies of all designs that reported outcomes in patients with TBAD treated with medical therapy, thoracic endovascular aortic repair (TEVAR), open surgery, or mixed approaches. Data extracted included study characteristics, treatment modality, follow-up duration, and all reported outcomes.

Results

A total of 153 studies comprising 240,389 patients were included. TEVAR was the most frequently studied treatment (78 studies), followed by mixed strategies (64), medical therapy (10), and one open repair study. Only 58 studies reported follow-up beyond one year. Mortality (105 studies), stroke (86), spinal cord ischemia (71), and renal failure (32) were common outcomes; quality of life was reported in only one study. Outcome reporting was highly variable.

Conclusions

TBAD research emphasizes hard clinical outcomes while neglecting patient-centered measures, highlighting the urgent need for a standardized COS

Surveillance and follow-up after TEVAR for blunt traumatic thoracic aortic injury: A regional multicentre analysis from West Midlands major trauma centres

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Background

Blunt traumatic aortic injury (BTAI) is an uncommon but potentially fatal condition, predominantly affecting younger patients with long life expectancy. According to the European Society for Vascular Surgery (ESVS) 2025 Clinical Practice Guidelines, BTAI is classified into three grades: Grade 1 injuries are generally managed non-operatively with blood pressure control and imaging surveillance, whereas Grades 2 and 3 injuries are most commonly treated with thoracic endovascular aortic repair (TEVAR). Given the polytrauma context and early aortic intervention, subsequent surveillance and follow-up may be overlooked during prolonged hospital admissions and thereafter.

Methods

A retrospective regional analysis was performed across all major trauma centres in the West Midlands. We conducted a retrospective audit on patients treated for BTAI between 2012 and 2024, assessing adherence to post-TEVAR imaging surveillance and vascular follow-up.

Results

Eighty-two patients (N=82) underwent TEVAR for BTAI. Median age was 40 years old (IQR 30-55 years old). Indications were Grade 1 injury in 1 patient (1%), Grade 2 in 42 patients (51%), and Grade 3 in 39 patients (48%). Thirty-day mortality was 11% (9/82). Among the 73 survivors, 12 patients (16.4%) had no documented post-procedural surveillance imaging, and 30 patients (41.1%) did not attend any vascular surgery follow-up appointment.

Conclusions

This regional multicentre experience demonstrates poor compliance with post-TEVAR surveillance imaging and follow-up after BTAI. Given the young age and the uncertainty of long-term risks associated with thoracic stent grafts, robust pathways are recommended to improve long-term surveillance and continuity of care in this vulnerable cohort.

Bridging stent patency after inner branch endovascular aneurysm repair

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Background

Fenestrated and branched endovascular aortic repair (FEVAR/BEVAR) are established treatments for complex aortic aneurysms, but long-term outcomes rely on target vessel patency, and data remains limited. This study aimed to evaluate target vessel stability following inner branch endovascular aortic repair (iBEVAR).

Methods

A single-centre retrospective cohort study was performed including all consecutive patients undergoing iBEVAR between February 2022 and January 2026. The primary outcome was target-vessel primary and secondary patency and assessed using computed tomography (CT) angiography at standardised intervals.

Results

Fifty-four patients underwent BEVAR, incorporating 227 target vessels. The cohort was predominantly male (94%) with a mean age of 78 years. Primary target vessel patency was 95%, with 12 occlusions (5%) in 10 patients (19%) involving the renal arteries (n=8), superior mesenteric artery (SMA) (n=2), and the coeliac artery (n=2). These vessels were found to be occluded at a median of 6 months and mean 7.6 months follow-up. Four reinterventions were performed in 3 patients: 3 endovascular renal reinterventions and 1 emergency laparotomy for SMA occlusion with mesenteric ischaemia. Two coeliac occlusions were noted incidentally and required no reintervention.

Conclusions

This cohort study demonstrates excellent target vessel stability and bridging stent patency at mid-term follow-up. Longer-term reporting is required to understand durability over time.

Female turndown for AAA repair- are devices fit for purpose?

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Background

Female outcomes in vascular surgery are known to be poor. Women with abdominal aortic aneurysms (AAA) are more frequently declined elective repair, yet their outcomes—particularly regarding EVAR suitability and rupture prevention—remain unclear. This study reviews that cohort.

Methods

A retrospective single-network review was conducted of female patients declined AAA repair over a six-year period ending in 2023, with virtual follow-up to June 2025. Data were collected from electronic records, imaging systems, and primary care where available. Results are presented as mean and median (IQR). Cause of death data were obtained from coroner and bereavement services when available.

Results

Seventy patients were identified (mean AAA size 7 cm; median age 84.5 years, IQR 79.1–90). Fifty-six had complete datasets. Among 23 patients with sub-threshold AAA (<5.5 cm), only two were EVAR-suitable (neither ruptured). Of the remaining 21, 20 had adverse neck anatomy and one had access issues; 3/21 died from ruptured AAA (rAAA). Among 33 patients with threshold AAA (>5.5 cm), only three were EVAR-suitable; one died from rAAA 30.5 months after turndown (AAA 7.1 cm). All 30 unsuitable patients had adverse neck features; 9/30 died from rAAA.

Conclusions

Women declined AAA repair commonly have anatomy unsuitable for standard EVAR and experience higher rupture rates than matched men. Current EVAR device design may limit treatment options for women and warrants reconsideration.

Duplex Ultrasound after Endo Revascularisation (DUSTER) feasibility randomised controlled trial

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Background

This NIHR funded study will investigate the feasibility, acceptability and impact on clinical decision making of a 1- year integrated ultrasound surveillance programme after endovascular therapy for chronic limb threatening ischaemia.

Methods

Phase I is a 3 site, feasibility, open-label, randomised controlled trial. The control arm is standard clinical surveillance by a vascular specialist at 1, 6 and 12 months. The intervention arm will receive 1,6 and 12 month ankle-brachial pressure index, toe pressure and duplex plus standard clinical surveillance. Feasibility outcomes are rates of attendance, completion of ultrasound components and percentage undergoing reintervention for restenosis. Secondary outcomes are limb salvage, amputation-free survival, reasons for amputation, complications, serious adverse events and mortality. Phase II comprises semi-structured interviews in the surveillance arm. Phase III has separate focus groups for participants and clinicians to identify which outcomes matter in future trials.

Results

DUSTER recruited to its sample size of 73 in December 2025 over 9 months. The eligibility rate of those screened was 63% and the participation rate was 65%. Baseline age was 70 (SD 13), 79% were male and 89% were Caucasian. Rutherford class was 4 in 33%, 5 in 60% and 6 in 7%. Endarterectomy or cutdown was performed in 12%. Baseline EQ5D global health score was 65/100 (SD 22) and Barthel independence levels were 82/100 (SD20).

Conclusions

DUSTER will inform the practice of ultrasound surveillance after lower limb endovascular and is set to report in early 2027.

Morphological phenotypes are associated with early type I endoleak despite failure of conventional hostile neck and access metrics

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Background

Traditional binary morphological neck and access thresholds have a limited ability to predict early type 1 endoleaks (T1EL) following endovascular aortic aneurysm repair (EVAR). This study aimed at using fully automated volume segmentation (FAVS) to identify anatomical phenotypes associated with early T1EL.

Methods

This was a multicentre retrospective cohort study of patients undergoing EVAR, whose pre-operative CT angiography were analysed FAVS, with linked National Vascular Registry clinical data. Unsupervised Gaussian mixture modelling was used to identify anatomical phenotypes. The primary outcome was early (≤ 30 -day) T1EL. Phenotypes were compared for endoleak rates and distribution of hostile anatomy. Performance of traditional hostile anatomy constructs was evaluated for comparison, and assessed using receiver operating characteristic, and area under the curve analysis (AUC).

Results

Among 1,003 patients, early T1EL occurred in 62 (6.2%). Traditional hostile anatomy constructs demonstrated poor discrimination for early T1EL (AUC 0.533). Six distinct morphological phenotypes were identified, with significantly different early T1EL rates (4.2%–21.6%, $p=0.001$). All phenotypes contained anatomies classified as both hostile and non-hostile by conventional criteria (38.9%–83.4%), with significant differences in neck thrombus and calcification burden ($p<0.001$). After adjustment for baseline characteristics, phenotype remained independently associated with early T1EL and significantly improved model fit compared with hostile anatomy-only models (likelihood ratio test, $p=0.041$). Overall model discrimination was modest (AUC 0.697, 95% CI 0.632–0.761).

Conclusions

Traditional hostile anatomy definitions inadequately predict early T1EL after EVAR. High-dimensional morphological phenotyping using FAVS identifies anatomical patterns associated with early failure, supporting a move toward morphology-driven EVAR planning.

Conformable Endovascular Aneurysm Repair (EVAR) stability in hostile neck Abdominal Aortic Aneurysms: A single-centre experience

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Background

Stent graft migration is a recognized complication of endovascular aneurysm repair (EVAR) and may result in type I endoleaks, renal artery compromise, and reintervention, particularly in patients with hostile proximal neck anatomy. The GORE Excluder Conformable AAA Endoprosthesis (CLEVAR) is designed to accommodate short, narrow, and highly angulated necks. This study evaluated early graft stability by assessing migration within the first postoperative year in patients with hostile neck anatomy.

Methods

A retrospective analysis was performed of patients undergoing EVAR with the CLEVAR device for hostile neck abdominal aortic aneurysms between January 2019 and December 2022. Patients with computed tomography angiography at both three months and one year postoperatively were included. Migration was defined as the change in distance between the proximal stent edge and the bilateral renal arteries. Descriptive statistics were calculated. Normality was assessed using the Shapiro-Wilk test, and comparisons were performed using the Wilcoxon signed-rank test.

Results

Twenty-five patients were included. Mean stent migration was 1.29 mm (SD 1.36mm), with a median of 0.85 mm and a maximum of 6.0 mm. Mean migration relative to the right and left renal arteries was 1.17 mm and 1.40 mm, respectively, with no significant difference between sides ($p = 0.4261$). Migration was statistically greater than zero ($p < 0.00000001$) but remained small.

Conclusions

The CLEVAR device demonstrated minimal early migration and stable proximal fixation in hostile neck anatomy during the first postoperative year. These findings support reliable early stability, although longer-term studies with larger cohorts are required to confirm durability.

Post-Endovascular Aneurysm Repair surveillance in the United Kingdom: A survey of current clinical practice

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Background

The aim of this survey is to establish current post-EVAR surveillance practice across vascular centres in the United Kingdom (UK) and report variations in practice, including adherence to the latest European Society of Vascular Surgery (ESVS) clinical practice guidelines.

Methods

Cross-sectional web-based survey was disseminated to 64 aortic centres in the UK, and data collected on the use of various imaging modalities at set time points after standard infrarenal and complex EVAR.

Results

Response rate was 84.4% (54/64 centres). Early imaging was CTA (44/54, 81.5%), DUS (22/54, 40.7%) and AXR (8/54, 14.8%) for standard EVAR and CTA (37/39, 94.9%), DUS (11/39, 28.2%) and AXR (6/39, 15.4%) for complex EVAR, with variability in timing. One year imaging for standard EVAR was CTA (21/47, 44.7%), DUS (30/47, 63.8%) and AXR (9/47, 19.1%), and CTA (26/32, 81.3%), DUS (11/32, 34.4%) and AXR (7/32, 21.9%) for complex EVAR.

The predominant choice for annual surveillance after standard EVAR was DUS (45/54, 83.3%) followed by CTA (10/54, 18.5%), with the dominant choice CTA at 22/39 (56.4%) centres and DUS at 21/39 (53.8%) centres after complex EVAR. Only one centre employed an extended interval after initial imaging until 5 years after EVAR as per ESVS guidelines.

Conclusions

This survey reveals the variation in surveillance practices after EVAR between vascular centres in the United Kingdom, with limited adherence to the ESVS clinical practice guidelines. There continues to be a reliance on CTA for early post-EVAR surveillance, with ultrasound mostly used for long-term follow-up.

Reducing delays in the diagnosis and management of arterial acute mesenteric ischaemia: A five-year audit informing development of a multidisciplinary regional care pathway

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Background

Arterial acute mesenteric ischaemia (AMI) is a time-critical vascular emergency with high mortality. Diagnosis is often delayed due to non-specific presentation and variable referral pathways, especially in transferred patients. Delays in recognition, imaging, and specialist involvement worsen outcomes. This audit aimed to identify causes of delay and inform development of a standardised multidisciplinary protocol to reduce time to definitive care.

Methods

A retrospective single-centre clinical audit was conducted between 2020 and 2025. Adult patients with confirmed arterial AMI were identified using hospital coding and vascular referral databases. Patients with incomplete documentation or non-arterial aetiology were excluded. Data were collected against 59 predefined criteria including demographics, comorbidities, referral source, CT imaging timelines, time to management decision, and treatment strategy. Descriptive analysis identified delays and variation in care. The project was registered as a clinical audit and did not require formal ethical approval.

Results

Of 145 screened patients, 88 met inclusion criteria. Admissions occurred under Vascular Surgery (n=40), General Surgery (n=24), combined teams (n=8), and other specialties (n=16). Mean CT request-to-scan time was 3h19m, scan-to-report 4h55m, and CT-to-revascularisation 5h38m. Only 30/88 CT requests documented suspected AMI. Revascularisation occurred in 23/88 patients. Overall mortality was 52/88.

Conclusions

Significant and potentially avoidable delays were identified across the arterial AMI pathway. A structured multidisciplinary protocol and MDT proforma were developed to standardise early recognition, explicit CT documentation, and timely escalation. Wider regional adoption with prospective data collection is expected to reduce diagnostic delay and improve patient-centred outcomes.

Clinical messages from the GLOBALSTAR registry: Improving care in Fenestrated Endovascular Aneurysm Repair (FEVAR)

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Background

GLOBALSTAR is a registry of complex EVAR; long-term outcomes of FEVAR have previously been reported. Aims: examine differential outcomes after FEVAR between 'high-risk' subgroups- octogenarians, women, secondary FEVAR and complex graft configurations; describe patient journeys to secondary sac rupture.

Methods

Retrospective cohort study of GLOBALSTAR. Standard descriptive/comparative statistics were applied to peri-operative complications. Kaplan-Meier/cumulative incidence with competing risks were applied to survival, reintervention and endoleaks. Log-rank/Fine-Gray were used to compare subgroup time-to-event functions. Swimmer plot analysis summarised progression to rupture.

Results

n=1651 FEVARs in GLOBALSTAR.

Octogenarians: equivalent incidence of peri-operative complications ($p=0.2$) and 1-year survival ($p=0.11$). Equivalent survival out to 7 years between 80-84 and ≥ 85 -year-olds ($p=0.284$). Women: compared to men, ~ double incidence of major complication (22.0%vs11.9%, $p<0.001$), ~ three-fold incidence of MACE (5.9%vs2.1%, $p=0.006$) and peri-operative death (5.9%vs2.1%, $p=0.004$). Secondary FEVAR: over follow-up, significantly higher risk of re-intervention (sHR 1.79, 95%CI:1.37–2.34, $p<0.001$) and graft-related endoleaks, Type I (sHR 2.37, 95%CI:1.45–3.88, $p=0.001$) and Type III (sHR 2.12, 95%CI:1.36–3.32, $p=0.001$). Graft configurations: equivalent incidences of peri-operative complication ($p=0.1$), although all SCI cases (1.0%) occurred in the 4-fenestration group; equivalent rates of reintervention over follow-up. Secondary rupture: n=36, 83.3% with detected endoleaks, 50.0% with reintervention preceding rupture.

Conclusions

Age alone should not be used to preclude patients from FEVAR, effective case selection can yield good outcomes for octogenarians. Significantly worse peri-operative outcomes for women suggests better pre-operative investigation/optimisation is required. Higher rates of reintervention and graft-related endoleak for secondary FEVAR may justify more aggressive surveillance.

Outcomes following femoro-popliteal stenting surveillance: A three-year single-centre experience

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Background

Optimal post-stent surveillance following femoro-popliteal stenting is controversial. We evaluated the effectiveness of an SFA stent surveillance programme and the factors influencing stent failure.

Methods

A retrospective analysis was conducted using a prospective database of all femoro-popliteal stents implanted between January 2022 and December 2024. Demographic data, peripheral arterial disease risk factors, antithrombotic therapy, Rutherford and TASC classification, PACCS score, vessel preparation techniques and stent-type were collected. The primary outcome was primary patency. Secondary outcomes included re-intervention, major adverse cardiovascular events (MACE), major adverse limb events (MALE) and mortality. Clinical follow-up was evaluated with attention to timing, symptoms and attendance to duplex US surveillance. Analysis was performed using IBM SPSS Statistics v31.0.2.0.

Results

166 patients were included, 112 males and 54 females, mean age 75.6 years (range 49-96). 68% were Rutherford stage 4-6 and the majority Rutherford 5 (50.6%). Re-intervention before 1-year surveillance occurred in 31.3%, major amputation in 10.2%, and mortality in 24.3%. Re-intervention and limb loss were higher in Rutherford 4-5 disease. TASC C lesions were significantly associated with major amputation (17.4%, $p=0.049$). Vessel preparation and stent type were not associated with patency. 97% attended clinical follow-up; however, 59% had clinical deterioration prior to duplex surveillance; only 19.8% underwent planned duplex assessment. Dual antiplatelet therapy demonstrated a lower non-significant trend towards MALE.

Conclusions

MALE following femoropopliteal stenting appears driven by disease severity and lesion complexity not device selection. The predominance of symptom-driven re-intervention demonstrates that annual surveillance is inadequate and supports more frequent duplex surveillance.

When antiplatelet is not enough: Platelet function monitoring and glycaemic control predict early adverse event in peripheral arterial disease

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Background

Antiplatelet therapy is a cornerstone of medical management in peripheral arterial disease (PAD). Despite known inter-individual variability in clopidogrel response, platelet function testing (PFT) is not routine, and the clinical significance of "clopidogrel resistance" remains poorly defined. We aimed to evaluate whether PFT, combined with clinical biomarkers, could identify patients at high risk of early post-procedural failure.

Methods

A prospective, single-centre study (2024–2025) included PAD patients undergoing lower-limb revascularisation on clopidogrel monotherapy. Perioperative platelet function was quantified using the Multiplate® analyser (ADP-test). The primary endpoint was a four-month composite of target lesion reintervention (TLR), major amputation, or all-cause mortality. Multivariable logistic regression was utilised to develop a risk-stratification model.

Results

Eighty patients completed the four-month follow-up. Platelet reactivity demonstrated significant heterogeneity, with markedly higher variance in patients who experienced adverse outcomes ($p=0.00022$). While traditional comorbidities including BMI, COPD, and cardiac and cerebral were not predictive of events, ADP-induced platelet aggregation and HbA1c were identified as significant independent predictors. A dual-variable model incorporating these two factors stratified the cohort:

High-Risk Group (35% of cohort): 46% adverse event rate.

Low-Risk Group (65% of cohort): 4% adverse event rate.

The model demonstrated excellent discrimination (AUC 0.89) and a significant difference in event-free survival (log-rank $p=0.00059$).

Conclusions

Clopidogrel response is highly variable in PAD. A strategy combining PFT and HbA1c reliably identifies a high-risk phenotype prone to early failure, providing a framework for personalised antithrombotic escalation and perioperative glycaemic optimisation.

Treatment decisions in peripheral artery disease: What do patients prioritise?

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Background

Symptomatic lower-limb peripheral artery disease (PAD) is heterogeneous, ranging from intermittent claudication to chronic limb-threatening ischaemia (CLTI). Management includes best medical therapy and exercise, endovascular or open revascularisation, and amputation for advanced disease. Many choices are preference-sensitive and depend on how patients weigh benefits, burdens and risks, yet evidence on what patients prioritise and how values are incorporated into shared decision-making (SDM) is limited. This review examined patient priorities and SDM across PAD treatment decisions, including endovascular choices.

Methods

A PROSPERO-registered systematic review (CRD420251106155) was conducted following PRISMA guidance. MEDLINE, EMBASE and CENTRAL were searched for English-language studies between 1 January 2000 and 17 December 2025. Eligible studies included adults with symptomatic PAD reporting priorities, information needs, decisional role preferences, or SDM experiences. Two reviewers independently screened and extracted data. Findings were synthesised narratively.

Results

Of 319 records screened, 34 studies were included. Across claudication, CLTI and peri-amputation, priorities centred on function and quality of life: walking, pain relief, independence and emotional wellbeing. Revascularisation decisions reflected anticipated benefit, durability, likelihood of technical success, repeat procedures, surveillance and rehabilitation, and included perspectives relevant to endovascular care. Many patients preferred SDM yet described lower-than-desired involvement, often alongside limited PAD knowledge and inconsistent communication. Stated-preference studies demonstrated heterogeneity in risk tolerance and trade-offs. Study quality was mixed.

Conclusions

Patient priorities in PAD vary and extend beyond procedural choice. Strengthening SDM through values elicitation, decision support, and clearer discussion of trade-offs may better align revascularisation treatment decisions with outcomes that matter to patients.

Utilization of Natural Language Processing (NLP) for visceral artery aneurysms identification from radiology reports

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Background

Visceral artery aneurysms (VAAs) are rare entities with poorly defined true population incidence, and estimated prevalence ranging from 0.01% to 2%. The rarity of VAAs limits the development of high-quality evidence of on their etiology, natural history and treatment outcomes. Delayed referral of patients with VAAs is poorly quantified because most VAAs are incidentally detected and referral pathways differ between centres. The machine learning (ML) using natural language processing (NLP) can automate detection and referral process to vascular services. We aimed to develop NLP-based machine learning models to identify patients with VAAs from radiology reports, and to analyse epidemiology and outcomes of patients with VAAs managed in a single quaternary vascular centre.

Methods

We screened radiology reports from the University Hospitals Birmingham NHS Foundation Trust from 2011 to 2021. Cases were labelled manually as positive for any visceral artery aneurysm and negative for their absence. Six different ML models were trained/validated and tested.

Results

We screened 114,378 radiological reports of CT scans and identified 93 VAAs in 85 patients. VAAs involved: splenic artery – 52 cases (55.9%), renal arteries – 19 cases (20.4%), hepatic artery – 9 cases (9.7%), CA – 8 cases (8.6%), SMA – 4 cases (4.3%) and gastroepiploic artery – 1 case (1.1%). Six models showed divergent performance: Stochastic Gradient Descent (98.1% accuracy, 75% sensitivity, MCC=0.792) and Decision Tree (97.7%, 75%, MCC=0.783) achieved optimal results. All models achieved >96% accuracy and >99% specificity despite varying sensitivity.

Conclusions

NLP-based ML algorithms can be used to identify VAAs cases from radiology reports.

Radiation protection training in endovascular surgery: A systematic review of educational interventions

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Background

Endovascular proceduralists are routinely exposed to ionising radiation, yet structured training in radiation protection (RP) remains inconsistent. In the UK radiation safety education is mandated however, there is limited clarity regarding teaching methods, competency standards, or measurable occupational outcomes. We conducted a PRISMA-guided systematic review to evaluate the effectiveness of radiation protection teaching interventions in vascular surgeons and interventional radiologists.

Methods

Databases were searched from 2016 - 2026 using predefined terms relating to RP, fluoroscopy/endovascular practice, and education/training interventions. Studies were eligible if they evaluated a defined RP teaching intervention targeting vascular surgeons or interventional radiologists and reported at least one measurable outcome. Two reviewers independently screened records, assessed texts, and extracted data on educational modality, intervention components, and outcomes. Owing to heterogeneity, results were synthesised narratively.

Results

Of 176 records identified, 18 underwent full-text review and 4 studies met inclusion criteria. All were single-centre studies, predominantly non-randomised pre-post designs. Educational modalities included simulation-based training, immersive virtual reality, augmented reality visualisation, and structured interventional radiology workshops. Short-term improvements in knowledge and procedural awareness were consistently demonstrated. Some studies reported improved radiation-conscious behaviours. Objective occupational dosimetry endpoints and long-term retention were infrequently measured. No multicentre comparative trials evaluating different teaching modalities were identified.

Conclusions

There remains a marked paucity of high-quality evidence guiding RP training for endovascular proceduralists. Despite mandatory UK training requirements, evidence-based pedagogical frameworks are lacking. Robust, competency-based, and dose-informed trials with standardised endpoints are needed to define training strategies and improve operator safety in practice.

Revascularization Outcomes in nonagenarians in Symptomatic Elderly with Peripheral Arterial Disease – the ROSEPAD registry

Dimitrios Vlastos on behalf of the ROSEPAD registry

Background

Continuous advancements in the medical field have significantly increased life expectancy, leading to a growing population of older individuals. However, data regarding the outcomes of revascularization for symptomatic peripheral arterial disease (PAD) in nonagenarians is scarce. The aim of this study is to analyze the safety and efficacy of invasive therapies in nonagenarians undergoing revascularization for lower limb atherosclerosis.

Methods

This is a multicenter, European, retrospective analysis of patients aged 90 years or older, who underwent endovascular, open, or hybrid treatment for symptomatic PAD (Rutherford Class 3-6) between December 2017 and December 2023. Primary endpoint of the study is amputation-free-survival (AFS). Overall survival (OS), amputation-free time (AF), and freedom from any reintervention of the index limb were additionally analyzed

Results

A total of 566 patients were included. The majority underwent endovascular- (n=462, 81.6%), followed by open- (n=60, 10.6%), and hybrid revascularization (n=44, 7.8%). At 36 months the AFS was 21.4%, while the freedom from amputation was 85.7% and the OS rate was 23.7%. Freedom from reintervention rate at 3 years was 73.7%. Male sex, history of coronary heart disease, periprocedural acute kidney injury, and periprocedural myocardial infarction were associated with reduced AFS [HR = 1.41 (1.10-1.79), 1.50 (1.17-1.91), 2.20 (1.55-3.1), and 2.14 (1.04-4.39), respectively], while postprocedural dual antiplatelet therapy conferred a beneficial effect [HR = 0.73 (0.56-0.95)].

Conclusions

Lower limb revascularization in nonagenarians with PAD is associated with low major amputation and re-intervention rates. However, a significantly increased mortality was observed at 3 years.

Contemporary experience of using intravascular ultrasound in the endovascular management of peripheral arterial disease

Arsalan Wafi, Vicknah Balarajah, Narayanan Thulasidasan, Ashish Patel
Guy's and St Thomas's, London

Background

Intravascular ultrasound (IVUS) use in peripheral artery disease (PAD) intervention remains controversial. We evaluated where IVUS changes endovascular decision-making and described outcomes across lesion complexity from a workflow perspective.

Methods

Retrospective analysis of consecutive IVUS-guided endovascular PAD interventions (2018–2026). We extracted treated levels, GLASS stage (infrainguinal), vessel preparation and definitive therapies, IVUS-guided actions pre/post-treatment, and IVUS-detected dissection/residual stenosis. Outcomes were reintervention, amputation and death; 1-year Kaplan–Meier estimates were calculated.

Results

345 procedures (364 limbs) were included (mean age 70±11 years; 66% male, 92% Rutherford≥4). Multi-level revascularisation occurred in 55% of limbs; among infrainguinal limbs, GLASS III comprised 50%. Vessel preparation was extensive (POBA 70%, IVL 32%, atherectomy 20%), with ≥2 preparation modalities in 47%. Definitive therapy commonly combined modalities (≥2 in 41%): DCB 61% and any stent 61% (BMS 37%, DES 31%, covered stent 12%). IVUS guided preparation choice in 18% and triggered post-treatment optimisation in 35%. IVUS detected dissection in 25% and residual stenosis in 21%, most often prompting further ballooning or additional stenting. At 1 year, freedom from reintervention was 78%, freedom from amputation 94%, survival 83% and amputation-free survival 78%. There was a strong temporal trend of improvement in reintervention rates.

Conclusions

In a real-world cohort dominated by complex multilevel/GLASS III disease, IVUS frequently provided actionable lesion phenotyping and optimisation feedback that altered workflow. Outcomes were excellent considering the extensive lesion and severity of ischaemia treated, supporting IVUS as a decision-support tool for PAD intervention.

Predictors of symptomatic improvement following endovascular treatment for pelvic congestion: The role of reflux territory

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Background

Endovascular intervention for pelvic congestion Syndrome often achieves radiological technical success, yet symptom improvement varies. We analysed symptom-severity and reflux-territory to understand whether targeted treatments may predict symptomatic response.

Methods

Retrospective, single-centre cohort study over three years (ending July 2025). Thirteen symptom domains recorded pre and post-intervention (0-13). Reflux-territory grouped as ovarian vein (OV)-dominant, internal iliac vein (IIV)-dominant, mixed (OV+IIV), low/none. Clinical response defined as $\geq 30\%$ reduction in symptoms in line with published literature. Technical success recorded on post-procedure duplex.

Results

54 patients (of 82) had data available for analysis. Median age was 39. Mean symptom-severity score was 8.4 pre-intervention, two thirds (36/54) of patients had mixed OV+IIV reflux pattern. No pre-intervention symptom-reflux alignment on univariate analysis. Coils used in 50/54 (92.6%) alongside STS in 44/54 (81.5%). No early complications recorded. Technical success was 90.4% (47/52) at follow-up. Post-intervention, mean symptom-severity score improved to 6.2, treatment effect -2.2. 46.3% (25/54) met response criteria. Symptomatic response appeared to vary by reflux-territory: IIV-dominant 60.0% (3/5), mixed OV+IIV 50.0% (18/36), OV-dominant 37.5% (3/8), low/none 25.0% (1/4). Greatest symptom improvement was in iliac fossa pain (88.9%:51.9%), dyspareunia (70.4%:35.2%) and pelvic dragging pain (88.9%:63.0%).

Conclusions

Endovascular pelvic venous interventions are safe and achieve high rates of technical success in our unit. Nearly half of patients achieved at least 30% symptomatic improvement, particularly iliac fossa pain and dyspareunia, within IIV-dominant or mixed OV+IIV reflux patterns. Pre-procedure symptom profile with reflux-territory may facilitate patient selection and targeted treatment.

Endovascular native arterial recanalisation after failed infrainguinal surgical bypass: A systematic review and meta-analysis

Darshan Barki, Vickna Balarajah, Harishankar Nari, Prakash Saha, Said Abisi, Hany Zayed, Junjie Ng
Guy's and St Thomas' NHS Foundation Trust, London

Background

Endovascular recanalisation of chronically occluded native arteries has emerged as a promising therapeutic option for patients with lower limb bypass graft failure. We performed a systematic review and meta-analysis to evaluate the clinical outcomes associated with this approach.

Methods

A systematic literature search was conducted in PubMed, Embase, and the Cochrane Library, adhering to PRISMA guidelines. Studies that had reported outcomes after endovascular recanalisation of chronically occluded native arteries after failed infrainguinal surgical bypass were included. A random-effects meta-analysis of proportions was performed to obtain the weighted outcomes. Our study outcomes were technical success (TS), 12-month primary patency (PP), 12-month assisted primary patency (APP), 12-month secondary patency (SP), 12-month amputation-free survival (AFS), and 12-month limb salvage (LS) rate.

Results

Eleven studies with 817 patients and a total of 820 treated limbs were analysed. The weighted pooled TS was 95.6% (95% CI, 92.4%-97.5%). At 12 months, the weighted pooled PP was 49.2% (95% CI, 33.6% - 64.9%), APP was 81.6% (95% CI, 65.1%-91.3%), and SP was 86.4% (95% CI, 68.2% - 95.0%). The 12-month weighted pooled AFS and LS rates were 90.4% (95% CI, 84.1% - 94.4%) and 94.4% (95% CI, 90.2% -96.9%), respectively.

Conclusions

Endovascular recanalisation of chronically occluded native arteries following infrainguinal surgical bypass graft failure is associated with high technical success, reasonable short-term patency rates and favourable limb salvage rates. This approach remains a valuable limb-preserving strategy for patients with limited revascularisation options.

Single centre experience of the Phoenix mechanical atherectomy system

Vickna Balarajah, Arsalan Wafi, Narayanan Thulasidasan, Mohamed Abdelhalim, Ashish Patel
St Thomas', London

Background

Published experience with the Phoenix rotational atherectomy system largely reflects mixed peripheral arterial disease cohorts with short lesions and limited chronic total occlusion (CTO) burden. Evidence in real-world chronic limb-threatening ischaemia (CLTI) with long, complex disease remains limited. We report mid-term outcomes from a UK tertiary centre in a predominantly CLTI population with high CTO burden.

Methods

A retrospective analysis was performed of all procedures using the Phoenix system between 2017 and 2024. Follow-up was available to January 2026. Primary outcomes were device-related complications, primary patency, and freedom from major adverse limb events (fMALE).

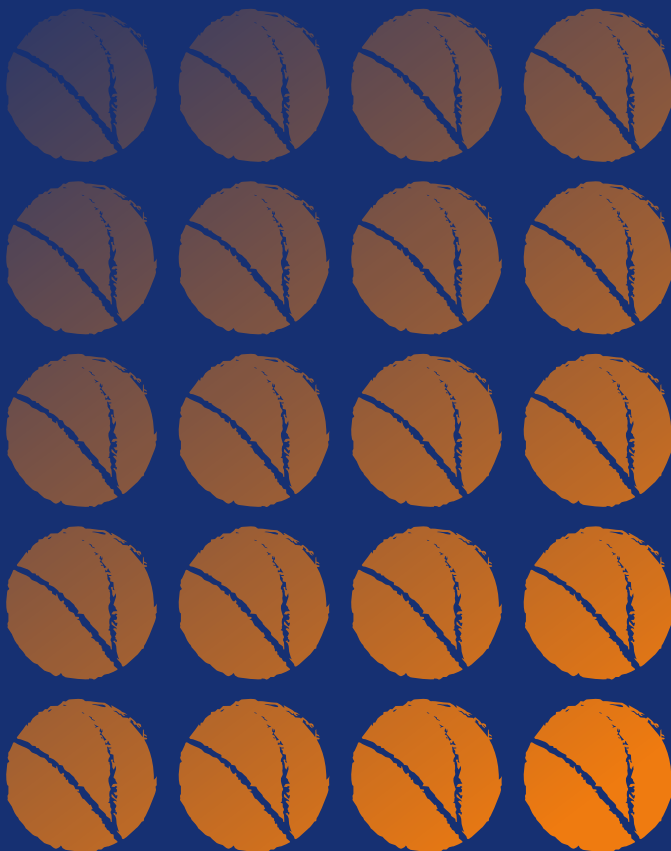
Results

Ninety-six procedures were analysed (mean age 69 ± 11.5 years; 66% male). CLTI (Rutherford 4–6) accounted for 96% of cases. Median lesion length was 190 mm (IQR 177 mm), with 83% CTOs. Device crossing failure occurred in 2%. Perforation and distal embolisation each occurred in 5%; perforations were observed when intravascular ultrasound (IVUS) was not used to confirm intraluminal wire position. Stenting was required in 32% of cases, though overall stent length was reduced following atherectomy. Crural interventions were associated with worse primary patency (HR 2.56, $p=0.038$) and limb salvage (HR 4.85, $p=0.004$). Drug-coated balloon (DCB) use was associated with improved primary patency (HR 0.34, $p=0.019$).

Conclusions

In a real-world UK CLTI cohort with long lesions and high CTO burden, Phoenix rotational atherectomy achieves acceptable mid-term outcomes. Outcomes are segment-dependent, with inferior results in crural vessels. Adjunctive DCB improves patency, and rotational debulking supports a stent-sparing strategy.

Posters



POSTER 1

The provision of vascular surgery in sub-Saharan Africa: A multi-country facility readiness survey

Nick Moody¹, Becky Sandford²

¹University of Birmingham, Birmingham

²Guy's and St Thomas' NHS Trust, London

POSTER 2

Comorbidity prevalence and clinical outcomes following endovascular aortic aneurysm repair in patients with and without diabetes mellitus: A systematic review

Shriya Karlapudi^{1,2}, Xiaoyang Li², Kawal Rhode²

¹Faculty of Life Sciences and Medicine, King's College London, London

²School of Biomedical Engineering & Imaging Sciences, King's College London, London

POSTER 3

Aortic Aneurysm repair in patients 85 years and over

Emily Uden¹, Rose O'Riordan¹, Shiva Dindyal¹, Vijay Gadhvi¹, Ankur Thapar²

¹Mid and South Essex Vascular Unit, Basildon

²Anglia Ruskin University, Chelmsford

POSTER 4

Comparison of post operative neck dilatation following in EVAR with Self-Expanding (SES) and Non-self Expanding (NSES) stent grafts

Anuradha Venugopal, Shazmeen Iqbal, Mariya Patel, Maneesha Weerasooriya,

Raksaini Sivasubramaniam, Mohammad Bukhari, Sana Patel, Deevia Kotecha,

Steve D'Souza, Thomas Joseph

Royal Preston Hospital, Preston

POSTER 5

Type B aortic dissection in pregnancy: A systematic review and meta-analysis of presentation, management, and outcomes

Diego Abelleyra Latoria, Michal Kawka, Anna Pouncey, James Budge, Iain Roy, Peter Holt
City St George's, University of London, London

POSTER 6

Clinical and economic outcomes of percutaneous versus open femoral access for endovascular aortic interventions

Ahmed Elshiekh, Sherif Hassan, Ahmed Hassan, Asharf Elshakawy

University Hospitals Coventry and Warwickshire NHS Trust, Coventry

POSTER 7

Predictors of 30-day readmission following elective lower limb angioplasty: A single-centre retrospective study

Eftichia Iossifidis, Isaac Jabang, Vijay Gadhvi

Basildon University Hospital, Basildon

POSTER 8

Contemporary patterns of femoropopliteal peripheral arterial disease treated with the Orbital Atherectomy System (OAS): A retrospective observational analysis

Alireza Sherafat^{1,2}, Dimitrios Vlastos^{1,2}, Badri Vijaynagar¹

¹Vascular Surgery Department, University Hospitals of Leicester, Leicester

²College of Life Sciences, University of Leicester, Leicester

POSTER 9

Does prior angioplasty influence bypass strategy in TASC C and D femoropopliteal lesions?

Mohamed Shamil, Mojahid Najem, Divesh Karki, Selva Theivacumar

Northwick Park Hospital, London Northwest University Healthcare NHS Trust, Harrow, London

POSTER 10

Endovascular management of cancer-associated ilioacaval and iliofemoral venous disease: single-centre outcomes and contemporary context

Fernanda Binati, Samuel Galea, Zahi Qamhawi, Andrew Wigham, Emma Wilton

Oxford NHS Trust Hospital, Oxford

POSTER 11

Transcervical carotid artery revascularisation complicated by retrobulbar haemorrhage: A case report

Ankita Keshwala, Mohamed Elsherif

Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield

POSTER 12

Establishing a new Endovascular Arteriovenous fistula service: A multidisciplinary team approach

Emma Scott, Eyas Qasem, James Andrews, Haytham Hamid, Erin Chuter

Sunderland Royal Hospital, Sunderland

POSTER 13

Vascular specialty training duration in comparison to other higher surgical specialties in the UK – A 15-year retrospective analysis (2010–2025)

Jason Lawson^{1,2}, Colin Bicknell¹, Hutan Ashrafian¹, Tom Petrov-Clayton², Celia Riga^{1,2}

¹Imperial, London

²NHS England, London

POSTER 14

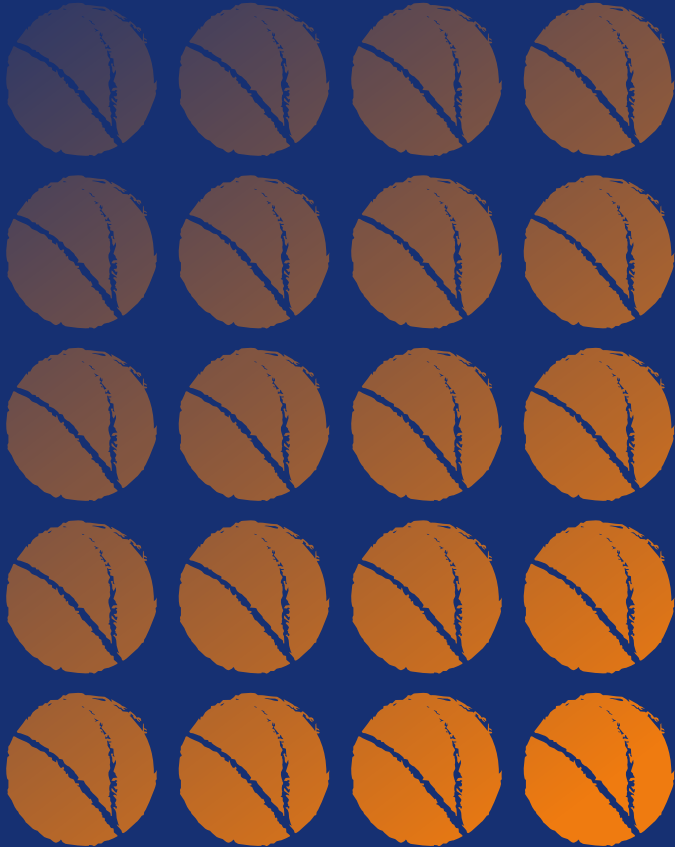
Comparison of Total Dose Area Product (DAP) between conventional and hybrid vascular theatres: An audit at one of the NHS Lanarkshire hospitals

Wasan Alhunaidi¹, Mr. Alex Vesey²

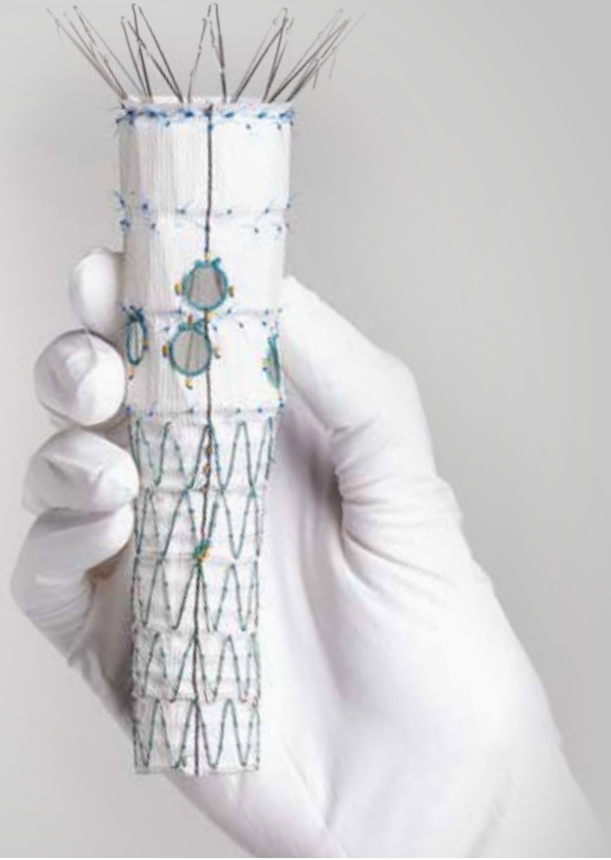
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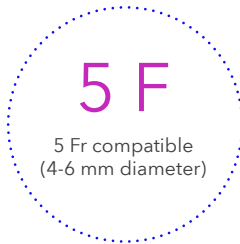
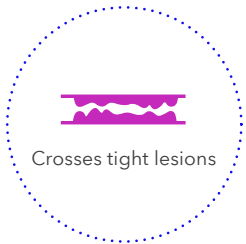
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References

² Laird JA, Schneider PA, Jaff MR, et al. Long-Term Clinical Effectiveness of a Drug-Coated Balloon for the Treatment of Femoropopliteal Lesions: 5-year results from the IN.PACT SFA Trial. *Circ Cardiovasc Interv.* June 2019;12(6):e007702.

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2028

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