ASITN
American Society of Interventional & Therapeutic Neuroradiology

The Embolus

Winter/Spring 2004

New Device Turns National Media Attention on Neurointervention

Neurointervention made headlines across the country in 2003 with the debut of the MERCI retriever. The new device, which consists of a nickel-titanium coil that straightens out in the catheter and then springs back to shape to capture the obstructing clot, was reported in such major media outlets as CNN, CBS Evening News with Dan Rather, and the AP. One of the most visible stories of the year was in *Newsweek* magazine, which named the MERCI retriever one of its Top 10 Health Stories of 2003. ASITN members Pierre Gobin and Thomas Grobelny were highlighted in the article regarding their use of the MERCI device. Kieran Murphy was also quoted on the subject of a procedure unrelated to the MERCI retriever being used at Johns Hopkins to attack vertebrobasilar stroke. The MERCI retriever, manufactured by ASITN Corporate Advisory Council Member Concentric Medical, is currently under consideration for FDA approval. Concentric applied for approval using data from more than 110 patients. ASITN will keep you updated on any new FDA developments AND any new publicity which highlights our specialty in the news!

ASITN Announces New Meeting – In Paradise!

ASITN is pleased to take you to the breezy tropics of Florida for what promises to be the new premiere interventional meeting, the First Annual ASITN Course & Workshops. The conference is scheduled for August 10-14, 2004 at the Boca Raton Resort & Club in Boca Raton, Florida.

Featuring the most up-to-date information on topics and trends in the field of neurointervention, this meeting will afford participants unprecedented time in interactive forums with the leaders in our field as well as well-planned, structured opportunities with industry leaders.

Integrating the best of both worlds, ASITN has worked hard to strike the perfect balance in providing participants with both a unique educational opportunity as well as a get-away sure to rank at the top of your family's list of favorite vacations! Listed as one of the "Leading Hotels of the World", the Boca Resort offers guests a host of luxuries including several themed dining establishments with entertainment, a world-class spa (recently named one of "The Best American Spas" by *Departures* magazine), games and activities for the entire family and white sandy beaches right outside of your accommodations.

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Inside *this issue*

ACR Update

As part of Resolution 5, Interventional Radiology and Interventional Neuroradiology Clinical Practice Resource Task Force, adopted by the ACR Council at the September 2002 annual meeting, the Commission on Interventional Radiology and Interventional Neuroradiology created a white paper on interventional radiology and interventional neuroradiology practice that was presented to the Board of Chancellors at the May 2003 AMCLC. The white paper, the purpose of which is to serve as the basis for a practice guideline on this subject, can be found at the following link http://www.acr.org/dyna/?doc=departments/stand_accred/standards/ir_white_paper.html.

The Guidelines and Standards Committee of the Commission on Interventional Radiology and Interventional Neuroradiology has developed the ACR Practice Guideline for Interventional Radiology and Interventional Neuroradiology Practice that will be presented to the Council for consideration at the May 2004 meeting. This will be an important resource when you go to your diagnostic radiology group to ask for the time and resources to build your clinical practice. We thank Joshua Hirsch, MD for working on ASITN's behalf on this paper.

President's Message

Buddy Connors, MD

Who Controls our Destiny??

The past few years have seen an explosive growth in the business in which we are experts. The training and experience that we have worked so hard to acquire and become proficient in has allowed us to grow a completely new profession, a new business, and a new way to help patients that did not previously exist. Our skills and knowledge have developed and perfected the ability to treat vascular abnormalities of the neck, brain, and spine in ways that have helped innumerable people.

Specifically, our members and present and former thought leaders developed such specialty procedures as particulate embolization, cyanoacrylate embolization, coil embolization, carotid angioplasty, cerebral protection for carotid stenting, vertebroplasty, intracranial angioplasty and stenting, and emergency catheter-directed intracerebral fibrinolysis. Our members are now working to advance stroke therapy by perfecting clot retrieval as well as augmented lysis. Indeed, we have made incredible strides.

However, the power of excellent and ethically responsible patient care will not serve our future well if we do not publicize our abilities and strive to protect the standards of care that we have so carefully fostered over our history. Our tendency to work extremely hard in our individual isolated practices will not further the development of our profession, nor protect us or our patients from incursions by untrained and potentially dangerous practitioners who think that what we do "looks easy".

When I wrote my textbook back "before the great war", I had 4 chapters on carotid stenting, one of which I wrote. All chapters were formulated around cerebral protection from embolic debris except one, the cardiology experience from UAB. I personally patented the first cerebral protection system for carotid stenting. We neurointerventionists knew that unprotected carotid angioplasty/stenting was potentially dangerous and did not offer protection from stroke, the only reason to even do the procedure, and could actually contribute to it. But while we have responsibly pursued this new procedure for the correct reasons (stroke prevention), others who only want to perform the procedure "because it is there" can potentially wreak havoc on patients for personal reasons. It is up to us to protect our patients and ethical standards of care. While cardiologists are competing with us for our patients and our jobs, it is the fields of neurology and neurosurgery that are our natural allies for patient safety and medical ethics for standards of care in cerebrovascular disease and stroke prevention.

By far the largest area of growth for our specialty in the future is "***stroke***". We are the leaders in stroke prevention; hemorrhagic and ischemic stroke therapy and intracranial angioplasty and stenting. However, no one in the United States would know that, and certainly not industry or even patients in general. Several years ago I said that our greatest challenge as a profession was to prove that what we do *works*, and I started the ***INSTOR*** and ***INTRASTOR*** registries. As of this writing, we now know that aneurysm coiling works (thanks to the British). We also know that warfarin for intracranial atherostenosis does NOT work (thanks to the neurologists), but we have no proof that what ***we*** do **DOES** work. This is particularly true for stroke therapy. While large numbers of hospitals and physicians in the United States perform emergency catheter-directed stroke therapy, the ***INSTOR*** registry captures a pitiful few of these even though the registry pays more than the procedure does. Industry desires to invest in this, OUR profession, but we have no proof that any of these procedures are even being done. Most patients entered into ***INSTOR*** have been submitted by peripheral interventionists, not by neurointerventionists. This is a sad truth.

How many interventional stroke therapies are being performed in the United States

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Editor's Column

Chuck Kerber, MD

GORILLAS AT THE TABLE

Two large problems loom over us today. The first of these is focal, about our identity as interventionists, and is well addressed by our president, Buddy Connors in his article at the beginning of this issue.

The second is more global. It's about our future as physicians. The problem is being debated every day by our representatives in Washington.

WONDERLAND* NOTES and OBSERVATIONS

* noun, A marvelous imaginary realm; synonym: Washington DC. See also Alice in….

Most of us are indifferent to national politics — otherwise we would have made being a senator our life's work, rather than practicing medicine. Unfortunately, the actions of our representatives bear strongly on the future health of our practice and of our ability to care for our patients. It is time to pay the federal government some careful attention.

By far the first and most important event is the just-in analysis by Medicare's own actuaries that within fifteen years, Medicare will go bust. Yes, bankrupt. This year they begin tapping into their own trust fund to pay daily expenses. None of this is being helped by the recent 50 billion a year payoff to seniors called the *prescription drug benefit*. That benefit now costs each American — man woman and child — about 180 bucks every year. Now consider: Americans' appetite for health care continues to compound 14 percent a year, almost three times faster than our economy grows. Something is going to give really, really soon, and unless we become effectively organized, we will be at the bottom of the elevator shaft when this crash comes.

Are we not trusted, as individual Americans, to pick the right car for ourselves? Why then are we considered to be too stupid to choose how we may pay for our own medical care? What's most worrisome is that much of this paternalistic attitude is found not only in the federal government, but also in our own profession?

Is it not time for a painful reassessment of this whole reimbursement issue?

It is not time for despair; there is hope. Check out what the Baylor Health Care system (a plan for its own employees) has done. See also American Century, the investment management firm's plan. With all of the wordage in both left and right leaning news media so obsessed with MEDICARE, you would think that there would be no other health plan available in our country. But these other plans are working today, and are doing so by giving power to the patient. Check out PAMFOnline.org too. As a patient, you would want the freedom and power these plans give you.

The real indicator: Medicare talk in the papers and in the Congress is about "expenditures", not about taking care of sick people.

Change always begins when dedicated minorities act on their convictions.

Time will be the judge of our actions — or inactions.

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INTERESTING and RECOMMENDED READING:

100 Years of JAMA Landmark Articles, George Lundberg, MD, Editor

This wonderful book reprints some of the classic articles that have shaped our profession since the early 1800s. One of the more interesting articles was rejected: *The Gynecologic Consideration of the Sexual Act*, and waited almost 100 years for its ultimate publishing. What is more interesting than the paper perhaps is the discussion by other physicians, who at the turn-of-the-century, rejected it. How times have changed.

There are classic articles by Harvey Cushing (*Trigeminal Neuralgia Therapy*), Walter Reed, (*The Etiology of Yellow Fever*), an excellent article on *Obstruction of the Coronary Arteries* by James Herrick, and the original article on *Intravenous Urography* by Osborne and Colleagues.

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Dues Invoices in the Mail

2004 ASITN Membership Dues Invoices have been mailed from the home office. Please help keep ASITN's mailing costs down by paying your invoice on the first notice.

We have a lot on tap this year, and you won't want to miss a thing!

Exercise Your Right to Vote!

If you are an Active member of ASITN, you will be receiving your 2004-2005 Executive Committee Ballot in the mail in mid-April. Please be sure and return it by May 14 so that your vote can be counted!

ASITN Readies For Second Annual Practicum

Joshua A. Hirsch, MD
Second Annual Practicum Program Chair

A breathtaking view of the Seattle skyline on the Puget Sound

The future of interventional neuroradiology, and of ASITN, is bright indeed. The response to our First Annual Practicum was better than we ever dared to imagine. Over 150 attendees and 10 exhibitors came away from the Practicum with an enhanced knowledge of neurointerventional procedures and multiple insights for creating a better practice. At the recommendation and urging of those who participated last year, we are holding the Second Annual ASITN Practicum immediately following the 2004 ASNR meeting in Seattle, June 11-13, 2004.

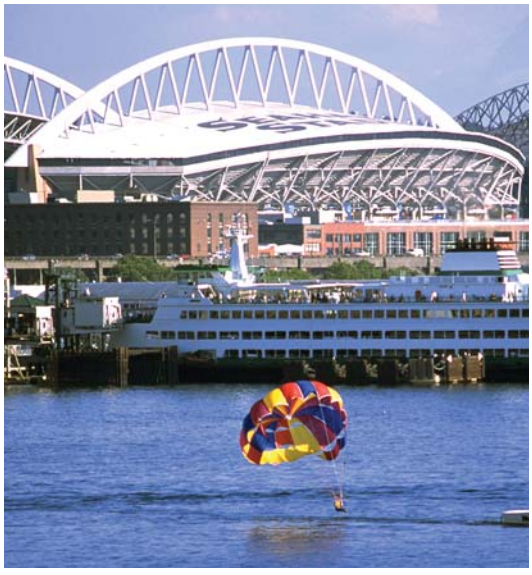
Neurointerventionists continue to lead in the development of innovative and effective therapy for stroke, brain aneurysms, carotid stenosis, and more. In addition, members of the society continue to chart bold new frontiers in minimally invasive spine surgery. ASITN is working to empower its membership in numerous ways. The Practicum represents an amalgamation of many things, but most specifically, it lives up to its name — Practical Solutions for Practicing Interventionists.

In keeping with last year's widespread participation and numerous attendee comments, the Practicum will once again feature multiple hands-on workshops. This year's didactic sessions will place a heavy emphasis on case discussion with lectures occupying the first 20-25% of each session followed by case presentations. Members of the audience will be invited to present cases from their own practice.

The Practicum will begin on Friday afternoon immediately following the ASNR with didactic sessions. The workshops will take place on Saturday morning, followed by an afternoon of problem-oriented, real-world didactic sessions. Sunday morning's sessions will be devoted to practice-related issues.

Whether you are a veteran of the interventional field or just entering this exciting world, you will find attending our Second Annual Practicum informative, thought provoking, valuable, and most importantly — fun!

We look forward to seeing you in Seattle!



Seattle Seahawks stadium

ASITN Joins the Brain Attack Coalition

Thanks to the lobbying and hard work of ASITN President Buddy Connors, ASITN has been invited to join the Brain Attack Coalition (BAC). Composed of professional, voluntary and governmental entities, the Brain Attack Coalition is dedicated to reducing the occurrence, disabilities and death associated with stroke. The overall goal of the Coalition is to strengthen and promote the relationships among its member organizations in order to help stroke patients or those who are at risk for a stroke.

Professional resources include Guidelines and Orders for systems development for acute stroke care (including stroke team or stroke center development), and Pathways for the rapid diagnosis and treatment (both immediate and long-term) of acute stroke.

Patient Resources include links to sites that provide helpful information to stroke patients, their families and caregivers.

More information about the BAC may be found on their website at **www.stroke-site.org**.

Practice Building Corner – Knowing the Costs of New Devices, (or how do I get the hospital to buy the new coils?)

Gary Duckwiler, MD

This is the third in a series of Practice Building articles that will appear this year in *The Embolus*. All of the articles will be consolidated in a special supplement to be handed out at the Second Annual ASITN Practicum. We hope you find this series helpful.

With medical centers under extreme financial burdens and with declining reimbursement rates, one area of cost containment focus is on new clinical technologies. The problem is that as new technologies (such as stents and coils) have been brought into the hospital, costs have skyrocketed. This, coupled with decreased reimbursements, has placed an emphasis on some hospitals to clamp down on new materials. Furthermore, depending upon the type of repayment, these improved treatments often reduce hospital stay, which further reduces repayment. As we are one of the groups in the hospital who are heavy users of new technology, knowledge of this problem and the possible solutions are essential.

A recent example is the Cypher coated stent. The list cost is approximately $3200.00 whereas bare metal stents are $1500.00. Cypher stents are more effective at reducing restenosis. The performance of the Cypher stent justified an improvement in reimbursement by Medicare (previously unheard of) from the 516 code to 526 code, which was about $1800.00 more. However, in practice, it was necessary to use 1.5 Cypher stents per case. This then results in a total increase in cost to the hospital per procedure of ($3200 x 1.5) - $1800 = $3000.00. Furthermore, you will also expect less restenosis (therefore fewer procedures over time), and fewer CABG procedures (which are financially profitable). Thus the contribution margin of the Cardiac Cath Lab has been very negatively affected by this wonderful new technology. That forgone income means other services have to make up the slack or get less subsidies. This is clearly a bad situation.

Hospitals can only react in a few ways to this cost rise. They can "hold the line" on costs, negotiate better payment, and/or make sure that appropriate payment is extracted. Many hospitals now have committees focused on these issues. My suggestion is that you spend the time to be involved in these committees so that you and your hospital's interests are best served. This will eventually impact every hospital and physician and directly affect your ability to stock your shelves.

One way the hospital can control expenses is to simply deny the purchase of newer generations of devices. Matrix and Hydrocoils are more expensive than regular detachable platinum coils. The hospital can decide that they will still be able to provide coil embolization of aneurysms, but deny your use of the latest device. This is an interesting strategy since they may be providing what the insurance contract stipulates, but at a lower cost than their competitors. This may not be providing the best in patient care (or at least what the patients want, as they always want the latest technology) but is economically attractive. Another way to hold down costs is to negotiate a better price from the vendors. Vendors will always have the newest device at a premium, especially when they are the sole providers of that new technology (i.e. Cypher stent). However, when there are roughly equal competitors, there is room for negotiation.

The vendors will try and justify a higher price based on performance, but also rely on physician relationships and beliefs. When they negotiate with the hospital, they may view the relationship with the physician end provider as an asset in their corner. If you are involved in this process, you will be better off in the long run. You can help in the negotiation for your hospital by being more assertive with the vendors. By buying into the hospital process of cost containment, you will have a say when other services present their devices/costs to the committee. This really can affect your bottom line with support staff, equipment and supplies

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ASITN and RSNA Highlight Neurointerventional Advances

ASITN joined with the Radiological Society of North America (RSNA) for a media briefing in New York on image-guided therapies. Jacques Dion, MD spoke on behalf of ASITN on brain aneurysms and coil embolization to treat cerebral hemorrhage. Reuters Health covered Jacques' talk and HealthDay.com also wrote an article entitled "Stopping Brain Aneurysms Without Surgery" with prominent mention of Dr. Dion.

ASITN will continue to be proactive in collaborating with RSNA and other societies on publicity initiatives such as these.

Jacques Dion, MD (left), speaks with a reporter about detachable coil embolization.

JCAHO Primary Stroke Center Certification – Available February 2004

Based on the recommendations for primary stroke centers published by the Brain Attack Coalition and the American Stroke Association's (ASA) statements/guidelines for stroke care, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed an advanced Disease-Specific Care Certification Program. It creates the first nationwide certification program to evaluate stroke care provided by hospitals.

Primary Stroke Centers that demonstrate compliance with program requirements will be awarded certification for one year. A one-year extension will be granted contingent on submitting an acceptable Periodic Performance Review and the results of the organization's performance measurement and management activities. ASITN Associate Member Rod Raabe is among the first five approved centers by JCAHO.

For more information about ASA/JCAHO Primary Stroke Center Certification, visit JCAHO's Web site at www.jcaho.org or contact Maureen Potter, executive director of the DSC Certification of JCAHO at (630) 792-5291 or at mpotter@jcaho.org.

Private Insurer Reimbursement for Implantables: Device Carve-Outs

Nicole D. Deuber
Manager, Reimbursement & Outcomes Planning
Boston Scientific Corporation

How do private insurers reimburse for implantable devices? The answer is it varies depending on the private insurer, hospital and geographic region. That said, it is common practice for many private insurers to provide separate reimbursement for implantable devices under a contractual arrangement known as a *device carve-out payment*. This differs from Medicare, which generally does not provide separate reimbursement for the devices used during inpatient stays.

A device carve-out is a special negotiated arrangement in which the health insurer agrees to "carve out" additional payment from that which is paid for the procedure itself. Reimbursement may be based on a percentage of billed charges, actual invoice cost, or other methods. Carve-out methodologies provide hospitals with financial support for utilization of high-cost medical technologies by securing separate reimbursement amounts for these technologies. It enables providers to embrace technological innovation more freely by allocating risk of device costs to the health insurer on behalf of the patient.

Hospitals first entered into carve-out contracts with private insurers to support costs of cardiovascular implants (for example, coronary stents and pacemakers) and orthopedic implants (for example, artificial hip implants). Carve-out contracts are particularly common in situations where hospitals receive per diem reimbursement for the inpatient service itself. Under per diem reimbursement methods, the private insurer pays a fixed daily rate for each day of the inpatient stay. Per diem rates may vary according to the type of inpatient service such as intensive care unit, surgery, and obstetric care. In the absence of carve-out payments, hospitals would face severe financial disincentives for provision of cost-effective and less-invasive therapies such as coronary stenting that reduce overall costs and lengths of stay compared to surgical alternatives. Carve-out contracts can be and are also used for neuroendovascular implantables such as detachable coils.

Ask your radiology administrator or hospital contracting department how inpatient procedures and implantables are reimbursed by private insurers at your hospital, and whether it makes sense to pursue carve-out payments for neurovascular implantable devices. You may find that the hospital already has carve-out contracts in place that can be used for these implantables. In that case, it is critically important that the hospital verifies that correct device coding and charge-master updates are in place to generate carve-out payments for neurovascular implantables.

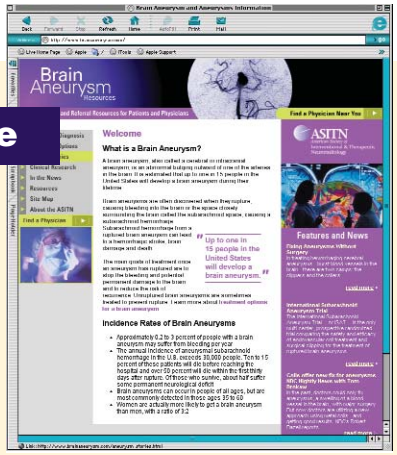
Also, for those private insurers that use a DRG-type (diagnosis related group) payment system similar to Medicare's, be sure to tell your hospital about the new DRG for treatment of ruptured brain aneurysms:

> *Effective October 1, 2003, the Centers for Medicare and Medicaid Services agreed to create a new DRG (DRG 528) for the endovascular coiling or surgical clipping of ruptured brain aneurysms under Medicare's Hospital Inpatient Prospective Payment System. This new DRG means payment for endovascular coiling or clipping of ruptured brain aneurysms will increase on average by 100 percent.*

Your hospital may want to negotiate with private insurers who use DRGs to incorporate Medicare's new DRG 528 into their systems.

Ultimately, each hospital is responsible for determining the appropriate approach for negotiating reimbursement contracts with private insurers. That said, it may be worthwhile to discuss device carve-outs and the new DRG 528 with your hospital colleagues.

ASITN Launches Patient Website



The ASITN is pleased to announce the launch of **www.BrainAneurysm.com**, a new website for patients and referring physicians dedicated to providing comprehensive referral resources and the latest treatment information about brain aneurysms.

BrainAneurysm.com features a continually updated database of physician specialists who are trained in endovascular coiling techniques. The Executive Committee of ASITN has determined that only *ACTIVE* members of ASITN shall be listed on the website so that we as a Society can stand behind the physician's featured.

In addition to the physician directory, other sections on BrainAneurysm.com include Symptoms/Diagnosis; Treatment Options; Patient Stories; Clinical Research; In the News; Image Gallery; Glossary; and Useful Links. If you have any questions about the site, please send an email to info@asitn.org.

ASITN would like to thank the Neurovascular Group of Boston Scientific for their financial and developmental support of BrainAneurysm.com.

ASITN Announces New Meeting – In Paradise! **continued from page 1**

Meeting program specifics include:

- State-of-the-art lectures with established experts giving updates on current concepts;
- Presentation of complications with methods of avoidance and rescue;
- "Live cases" with video presentations of interesting cases; and
- Presentation of new techniques or interesting case series

The program will also include an extensive menu of hands-on labs using fluoroscopy equipment so that participants can learn basic and advanced techniques in:

- Carotid artery stenting;
- External carotid embolization techniques (epistaxis and tumor embolization);
- Cerebral aneurysm coiling techniques (with new coils and stents);
- Neurovascular rescue and Intracranial thrombolysis; and
- Basic and advanced techniques in spine interventions

A prominent meeting highlight will be an ASITN/SIR/ASNR cooperative carotid stenting training course (including lectures and full hands-on labs). One of the first comprehensive courses to be offered in carotid artery stenting, this program is designed in compliance with ASITN standards published in September in the *Journal of Vascular and Interventional Radiology* (JVIR). Sure to be one of the more popular offerings, this meeting is space-limited. Participants should sign up as early as **May** to ensure their spot!

To insure that participants can enjoy the full scale of the Boca experience, most didactic sessions will be held in the morning to allow afternoons free for optional labs or one of the many activities available to you and your family, whether it be golf, boating, snorkeling, fishing or just relaxing on the beach.

A full registration brochure will be mailed in April, so be on watch and take advantage of our early bird registration which will entitle you to participate in a drawing for an exclusive spa package which you or your spouse may enjoy in August. You may also visit our website, **www.asitn.org**, for more information in the coming months. We look forward to seeing you in Boca!

People in the News

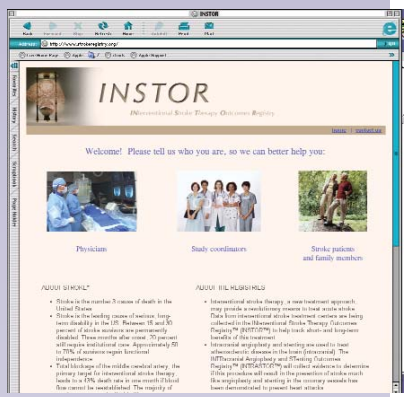
A special thanks goes out to ASITN Executive Committee Member-at-Large **Gary Nesbit** for mentioning asitn.org in an interview with an AP reporter writing a story on MERCI. Our website hits jumped 1000% on the day that the story hit the wire. Thanks Gary!

"Innovative Methods to Battle Brain Attack," featuring **Joan Wojak**, aired on CBS affiliate KLFY-TV10 of Lafayette, LA in conjunction with Our Lady of Lourdes Regional Medical Center's **Stroke*Sense*** program.

ASITN Members **Pierre Gobin**, **Thomas Grobelny**, and **Buddy Connors** all appeared in stories covering the MERCI retriever in recent months.

If you have been featured in a local, national or worldwide publication, please let us know! Contact Marie Williams at **703-691-2272** or via e-mail at **info@asitn.org**.

What INSTOR™ Holds "In Store" for the Field of Neurointervention



In this day and age of scientific advancement, neurointerventionists enjoy multiple opportunities to both witness and participate in the proliferation of their field. At no other time has such dynamic growth resulted in a comprehensive understanding and resultant cutting-edge therapies for stroke, brain aneurysms, and other disease processes such as intracranial atherosclerosis. Ultimately, such advances have directly impacted patients as they have enjoyed improved outcomes and enhanced quality of life.

But with such progress, there is still much work to be done. Whereas we may know the general points on stroke — causes, consequences and which therapies to use when — we still stand in wait when it comes to what elements lead to overall success in the long-term. What is the optimal appropriate drug? At what dose? For which patient population? In what timeframe? We all have ideas, and even strong opinions. But how can we know?

INSTOR™ (INterventional Stroke Therapy Outcomes Registry™), the only world-wide interventional stroke registry, was created to address the remaining question marks in our battle against stroke. Serving as the definitive evaluation for interventional stroke treatment and encompassing all therapies and techniques to reverse the acute insult, this registry provides a means to evaluate the safety and efficacy of presently performed interventions for acute stroke. Currently, information on over 100 patients has been entered into the registry (much thanks to **Tom Tomsick** for his frequent participation and energetic support of the registry process and concept) and initial publications concerning several aspects of the registry are now underway.

INSTOR™ leaders have endeavored to make the entry process easy for you and/or your assistants. To begin with, registrants are **PAID** to enter data on their patients: **$250** for initial entry of all information including details of the patient's stroke and treatment and **$250** for entry of three-month outcome data (which involves only **ONE** question). That's **$500** total, an incentive which makes most nurses or techs happy to invest their time. To find out more about INSTOR™ including instructions for enrollment, material to assist with IRB approval, tips for data collection, equipment lists, frequently asked questions and more, please visit **www.strokeregistry.org**.

Please join us. Your participation helps us to continue to clear the pathway for continued advancements in emergency stroke therapy. Our collaborative participation in such a valuable tool, in the long run, will enable us to bring enhanced knowledge and resources to the treatment rooms of our hospitals and most importantly to the bedsides of our patients. THAT'S what's "in store" for all of us!

President's Message **continued from page 2**

per year? 50? 1000? How many intracranial angioplasties/stents? 50? 1000? Cardiologists have sponsored registries of their adventures for years (Remember their 20 atmosphere balloons/stents? They now use neuro devices with 6 atmospheres for coronaries!) and are reporting their own cerebral angiography results, and intracranial angioplasty/stenting and emergency stroke therapy experience. Their documentation induces industry to support their efforts. ***But we are not supporting our own***. It is medically irresponsible for us to sit and watch untrained individuals "reinvent the wheel" on patients with procedures for which they are not trained, with all the attendant mistakes associated with the price of "human experimentation".

Is this our specialty or not? Do we care enough to advance our field and protect our patients? Will anyone notice we are here or when we are gone? Will our patients notice? I think they need to know that we are the experts in cerebrovascular hemodynamics, stroke prevention and stroke therapy, and I think we need to let everyone else know, too.

Buddy Connors

ASITN & SIR Develop Important Blueprint for Interventional Stroke Treatment and Hospital Resources

Tricia McClenny & Marie Williams

The ASITN-SIR Stroke Consensus Conference, held June 21-22, 2003 in Chicago, Illinois, was convened to reach consensus on controversial issues in the treatment of stroke and the development of necessary hospital resources to optimally utilize intra-arterial catheter-based techniques. Co-chaired by Drs. Buddy Connors and David Sacks, the conference brought together a multi-specialty group of 16 invited experts to identify clinically important areas in the field of interventional stroke therapy and to reach consensus as to how patients should best be managed at this time. According to Dr. David Sacks, "This was a particularly important topic for a consensus conference because of the tremendous opportunity for radiologists to use their clinical and technical skills to help patients with a devastating illness."

The short-term result of the conference is a consensus document which will be published in the next several months. The long-term objective is that the results of this conference will encourage practitioners to evaluate the resources devoted at their institution to achieving the goals intended, and to determine if they are doing the best job they can in a complex and difficult field with evolving data. Consensus opinion can provide the impetus for more physicians to treat stroke with interventional catheter-directed therapy and provide more patients with the opportunity for cutting-edge stroke treatment. "This consensus document will be critically important in that it will provide a much needed blueprint for optimizing the development of comprehensive stroke treatment centers and highlight the necessity and benefits of the role of radiologists in stroke therapy," said Dr. Buddy Connors. "Indeed, radiology is absolutely mandatory for the diagnosis of stroke and beneficial in the comprehensive treatment of stroke."

Joint Task Force to Provide INRs a Competitive Edge

Tricia McClenny & Marie Williams

ASITN and the Society of Interventional Radiology (SIR) have joined forces to ensure that neurointerventionists and interventional radiologists establish themselves as recognized leaders in the rapidly emerging development of carotid stenting.

ASITN President Buddy Connors, MD, said, "Stroke prevention and acute stroke therapy are tasks exceptionally well-suited to neurointerventionists and interventional radiologists. Our background and training in the science, imaging and hemodynamics of cerebral ischemia, mechanical revascularization and optimal medical therapies are fundamental aspects of our professional knowledge base. Advancing the optimal therapies for prevention and treatment of stroke is a field for which we are uniquely qualified." Agreeing, Dr. Michael Brunner, SIR President, stressed, "To minimize the effects of the learning curve (that many of us have already traveled in diagnostic and interventional cerebrovascular work) on this emerging technology, it is critical that INRs and IRs participate in the early evolution of this therapy and see it to successful fruition."

The leadership of both organizations has made their collaboration a priority by establishing the ASITN-SIR Carotid Stent and Stroke Prevention Task Force. The Task Force is co-chaired by Buddy Connors, MD (ASITN) and Rodney Raabe, MD (SIR). ASITN members of the Task Force include Gary Duckwiler, Avery Evans, Charles Guidot, Randy Higashida, Kieran Murphy and Gary Nesbit. SIR members include Mike Dake, Jan Durham, Barry Katzen, Kathy Krol, Tim Murphy, Mahmood Razavi, and Mark Wholey. The Task Force's charge is: "To provide recommendations to the Societies leadership committees to help guide

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ASITN Carotid Stent Educational Opportunities

Second Annual ASITN Practicum
June 11-13
Seattle, Washington

First Annual ASITN Course & Workshops
August 10-14
Boca Raton, Florida

Additional carotid stent courses to be announced in the future.

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PERSONAL HEALTH ISSUES

It seems that the high blood pressure question has been pretty effectively answered by good studies. Lower is certainly better. Lower your peak systolic from 160 to 140, and you cut your incidence of coronary events almost in half. There is some suggestive evidence that if you lower it from 140 to 120, you get a similar result.

But the question is, does lowering your low-density lipoproteins back to teenage levels really make a difference?

The manufacturers have entered the fray. No surprise I guess. (See Nissen, S. paper presented at the American Heart Association meeting in Orlando). Pfizer's Lipitor has shown in 502 patients to lower the LDL to about 80, and actually help stop progression of disease. The big competitor, Pravachol from Bristol Myers Squibb, didn't seem to do nearly as well. Imagine the media turmoil this will cause. It is hard to avoid the conclusions of the large-scale studies showing that lowering low-density lipoproteins do save lives and prevent heart attacks (and probably strokes too), but the side effects in many people are significant and insidious. Whether to take these drugs routinely is a difficult question for most of our aging colleagues.

How do you feel?

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VACCINATIONS AND OTHER AGGRAVATIONS:

Have you recovered from your annual flu shot? Do you even bother to get one? Perhaps it is the sore arm and the flu-like syndrome that comes afterward that makes us question the science and the practice of immunizations.

But there is pretty good science behind most of the childhood immunizations. And hepatitis? I remember a dear and respected colleague who stuck himself during a case years ago, and 9 months later, died of his hepatitis. It was a tragic loss, especially given the availability of Hep A and B vaccines today.

Get hepatitis, and your life and your practice will be changed forever. Though there is no C vaccine available yet, it is a prudent precaution to think about bringing your immunizations up-to-date.

It is worth looking on the Centers for Disease Control and Prevention website. They have an immunization schedule recommended for you — and for your family. I am not recommending you enroll in a Registry, but it certainly is worthwhile to get your own and your family's immunizations organized, current, and in your computer's Bring Up file.

Check out www.IIa.cdc.gov/nip/scheduler_le/default.asp (that is just for your kids).

Actually it is a good site, and you can get information on the newer vaccines (pneumococcus comes to mind).

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MISCELLANEOUS OBSERVATIONS ON OUR CIVILIZATION:

Have you noticed that Jessica Lynch, the unfortunate young lady who got herself captured when the driver of her truck took a wrong turn during the active part of the Iraq war, has become a national celebrity? The book is out; can the movie be far behind? The question in my mind is how we have come to the point where who we are interested in is the victim rather than the hero. Do you know who rescued her? Have you heard of Captain Zan Hornbuckle? He gets most of the credit. But you probably haven't heard of him. It was also the members of Marine Helicopter Squadron HMA 513. It was, like most important endeavors, a team effort.

Have you wondered what the course of a society will be when that society changes from honoring the hero to honoring an unfortunate young woman who was in the wrong place at the wrong time, and who became sadly, another victim? Something to think about, isn't it?

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FROM THE DOUBLE BIND FILE:

Both the Drug Enforcement Administration of our Federal Government and our Food and Drug Administration are beginning enforcement measures and have developed plans *"to decrease the potential of narcotic abuse"* (emphasis mine). OxyContin is available in a time-release form, but a few clever patients have figured out how to defeat the time-release mechanism, and get high. Oh heavens. Now we are to be bombarded (I am not making this up, it is in the plan) with abuse-management programs — physician education especially — and drug company restrictions from bringing new narcotics to the market. The Drug Enforcement Administration, not wishing to be outdone, wants to add training in narcotics use to continuing education requirements for us all.

There is also an FDA Advisory Panel (which includes physicians) that wants to limit the distribution of "easily abused drugs" whatever that means, to certain physicians and certain pharmacies.

For the other side of the coin, the University of California, San Diego has *ordered* all physicians to obtain narcotics pads because "Pain is an essential part of the evaluation." No new narcotics pads; no staff reappointment." Which is even reasonable — if you're going to manage outpatients' pain. But read on.

On to the dark side: Mr. Bob Williamson, a deputy chief at DEA says, "legally, they (doctors) are treated like drug dealers." Chilling? To go on, the DEA by its own admission doesn't even need to prove a doctor operated with criminal intent. All they need to demonstrate is that the doctor prescribed drugs "outside the scope of legitimate medical practice."

There are only half a dozen reasons patients seek out a physician, the relief of pain one of the most important and insistent. We must wish the cancer patients good luck. How many physicians will be willing to take the risk? There have been incredible advances in pain management over the last decades, but Catch-22 still operates.

ANOTHER WONDERLAND (Academia)

From the Ain't Science Grand file.

See ***An fMRI investigation of the impact of interracial contact on executive function***. Richeson JA, Baird AA, Gordon HL, Heatherton TF, Wyland CL, Trawalter S, Shelton JN. Not to put too fine a point on this paper, the investigators measured activity in "well-educated and well-meaning" white student brains after showing them images and words associated with black people in the presence of a black experimenter. This showed "hidden racial bias." Which later correlated to poorer cognitive ability. Conclusion: The biased white brain, when in the presence of a minority, was unable to concentrate. "These results are consistent with a resource depletion account of the temporary executive dysfunction seen in racially biased individuals after interracial contact." Author's abstract.

Isn't the academic world awesome?

I'm not making this up.

Respectfully submitted,

Chuck W. Kerber, MD

Practice Building Corner **continued from page 5**

and overall hospital profitability and stability. By assisting the hospital, you will understand the process, and when you apply to have a new device brought into the hospital, you will have the skill to make a cogent and logical presentation to your peers on the committee.

Hospitals may also try to obtain package deals across a vendor's entire line of businesses. Make sure that those essential tools for your practice are available when these contracts exist. When cost containment policies go into effect, there may be incentive funds available. Even when there are not, by showing that you are, in good faith, trying to reduce supply costs, your standing in the hospital will improve.

In order to increase payments for these materials, the hospital may try and renegotiate the insurance contracts. This may involve "carve outs" for the high ticket, unusual services (such as AVM or aneurysm embolization). Changing from per diem rates to percentages of charges may also be helpful. This is especially true for procedures, typically minimally invasive procedures, that result in shorter length of stay. If it is at all possible, get your billing and reimbursement information to help the contracts office negotiate a favorable rate. If you lose money on your service, no help will come your way when you need that new room.

The billing and reimbursement issues cannot be stressed enough. Without information, you are flying blind. So is the hospital. Convince them that together you can improve the bottom line. Meet with the billing staff. Work out a system of charge capture. Your dictations are critical to billing, and implants may be reimbursable-if dictated correctly and the contract so stipulates (see companion article by Nicole Deuber on page 6), Also, it is typical for insurance companies to stall or refuse to pay even though the contract says that they will. Make sure the invoices of the materials or at least the reorder form is available to justify and prove to the insurance company that said materials were in fact used. Follow these bills to make sure that you have obtained fair compensation. You can then use this data with the hospital and the committee the next time you upgrade your coils.

To paraphrase a famous quote, "Times they are a' changing". Protect your practice by being involved and proactive. Monitor your costs and your reimbursements and get connected in the hospital system. Unfortunately, no one will do this for you. But, with a little work, the payoffs can be significant.

Joint Task Force to Provide INRs a Competitive Edge

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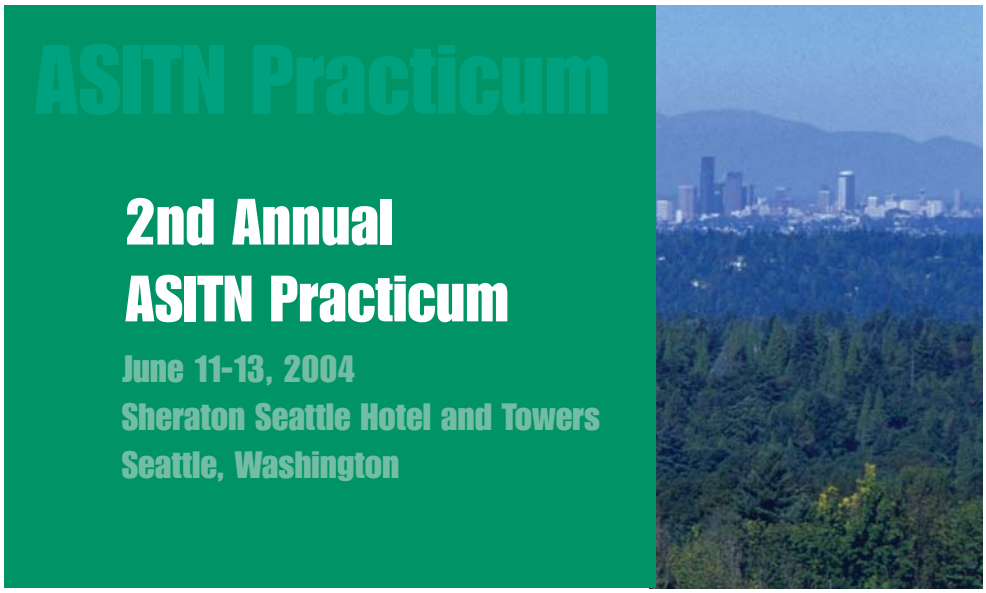
collaborative policy and activities with regard to carotid stenting and stroke prevention. Working groups representing professional education, public information, economics, research and standards will be established to address specific areas." The Task Force will also coordinate with the American Society of Neuroradiology (ASNR).

Joint work on carotid stent standards, payor coverage, and coding are ongoing initiatives and will continue to be an important focus area.



Calendar of Events

American College of Radiology
Annual Meeting & Chapter
Leadership Conference
May 8-13, 2004
Washington, DC
Contact: ACR, 800-227-5463

American Society of Neuroradiology
42nd Annual Meeting
June 5-11, 2004
Seattle, Washington
Contact: ASNR, 630-574-0220

American Society of Interventional & Therapeutic Neuroradiology
2nd Annual Practicum
June 11-13, 2004
Seattle, Washington
Contact: ASITN, 703-691-2272

American Society of Interventional & Therapeutic Neuroradiology
1st Annual Course & Workshops
August 10-14, 2004
Boca Raton, Florida
Contact: ASITN, 703-691-2272

The Embolus

Editor in Chief:
Charles W. Kerber, MD
Managing Editor:
Marie Williams
Graphic Designer:
Barbara Erickson

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Send your articles, letters and comments to:
Charles W. Kerber, MD
The Embolus
10201 Lee Highway, Suite 500
Fairfax, VA 22030
703-691-2272
FAX 703-691-1855
www.asitn.org

ASITN
American Society of
Interventional & Therapeutic
Neuroradiology
10201 Lee Highway
Suite 500
Fairfax, VA 22030