Agenda

09 September 2026

8:00 pm - 9:00 pm
ANZSVN Executive Meeting

Business Meeting - Vascular Nursing - Ripple Room 1

10 September 2026

8:00 am - 10:00 am
Peripheral Artery Disease

Scientific Session - Vascular Nursing, Vascular Surgery - Bloom Room

8:00 am
Welcome to ANZSVS QTN 2026
Meg Beaumont

8:10 am
PAD: adverse impacts, disparities in outcomes and the path ahead
Jonathan Golledge

8:18 am
Directional Atherectomy Followed by DCB: A Strategy for Complex Femoropopliteal Disease
Bobby Mendes

8:26 am
An update on E-Femoral - First In Human Trial
Manar Khashram

8:32 am
Long-Term Outcomes of Directional Versus Rotational Atherectomy for Femoropopliteal Artery Disease: A Multi-Centre Study
James Colbourne
Background: Directional (HawkOne/TurboHawk) and rotational (Jetstream) atherectomy are increasingly used in the management of femoral-popliteal steno-occlusive disease. There is little real-world data comparing the long-term outcomes of the two different devices Methods: A retrospective multi-institutional cohort study was conducted evaluating both efficacy (technical success, 12-month primary patency, target-lesion revascularisation rates) and safety outcomes (complication rate, major limb amputation, mortality). Outcomes were compared by device in addition to a subgroup analysis of in-stent lesions (ISR). They were compared using Fisher exact tests, multivariable logistic regression and propensity-score matching. Results: Across 163 limbs, median age was 71 years, 36 (22%) were female, 40% had chronic limb-threatening ischaemia, 44% were diabetic, and the modal lesion was TASC II. HawkOne/TurboHawk (n=47) trended toward fewer periprocedural complications than Jetstream (n=116) (17% vs 35%; adjusted OR 0.39, 95% CI 0.16ï¿½0.95, p=0.04) with no device difference seen for patency, TLR, mortality or amputation. ISR lesions (n=35) had a significantly lower 12-month patency loss than native lesions (68.8% vs 34.7%; p=0.001), independent of device (adjusted OR 3.93, 95% CI 1.68ï¿½9.19, p=0.002). Conclusions: Atherectomy device did not independently affect any of the evaluated efficacy outcomes. The trend toward fewer complications with directional atherectomy warrants prospective evaluation. ISR lesions conferred a four-fold lower 12-month patency rate when compared to native lesions.

8:38 am
Pulsatile Intravascular Lithotripsy for Heavily Calcified Femoropopliteal Arterial Disease: First-in-Human Results from the POWER PAD I Feasibility Study

Davina Daudu

Background: Severe femoropopliteal calcification increases endovascular complexity and is associated with impaired luminal gain, vessel injury, restenosis and bailout stenting. Pulsatile intravascular lithotripsy (PIVL) delivers hydraulic pressure waves through a non-compliant balloon. POWER PAD I evaluated first-in-human feasibility and safety of PIVL in calcified femoropopliteal disease. Methods: POWER PAD I was a prospective, single-arm, two-centre study. Adults with Rutherford 2-4 symptomatic peripheral arterial disease and calcified superficial femoral or popliteal lesions underwent PIVL, with adjunctive therapy as indicated. Angiographic and duplex outcomes were core-lab assessed; adverse events independently adjudicated. Results: Nine patients underwent treatment of 20 lesions. Mean age was 76.2 ± 12.6 years, five were male, 19 lesions were severely calcified and five were chronic total occlusions. Device and procedural success were achieved in 8/9 patients, and technical success in 9/9. All 15 balloons were delivered, inflated, deflated and retrieved. One balloon ruptured after therapy delivery, causing automatic system shut-off without clinical sequelae. Mean diameter stenosis improved from 76.5 ± 18.0% to 28.1 ± 6.9% after PIVL and 20.6 ± 5.8% after adjunctive therapy. Mean minimal luminal diameter increased from 1.3 ± 1.0 mm to 3.8 ± 0.5 mm after PIVL and 4.3 ± 0.6 mm at final angiography. There was no perforation, distal embolisation, thrombus, abrupt closure, no-reflow, bailout stenting, or grade D or higher dissection. Freedom from clinically driven target-lesion revascularisation was 100% at 30 days and 6 months, with one event by 12 months. Conclusions: In this first-in-human study, PIVL was feasible for heavily calcified femoropopliteal lesions, achieving substantial acute luminal gain without severe vessel-wall complications or bailout stenting. Larger controlled studies with longer follow-up and intravascular imaging are warranted.

8:44 am
Discussion

8:49 am
The Foot-PAD Trial: A Double-Blind, Randomised Placebo-Controlled Trial of Footplate Neuromuscular Electrical Stimulation on Walking Capacity in Patients with PAD
Christopher Askew

Purpose: Patients with peripheral artery disease (PAD) experience leg muscle pain that limits walking and the ability to adhere to exercise therapy. Neuromuscular electrical stimulation (NMES) induces exercise-like muscle contractions and can be performed without pain. We hypothesised that a 12-week program of NMES would improve walking capacity compared with placebo-control in patients with PAD. Methodology: This was a single-centre, double-blind, randomised placebo-controlled trial. 180 patients with PAD (n=90 per group; mean age: 72 ± 9 y; ABI: 0.69 ± 0.20) were randomised to a 12-week program of NMES or sham placebo-control (CON). This was followed by a 6-week off-intervention follow-up. Outcomes were assessed at baseline (week 0), midway (week 6) and at the end of the intervention period (week 12), and again at the end of the follow-up phase (week 18). Participants used a footplate-NMES device (Revitive Medic Coach) for 2x30 min periods each day to deliver stimulation sufficient to induce contraction of the leg muscles. Control participants used a sham device that does not induce muscle contraction. Primary outcome was maximum distance during the six-minute walk test (6MWT). Secondary outcomes included pain-free distance during the 6MWT, and maximum and pain-free walking time during a graded treadmill test. Results: There was no difference in 6MWT distance between groups at week 12 (marginal mean difference (MMD): 3.68 m; 95% CI: -4.21 to 11.56; P = 0.361). At week 18, six weeks after the intervention ceased, 6MWT distance was greater in the NMES group compared with CON (MMD: 10.77 m; 95% CI: 2.82 to 18.72; P = 0.008). Pain-free 6MWT distance increased and was greater in the NMES group compared with CON at week 12 (MMD: 23.08 m; 95% CI: 6.55 to 39.61; P = 0.024). Conclusion: NMES may represent a valuable adjunct therapy to improve symptoms in patients with PAD.

8:57 am
SWEDEPAD has changed my practice
Nedal Katib

9:03 am
SWEDEPAD has not changed my practice
Guilherme Pena

9:09 am
Discussion

9:16 am
Paywalled Protection: The Socioeconomic Divide in AI-Generated Health Literacy for Peripheral Arterial Disease.

Mina Mikhael

Purpose: Patients increasingly utilise artificial intelligence (AI) for medical advice. While socioeconomic inequality in vascular healthcare is well-documented, the disparity in AI health literacy remains a critical gap in literature. This novel study compares the clinical accuracy, readability, and safety of free versus premium large language models (LLMs) in peripheral arterial disease (PAD) to evaluate this emerging digital divide. Methodology: Fifteen standardised PAD queries were inputted into three free LLMs (ChatGPT, Claude 4.6 Sonnet, Gemini 3.5 Flash) and their premium counterparts (GPT-5.5, Claude 4.8 Opus, Gemini 3.1 Pro). Clinical quality was graded using the validated 16-item DISCERN instrument. Readability was assessed via the Flesch-Kincaid Grade Level (FKGL). The frequency of universal safety-netting (explicitly advising medical review) was tracked across all 15 prompts. Results: Premium LLMs demonstrated superior clinical reliability (mean DISCERN 55.0 vs 50.1) and nuanced differential diagnosis. Crucially, safety alerts advising urgent medical review were markedly higher in premium models (up to 93% via hard-coded disclaimers) compared to free versions (47%–60%). Readability was universally poor (FKGL 8.5–12.6, requiring up to a university reading level), vastly exceeding the Grade 6 health literacy target. Notably, one free model exhibited algorithmic hallucination by leaking its internal system prompt, demonstrating the unpredictability of unregulated AI. Conclusion: Premium AI provides significantly safer PAD education than free versions. For lower socioeconomic patients, reliance on unregulated free AI risks compounding existing vascular inequities and delaying presentation for chronic limb-threatening ischaemia (CLTI). Vascular surgeons must actively mitigate this digital wealth gap by prescribing verified resources. Future research should focus on developing equitable, open-access medical AI featuring mandatory triage safety-netting and low-literacy adaptations.

9:22 am

The contemporary patterns of endovascular surgery for peripheral arterial disease in Australia and Aotearoa New Zealand

Mike Wu

Purpose The endovascular treatment of peripheral arterial disease (PAD) has grown compared to open surgical procedures, to a greater degree in some states than others. This could be due to state-related differences in population health, health system structures and resources, and privately-insured status. We examined PAD procedures in terms of state and insurance status of patients to better understand the contemporary patterns of practice in Australia and Aotearoa New Zealand. Methodology Using AVA data on all the consecutive procedures performed in 2021 to 2023 for PAD in Australia and Aotearoa New Zealand, the 5 most common indications for PAD interventions were examined by state and by financial class. The data was analysed in R using summary statistics, multinomial logistic regression and generalised linear models. Results There were 30200 endovascular procedures for PAD between 2021 and 2023. 29370 procedures occurred in Australia and 830 in Aotearoa New Zealand. Using Australian Capital Territory (ACT) as the reference state, most other states had a higher rate of intervention ($p<0.01$), Victoria had the same rate, and Northern Territory had a lower rate ($p<0.01$). There is a significant positive correlation between private-to-public ratio and intervention rate across the states for all indications combined. After controlling for state, public patients compared to private have 65% lower odds for claudication, 53% lower odds for rest pain and 24% lower odds for ulcer as the intervention indication. Conclusion In Australia, the states with higher rates of interventions also had higher ratios of private to public patients.

9:28 am

Beyond the Statin: Distinct Patterns of Persistent LDL-C Non-Control in Peripheral Artery Disease

Oliver Zhang

Purpose: PAD is associated with high cardiovascular risk, and recent guidelines recommend substantially lower LDL-C, requiring treatment escalation beyond routine statin prescribing. Vascular practice commonly relies on indicators such as statin use, which may not reflect adequate LDL-C control. Lipid control is influenced by multiple interacting factors, including treatment intensity, patient factors, and system-level constraints. As a result, patients with similar lipid levels may differ substantially in their required level of intervention. This study aimed to identify lipid management patterns in the TEAM-PAD RCT, determining associations with recognisable patient characteristics. Methodology: The TEAM-PAD RCT allocated patients with PAD to MDT or routine vascular care. We analysed lipid profiles at baseline and 9-months and performed hierarchical cluster analysis using LDL-C target achievement, number of lipid-lowering therapy (LLT) agents, and high-intensity statin use at 9-months in 123 patients with complete data. Clusters were described using clinical and demographic characteristics, with before and after comparison. Results: At 9-months, 62 patients (50.4%) had not achieved LDL-C targets, occurring in two distinct clusters. The first had limited treatment (n=34). None were on high-intensity statins, with 41% on no LLT. The second had residual poor-control despite high-intensity statins (n=28) but 79% were on statin monotherapy. Overall, 45 of 62 patients not at target were on a statin (73%). Persistent non-control was not identifiable by PAD severity ($p=0.868$), prior vascular procedures ($p=0.125$), or MDT allocation ($p=0.718$). Of 63 patients not at target at

baseline, only 14 (22%) achieved target by 9 months. Conclusion: Poor lipid control occurred in two distinct patterns of undertreatment and inadequate treatment escalation. Achieving contemporary LDL-C targets in PAD will require practice changes to actively optimise therapy beyond statin prescription.

9:34 am
Peri-Operative Adherence To Anticoagulation Protocols In Patients Undergoing Open Arterial Surgery At Lautoka Hospital
Manisha Prakash
Purpose Peri-operative anticoagulation is essential in reducing thrombotic complications following open arterial surgery. In Fiji, where open arterial procedures remain the primary treatment for advanced vascular disease, there is no formal local anticoagulation protocol. This study aimed to evaluate adherence to international peri-operative anticoagulation guidelines and its relationship with clinical outcomes at Lautoka Hospital. Methods A retrospective audit was conducted at Lautoka Hospital, Fiji, including all adults who underwent open arterial surgery between January 2025 and April 2026. Adherence was assessed against ESVS and SVS recommendations using electronic medical records and drug charts. Results A total of 108 patients were included. Overall adherence to peri-operative anticoagulation guidelines was 63.0% (68/108), while 37.0% (40/108) demonstrated protocol non-adherence. Adherence rates were 83.3% pre-operatively, 71.3% intra-operatively and 90.7% post-operatively. Surgeon preference was the leading cause of non-adherence (85.0%). At least one postoperative complication occurred in 33/40 (82.5%) non-adherent patients compared with 11/68 (16.2%) adherent patients. This association was statistically significant (x^2 = 43.18, $p < 0.001$). Protocol non-adherence was associated with increased odds of postoperative complications (OR 24.4, 95% CI 8.63-69.12). Following establishment of a vascular unit, overall adherence improved from 8.5% to 89.0%. Conclusion Peri-operative anticoagulation practices at Lautoka Hospital demonstrated moderate overall adherence to international guidelines, with most deviations attributable to practice variation. The establishment of a dedicated vascular unit was associated with significant improvement in protocol adherence. Development of standardized local anticoagulation protocols may further improve patient outcomes and enhance the quality of vascular care in Fiji.

9:40 am
Discussion

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10 September 2026

10:00 am - 10:30 am
Morning Tea

Catering - Vascular Nursing, Vascular Surgery - Level 5

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10 September 2026

10:30 am - 12:30 pm
World Federation for Vascular Surgery

Scientific Session - Vascular Nursing, Vascular Surgery - Bloom Room

10:30 am
World Federation of Vascular Societies and Global Vascular Companionship Update
Iman Bayat

10:42 am
Integration & Collaboration of International & National Societies – Why is this important and Where are we going?
Palma Shaw

10:54 am
Establishing Aortic Programs in Developing Countries
Mamoun Albasheer

11:06 am
Establishing a Vascular Surgery Service in South Africa
Asha Malan

11:18 am
Update on Vascular Surgery in Fiji
Sela Koyamaibole

11:30 am
Vascular surgical service in the Fiji Islands – a model in capacity building
David McClure
For generations, RACS Fellows have been involved in providing volunteer surgical support to communities in the South Pacific. While the focus has generally been on service delivery, the broad aim has been to foster sustainable in-country health care delivery. The RACS Pacific Clinical Services Health Workforce Improvement Program currently sponsors Visiting Medical Teams (VMT) for volunteer service to 11 countries in the Asia-Pacific region. 2026 saw the first VMT for Vascular Surgery to Fiji. Unlike the service delivery model of Vascular VMTs to Nauru in previous years, the Fijian Vascular VMT had capacity building as its primary focus. This was made possible by the return of two Fijian Surgeons; following Vascular Surgery Fellowship training in Australia and New Zealand, respectively; to establish specialist Vascular Surgery Units in Suva and Lautoka. To provide the full breadth of Vascular Surgical care to their communities, these nascent Units have sought to ·build a surgical team – with dedicated resident trainees - delivering open and endovascular surgery; ·upskill local radiographers in Vascular ultrasound ·upgrade podiatric and orthotic care to the overwhelming population of patients with diabetic foot disease. This paper describes the outcome of this year's RACS Vascular VMT to Fiji, and the ongoing mentorship that exists for our Fijian Vascular Surgery colleagues – through personal contact, with previous training relationships, and through the broader support network that exists in Global Vascular Companionship. A scholarship program in vascular ultrasound training has been established, with its first award recipient to complete the program in September. Future mission trips to Fiji are planned to include podiatric and orthotic educative support. Our Fijian Vascular Surgeons are playing an integral role in "Shaping the Future of Vascular Surgery" for the people of the Fiji Islands. Their support in this endeavour is our collective responsibility.

11:42 am
World Health Organisation and its partnerships with non state actors and NGOs
Lee Wallis

11:50 am
Discussion

12:00 pm
The Rutherford Lecture: Management of carotid artery disease for stroke treatment and prevention: an evolutionary tale
Wesley Moore

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10 September 2026

12:30 pm - 1:30 pm
Lunch

Catering - Vascular Nursing, Vascular Surgery - Level 5

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10 September 2026

12:45 pm - 1:15 pm
Medtronic Lunch Symposium: Lessons from a Recorded Case: Directional Atherectomy and Drug-Coated Balloon Therapy in Complex Femoropopliteal Disease

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Scientific Session - Vascular Surgery - Bloom Room

12:45 pm
LESSONS FROM A RECORDED CASE: DIRECTIONAL ATHERECTOMY AND DRUG-COATED BALLOON THERAPY IN COMPLEX FEMOROPOPLITEAL DISEASE
Bobby Mendes

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10 September 2026

1:30 pm - 3:00 pm
Vascular Imaging & Surveillance

Scientific Session - Vascular Nursing, Vascular Surgery - Bloom Room

1:30 pm
Lower limb CVI examinations - improving efficiency by focusing on what's important
Martin Necas

1:40 pm
Duplex Ultrasound Surveillance After Endovascular Therapy for Peripheral Artery Disease: An Australian and New Zealand Study
Thomas Warburton
Purpose: Current practice guidelines lack consensus on optimal surveillance strategies following endovascular interventions for peripheral artery disease (PAD). This study evaluated surveillance practices among vascular surgeons in Australia and New Zealand (ANZ), focusing on duplex ultrasound (DUS) use and factors influencing surveillance protocols. Methodology: All consultant vascular surgeons in the Australian and New Zealand Society for Vascular Surgery were invited to participate in an online survey examining demographics, practice characteristics, surveillance protocols after endovascular interventions, and decision-making regarding surveillance and reintervention. Results: Of 266 surgeons, 73 responded (27%). Respondents were predominantly experienced (77% with ≥ 10 years practice) and worked in teaching hospitals (88%). Most performed an initial post-procedural DUS (89%) and ongoing routine DUS surveillance (83%). Surveillance protocols varied considerably, with 67% tailoring intervals based on patient/lesion factors rather than predetermined schedules. Practice variation was independent of surgeon experience, practice setting, or geography. All surveyed chronic limb-threatening ischaemia patients, versus 93% for intermittent claudication. Reintervention thresholds varied by anatomy: 58% required symptoms before intervening for infrapopliteal disease compared to 15% for aortoiliac disease. Most surgeons (82%) acknowledged significant uncertainty regarding optimal surveillance strategies. Conclusion: Substantial practice variation exists in post-endovascular surveillance among ANZ vascular surgeons. While most employ DUS surveillance, frequency, duration, and intervention thresholds differ markedly. These findings highlight the need for prospective studies to determine optimal surveillance protocols balancing clinical outcomes with resource utilisation.

1:48 pm
Renal artery aneurysm surveillance: a multi-centre perspective
Amnshumaan Kishore
Surveillance protocols for renal artery aneurysms (RAAs) vary considerably between institutions, with limited evidence to guide optimal imaging intervals and modalities. As the widespread adoption of advanced three-dimensional imaging techniques has increased the incidental detection of RAAs has drastically increased. While generally accepted to be indolent, the natural history of many RAAs remains poorly defined. Despite this, the life-threatening risk of rupture makes establishing safe, effective, and economical surveillance strategies of utmost important. A retrospective review was performed of patients within Metro North Health who were followed up in the nurse led surveillance clinic. Patients were identified from all the patients with renal artery aneurysms under surveillance from the conception of the

clinic in 2014. Inclusion criteria required patients to have undergone at least two surveillance scans. Demographic, clinical, and imaging data were collected and analysed. A total of 41 patients met the inclusion criteria and were included in the study. Aneurysm size ranged from 8-24mm, with a mean diameter at the commencement of surveillance of 13.4mm. The average duration of surveillance was 1409 days. During surveillance, aneurysms demonstrated measurable growth, corresponding to an average growth rate of -0.55 +/- 1.73mm per year. The majority of aneurysms remained stable throughout the surveillance period. No aneurysm ruptures were observed, and no patients underwent intervention during follow-up. In this cohort, renal artery aneurysms minimal growth, with most lesions remaining stable during the study period. Furthermore, this study highlights the significant discrepancy in measurement between different imaging modalities. These findings support a conservative surveillance regime. Further studies with larger patient populations and longer follow-up are required to better define the natural history of RAAs and inform optimal surveillance strategies.

1:56 pm
Discussion

2:00 pm
Pedal and Hand acceleration time: what, when, why
Jill Sommerset

2:15 pm
Open Revascularisation Delivers a Greater Improvement in Pedal Acceleration Time Compared to Endovascular Revascularisation
Charles Buchanan
Objective: Pedal acceleration time (PAT) is a novel sonographic method for assessing foot perfusion in peripheral arterial disease (PAD), which has been shown to correlate with wound healing and amputation-free survival. This study aimed to assess the response of PAT to open compared to endovascular revascularisation approaches. Secondary outcomes were major limb amputation (MLA) and death. Methods: This was a retrospective study that included patients who underwent a revascularisation procedure for PAD of any severity from 2021-2024 at a single tertiary-centre. PAT were obtained by trained sonographers prior to and after the revascularisation procedure. Data was collected on disease severity, renal function, diabetes, MLA, and mortality. Data was analysed using t tests and reported as % or mean +/- SD. Results: There were a total of 1,111 revascularisation procedures over the study period, of whom 463 patients had pre- and post-PAT measurements and were included. Average age was 71.4 +/- 10.3yr, 66.3% diabetic, creatinine 162.9 +/- 203.1 umol/L and median Rutherford class 5. PAT improved with revascularisation in all groups, open (n=79) pre 241.6 +/- 62.0 vs post 120.0 +/- 42.3, endovascular (n=356) pre 192.3 +/- 65.0 vs post 138.5 +/- 48.1, hybrid (n=28) pre 235.2 +/- 51.3 vs post 146.4 +/- 45.6, all P <0.0001. Open revascularisation was associated with a greater change in PAT compared to endovascular revascularisation, change in PAT with open 109.0±66.9 vs endovascular 53.1 +/- 66.9, P <0.0001. Open revascularisation was associated with lower rates of MLA and 1yr mortality, 8.9% vs 14.0% and 5.0% vs 20.8%, respectively. Conclusion: This study showed that open revascularisation resulted in the greatest improvement in PAT. Future studies should seek to validate these findings in larger cohorts and assess the impact of disease severity on PAT.

2:21 pm
Hand acceleration time: A novel tool for assessing upper limb perfusion
Philip Allan
Purpose Assessment of upper limb ischaemia is primarily clinical, with current non-invasive methods of quantifying upper limb perfusion (e.g. oxygen saturation or digital-pressures) being non-standardised. Hand acceleration times (HATS) is a novel non-invasive ultrasound based perfusion measurement that could aid in the diagnosis of upper limb ischaemia, however there has been limited characterisation of it in the literature. This study sought to compare HATS values in a patients with or without sonographic evidence of arterial disease. Methodology This was a single-centre prospective study of patients who were referred to Vascular Surgery with clinical concern for upper limb ischaemia or with a arteriovenous fistula issue, and who underwent HATS measurement. Patients were categorised into those that had a sonographic evidence of arterial disease (PAD; stenosis >50% or occlusion), and those that didn't. Demographic, comorbidity, and clinical presentation data was collected. Data was analysed using t- and $\chi 2$ tests and is expressed as mean±SD or %. Results 28 patients were included, 15 (59±18y, 47% male) with PAD and 13 (57±21y, 62% male) without. There was no difference in comorbidities between groups, except for higher antiplatelet use in the PAD group (60 vs 23%, p=0.049). Across the cohort, rest pain was the most common presentation (57.1%), followed by tissue loss (17.9%), then claudication (10.7%). There was no difference in the proportion of patients presenting with each symptom between groups. HATS was significantly worse (higher) in the PAD group 162ms vs 83ms (p=0.0097). In a subset of five patients with digital tissue loss, HATS values were the

same in digits with and without tissue loss (128 vs 132ms). Conclusion HATS measurement appears to correspond appropriately to stenotic or occlusive arterial disease, and may be a sensitive diagnostic tool for upper limb ischaemia. Further work is required to validate HATS against current upper limb perfusion measures.

2:27 pm
Discussion

2:32 pm
IVUS use in femoral popliteal dissections
Chris Delaney

2:40 pm
Carotid Doppler - pitfalls and pearls and unusual cases
Martin Necas

2:50 pm
Psoas muscle density correlates better with age-related sarcopenia and operative risk than psoas muscle area
Louis Scarrold

2:56 pm
Discussion

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10 September 2026

3:00 pm - 3:30 pm
Afternoon Tea

Catering - Vascular Surgery, Vascular Nursing - Level 5

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10 September 2026

3:30 pm - 5:30 pm
Diabetic Foot disease, Limb Salvage & Multi-Disciplinary Team Approach

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Scientific Session - Vascular Nursing, Vascular Surgery - Bloom Room

3:30 pm
The Impact of Cognition, Concordance and Context on DFU Healing
Kathleen Finlayson

3:36 pm
Challenges of limb salvage in rural and remote areas of Australia and New Zealand
Peta Tehan

3:46 pm
Closing the Gap? Disparities in Outcomes of Diabetic Foot Disease in Aboriginal and Torres Strait Islander Patients
Myrna Ishak
Purpose First Nations Aboriginal and Torres Strait Islander people have a higher prevalence of diabetic foot disease and consequent major limb amputations in Australia. Our aim is to examine the outcomes of Aboriginal and Torres Strait Islander patients undergoing toe amputation for diabetic foot disease (DFD) in comparison to others and identify contributing risk factors for less favourable outcomes. Methodology A

retrospective cohort study was conducted in Cairns Hospital amongst inpatients of the vascular surgery unit who were admitted for management of DFD from 1st of January 2015 to 31st of December 2024. Primary outcomes were requirement of further foot debridement and/or minor amputations following index procedure and subsequent ipsilateral major limb amputation. Secondary outcomes included all-cause post-operative mortality and perioperative incidence of MACE. Results 231 patients were included over a period of 10 years. Aboriginal and Torres Strait Islander residents represent 12.6% of the Cairns and Hinterland Hospital and Health Service (CHHHS) population. In our cohort, 48.1% were of this background. In comparison to other patients, Aboriginal and Torres Strait Islanders had a significantly lower median age of presentation to hospital ($p = 0.016$), significantly higher likelihood of requiring further digital amputation/s ($p = 0.002$), and a significantly shorter duration of time before re-presentation for a recurrent minor amputation ($p < 0.02$) following the index minor amputation. This affected males and females almost equally (55.8% and 44.2%), in contrast to males being more affected in other patient groups. Conclusion This is one of the largest representations of Aboriginal and Torres Strait Islander patients in current Australian literature looking at outcomes following minor amputations in patients with DFD. There is a notable over-representation and significant discrepancy in outcomes among Aboriginal and Torres Strait Islander peoples in comparison to others with DFD.

3:54 pm
Comparing BEST-CLI participants with patients treated at a tertiary centre serving a regional-remote population
David Sun

4:02 pm
Discussion

4:12 pm
Functional and Clinical Outcomes of Hallux and Lesser Digit Amputations in Diabetic Foot Disease
Myrna Ishak
Purpose Digital amputations are frequently used in the treatment of diabetic foot ulcers and infections. It is widely believed that hallux amputations disrupt gait patterns and foot anatomy, leading to poor outcomes compared to lesser toe amputations. However, there is minimal evidence to support this idea from research comparing the short and long-term outcomes of patients undergoing hallux versus lesser toe amputations. Additionally, there are only a few studies comparing outcomes of transphalangeal with transmetatarsal amputations. The aim of our study was to compare the following outcomes; ipsilateral further digital amputations, major amputations, major adverse cardiovascular events (MACE), and death. Methodology A retrospective cohort study was conducted amongst vascular surgery inpatients of Cairns Hospital from January 2015 to December 2024. Patients with a diagnosis of diabetes mellitus undergoing single hallux or lesser digit amputation were included. Those undergoing digital amputation for pathology other than diabetic foot disease were excluded. Outcomes were examined using Cox-proportional hazard analyses. Results Of the 480 patients that were included, 207 underwent hallux amputation and 273 underwent a lesser toe amputation. A significant proportion of hallux amputations were performed as an emergency procedure ($p = 0.014$). There was no significant difference between the proportion of patients requiring further digital amputation or ipsilateral major limb amputation. Time to an ipsilateral further digital amputation was significantly shorter in the hallux amputation group ($p = 0.021$). There was no significant difference between incidence of MACE or post-operative death between the two groups. Conclusion Minor diabetic foot amputations are associated with risk of repeat digital amputation, MALE, MACE, death. There are comparable rates of these consequences amongst those undergoing hallux or lesser toe amputation; one is not “safer” than another.

4:18 pm
Outcomes of the use of PolyNovo Biodegradable Temporising Matrix (BTM) and MTX in diabetic foot wounds
James Kellie

4:24 pm
Biodegradable Temporising Matrix in High-Risk Diabetic Foot Wounds: Who Benefits Most?
Chui Foong Ong
Purpose Complex diabetic foot wounds (DFUs) with exposed bone, tendon, or extensive soft tissue loss remain a major challenge in limb salvage. Biodegradable Temporising Matrix (BTM) is an emerging dermal substitute for wound bed reconstruction; however, predictors of success in high-risk diabetic foot populations remain poorly defined. This study evaluates outcomes following BTM and identifies patient and wound factors associated with successful wound healing. Methodology A prospective observational study of

BTM cases from April 2024 to June 2026 was conducted at a single tertiary Australian Diabetic Foot Service. Twenty-three patients (24 limbs) were included. Baseline demographics, wound characteristics, WIfI stage, dialysis dependence, and osteomyelitis were recorded. Outcomes included complete wound healing, amputation, mortality, length of hospital stay (LOS), and readmissions. Results Mean age was 66 years (54–80) with median follow-up of 29 weeks (IQR 0–43). Mean LOS was 25 days (IQR 3–66). Complete wound healing occurred in 11 limbs (45.8%) at a median of 29 weeks. Most achieved graft integration, with 2 required split-skin graft. Complications included graft loss in 6 limbs, minor amputation in 5, and major amputation in 3. Three deaths (12%) occurred, all unrelated to the procedure. Readmissions occurred in 14 cases, primarily for wound management or further intervention. WIfI stage 3–4, osteomyelitis, and dialysis dependence were associated with poorer outcomes, though dialysis numbers were small. WIfI stage was most consistently associated with delayed wound healing, higher LOS and readmissions. Conclusion BTM is a useful adjunct in selected complex DFUs, achieving moderate wound healing. Outcomes are primarily driven by limb threat severity and infection burden, particularly WIfI stage and osteomyelitis. Resource utilisation remains substantial, with prolonged admission and readmissions. Careful patient selection is essential to optimise limb salvage and reduce treatment burden.

4:30 pm
Chemical Lumbar Sympathectomy in Non-Revascularised Chronic Limb Threatening Ischaemia: A Retrospective Single-Centre Cohort Study
Tin Yau Ngan
Background Management options for patients with chronic limb-threatening ischaemia (CLTI) that do not undergo revascularisation remain limited, particularly when major intervention is not feasible or is being deferred. Chemical lumbar sympathectomy (CLS) is used in some centres as an adjunct for ischaemic pain, but contemporary outcome data are sparse. This study evaluated short-term symptomatic response and limb outcomes following CLS in a tertiary referral practice. Methods A retrospective single-centre cohort study was performed of patients undergoing CLS between 2015 and 2025. Patients treated for peripheral arterial disease/CLTI were identified from institutional records. Baseline demographic, clinical and procedural data were extracted from the electronic medical record. Outcomes included early subjective pain response, procedure-related complications, minor amputation, major amputation and in-hospital death. Exploratory analyses assessed associations between baseline characteristics and pain response. Results Sixty limbs underwent CLS during the study period; 47 procedures were performed for peripheral arterial disease. Mean age was 73 years and 50% of patients were male. Early pain reduction was documented in 25/46 evaluable cases (54.3%). Reintervention occurred in 11 patients (18.3%), minor amputation in 7 (11.7%), major amputation in 8 (13.3%), and death during the index admission in 4 (6.7%). Procedure-related major complications were rare, with one patient (1.7%) sustaining acute spinal syndrome with associated bowel/bladder dysfunction. Conclusion In a contemporary single-centre experience, CLS was used as an adjunct in a high-risk cohort with limb ischaemia that did not undergo revascularisation. CLS was associated with early pain improvement in approximately half of evaluable patients, with a low rate of serious procedural complications.

4:36 pm
Topical Oxygen Therapy in Vascular Surgery: A Review of Technologies, Evidence, and Clinical Applications
Rebecca Aburn

4:42 pm
Discussion

4:52 pm
Composite Cardiovascular Risk Improved with Multidisciplinary Team Care of Patients with Peripheral Artery Disease in the TEAM-PAD Trial.
David Savoan
Purpose: The high cardiovascular mortality in Peripheral Artery Disease (PAD) means secondary prevention needs accurate risk assessment and monitoring. The TEAM-PAD randomised trial compared reduction in cardiovascular risk in multidisciplinary team (MDT) care to usual care using the SMART-REACH score. We assessed 9-month outcomes and explored if treatment effects were also measurable using an Australian risk calculator (AusCVD). Methodology: The primary endpoint in the TEAM-PAD trial was change in cardiovascular risk from baseline to 9-months, assessed using SMART-REACH. AusCVD scores were analysed for exploratory comparison. Between group differences in risk change (MDT vs usual care) were assessed and predictors of improvement were evaluated by correlation and logistic regression. Results: A total of 130 patients were included (MDT n=66; standard care n=64). MDT significantly improved cardiovascular risk as measured by SMART-REACH, with a mean between group difference of 3.8 (p=0.018), but not as measured by AusCVD (p=0.457). Overall, there was no significant risk change across the cohort for either SMART-

REACH (46.9 vs 48.2; p=0.066) or AusCVD (16.3 vs 17.4; p=0.152). SMART-REACH and AusCVD change scores were weakly correlated (ρ=0.084, p=0.348). SMART-REACH improvement was associated with higher baseline LDL (OR 1.7; p=0.014), while current smoking reduced likelihood of improvement (OR 0.3; p=0.025). Improvement in AusCVD measured risk was associated with CLTI (OR 2.5; p=0.03), weekly exercise (OR 2.7; p=0.02), and higher baseline SBP (OR 1.0; p=0.03). Conclusion: At 9-months, MDT care improved cardiovascular risk for PAD patients, as measured by SMART-REACH, and despite no overall cohort change, we demonstrated that risk can be modified with structured care. The absence of detectable change using AusCVD suggests differences in treatment sensitivity. Risk scores must support both risk stratification and monitoring, needing further validation in clinical use.

4:58 pm
Title: Redefining Responsibility in PAD Care: Australian Doctors' Perspectives on Multidisciplinary Management
Miriam Wiersma
Purpose: Long-term outcomes of peripheral artery disease (PAD) are driven more by cardiovascular risk than adverse limb events. Although effective risk reduction therapies exist, their implementation is inconsistent. Multidisciplinary (MDT) care improves outcomes, but in vascular surgery, MDTs focus primarily on surgical decisions with limited input into cardiovascular risk prevention. The TEAM-PAD RCT evaluated whether a virtual MDT improved guideline-based secondary prevention, while an embedded early-phase implementation study explored clinician perspectives on the MDT model, including barriers and facilitators. Methodology: Qualitative semi-structured interviews with 14 MDT clinicians (6 vascular surgeons, 2 endocrinologists, 2 drug and alcohol clinicians, a nephrologist, cardiologist, geriatrician and pharmacist) were conducted. Data were analysed using thematic analysis and mapped to the CFIR framework. Results: Perceived facilitators included clear communication, actionable recommendations for general practitioners (GPs), and improvements in patient care. The main barrier was inconsistent GP uptake of MDT recommendations, partly due to communication gaps. Clinicians expressed uncertainty about who should be responsible for cardiovascular risk management. Despite the MDT not directly involving GPs, many still felt they ought to be primarily responsible for cardiovascular risk management. However, hospital-based clinicians recognised constraints in primary care, including limited time, resources, and variable expertise. Conclusion: While there is consensus that cardiovascular risk management should occur in primary care, its delivery remains suboptimal for patients with PAD. A gap in ownership of preventive care persists. Effective MDT implementation requires clearer delineation of responsibilities, with vascular surgeons taking a more proactive role in cardiovascular risk prevention.

5:04 pm
A Dedicated Vascular Home Hospital Pathway Safely Delivers Complex Limb Preservation Care While Increasing Acute Surgical Bed Capacity
Tishanthan Pathmarajah
Purpose: Patients with diabetic foot disease frequently require prolonged inpatient admission for intravenous antimicrobial therapy, wound management and multidisciplinary care. We evaluated the clinical outcomes, resource utilisation, financial impact and service capacity of a dedicated Vascular Home Hospital (HH) pathway within a tertiary vascular surgery service. Methodology: A retrospective review was undertaken of all patients managed through the Royal Perth Vascular HH pathway between March and June 2026. Patient demographics, HH length of stay (LOS), readmission rates, bed occupancy and estimated cost implications were analysed. Results: Twenty-four vascular episodes of care were identified. Most patients were managed for diabetic foot complications, osteomyelitis and complex wounds requiring prolonged treatment following inpatient vascular assessment and intervention. Median HH LOS was 10.6 days (mean 15.2), generating 366 HH bed-days over four months, equivalent to the continuous availability of three additional inpatient beds. Three patients (12.5%) required readmission within 28 days; however, none were related to the index vascular diagnosis. Inpatient bed occupancy remained high (81–92%), comparable to the preceding 12 months, facilitating treatment of additional patients without increasing bed numbers. Based on activity-based costing, HH care reduced daily expenditure by 9.8% compared with inpatient management ($1,286 vs $1,425/day), generating estimated savings of $50,874. Conclusion: A dedicated vascular HH pathway provides a safe and effective model for managing selected limb preservation and complex wound patients. Beyond direct cost savings, its principal benefit was increased service capacity, functioning as a virtual expansion of vascular ward capacity without increasing physical bed numbers. Expansion of vascular-specific HH services may help meet growing demand on tertiary vascular services while preserving access to acute inpatient care.

5:10 pm
An observational study on the extent of peripheral arterial disease in the Fijian lower limb amputee.
Shahzad Sadiq

Purpose In the Fiji Islands the number of major lower limb amputations being performed has reached epidemic proportions. At the Colonial War Memorial Hospital (CWMH) this number has exceeded 300 each year over the past decade. The question has been asked of whether pre-emptive treatment of lower limb artery disease by endovascular intervention might have a role. The profile of lower limb arterial disease in the Fijian population is unknown, and this study was undertaken to define such need. Methodology A cross-sectional study was conducted at CWMH, Suva, Fiji. Adults with a prior unilateral lower-limb amputation underwent duplex ultrasound of the contralateral limb from the common femoral artery to the ankle. PAD was defined as ≥50% stenosis (peak systolic velocity ratio ≥2.0) or occlusion. Disease was classified as femoral–popliteal, tibial, or combined. Lesions were designated "consider for intervention" when judged anatomically suitable for endovascular therapy within the local service context. Results Forty-eight adults were enrolled (mean age 58 years; 97.9% with diabetes). Most index amputations were sepsis-related below-knee procedures within six months of assessment. Clinically, 27.1% of contralateral limbs had ulceration and only 41.7% had normal sensation. Duplex ultrasound demonstrated PAD in 54.2%; tibial-only disease accounted for 31.3%, femoral–popliteal-only for 4.2%, and combined disease for 18.8%. Approximately half of PAD-positive limbs were considered potentially amenable to endovascular intervention. Conclusion Amputation rates for diabetic foot disease are substantially higher in centres across the South Pacific than those observed in high income countries. The identification of remedial lower-limb arterial disease in this cohort of Fijian amputees has provided the impetus to develop an endovascular service in the country, managed by local surgeons under the mentorship of Australian vascular surgical colleagues.

5:16 pm
Discussion

3:30 pm - 5:00 pm
Vascular Ultrasound Workshop

Workshop - Vascular Nursing, Vascular Surgery - Ripple Room 1

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10 September 2026

5:30 pm - 6:30 pm
Welcome Reception

Cocktail - Vascular Nursing, Vascular Surgery - Rooftop at QT

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10 September 2026

7:00 pm - 10:30 pm
Trainees Dinner

Speciality Dinner - Vascular Surgery - Notch

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11 September 2026

7:00 am - 8:20 am
Women in Vascular Surgery Breakfast

Breakfast Session - Vascular Surgery - Notch

11 September 2026

8:15 am - 10:30 am
Peaks, Pathways & Possibilities

Scientific Session - Vascular Nursing - Drift Room 2 - Drift Room 1

Focus: Policy, Equity, Research & Framework

8:15 am
Nursing Welcome
Frances Horner

8:30 am
Shaping the Future of Vascular Nursing Care: A Māori Health Perspective
Delanie Nepia

9:00 am
Beyond the Dressing: Exploring Variation in Vascular Wound Care
Joshua Cho
Purpose: Vascular-related wounds are a significant burden on patients and the healthcare system, and the patient journey is often complicated by pain, delayed healing and high recurrence rates. Despite advances in vascular surgery and wound management, variation in clinical practice persists. This study aimed to explore current management of vascular-related wounds from specialist vascular nurses. A secondary aim was to identify barriers to evidence-based management and opportunities for service improvement. Methodology: A mixed methods study was undertaken using an online survey and semi-structured interviews. Specialist nurses working in Australian vascular units were recruited through the Australian and New Zealand Society of Vascular Nurses. Survey data were analysed descriptively, while interview transcripts underwent thematic analysis. Results: Twenty-one nurses completed the survey, and four participated in follow-up interviews. Findings revealed substantial variation in vascular wound management, including assessment, documentation, referral pathways and follow-up care. Participants identified workforce shortages, limited access to specialist resources, and competing clinical demands as barriers to care. Limited vascular education pathways and variability in expertise affected confidence in evidence-based management. Fragmented models of care led to poor continuity because of limited integration across services. Interview findings highlighted challenges in interdisciplinary communication and the absence of standardised protocols for complex vascular wounds. Conclusion: This study highlighted variability in vascular wound management practices within Australian healthcare services, largely driven by organisational and workforce constraints. Enhancing interdisciplinary education, collaboration and evidence-based protocols may improve continuity of care, support clinical decision making, and optimise patient outcomes.

9:12 am
Implementing a Wound Hygiene Quality Improvement Project: The Journey So Far—From Concept Development to Ethics Approval and Future Directions
Rebecca Aburn
Abstract Background Chronic wounds remain a significant burden for patients and healthcare services, with delayed healing often associated with biofilm, infection, and inconsistent wound bed preparation. Wound hygiene, incorporating systematic cleansing, debridement, wound edge management, and appropriate dressing selection, has emerged as an evidence-informed approach to optimize healing. Aim: To describe the development and implementation journey of a wound hygiene project, including stakeholder engagement, protocol development, ethics processes, and planned evaluation strategies. Methods A team led and key personal comprising wound care specialists, clinical nurse leaders, and key stakeholders was established to design a standardized wound hygiene pathway. I A project framework was developed incorporating staff education, competency assessment, standardized documentation, and outcome measurement. As the project involved prospective collection of patient and clinician data, an ethics application was prepared addressing participant recruitment, informed consent processes, data management, privacy considerations, and governance requirements. Discussion The ethics application process provided an opportunity to strengthen study methodology and ensure patient safety and data

integrity. The journey toward implementing a wound hygiene project has highlighted the value of structured planning, multidisciplinary collaboration, and governance oversight. Sharing early lessons learned may assist other services seeking to implement evidence-based wound hygiene practices and evaluate their impact on patient outcomes.

9:24 am
The Hidden Backbone of the Vascular Unit: The Value of the Vascular Clinical Nurse Consultant – A Registrar's Perspective
Paulina Bruessel
Purpose: Contemporary vascular surgery manages a complex patient population defined by advanced CLTI, diabetic foot disease, frailty, multimorbidity and recurrent interactions. Care increasingly relies on multidisciplinary (MDT) models integrating surgical, medial, allied health and nursing expertise. The vascular Clinical Nurse Consultant (CNC) provides continuity, coordination and specialist knowledge throughout the patient journey; however, the broader contribution of the CNC is often under-recognised. This review examines the evidence supporting specialist vascular nursing roles and the contribution of the CNC to patient outcomes, MDT function and vascular service performance. Methodology: A focused literature review was undertaken examining vascular nursing, MDT limb-preservation services, CLTI management, vascular surveillance programmes and nurse-led models of care. Particular attention was given to care coordination, patient education, wound management, discharge planning and continuity of care. Results: The literature consistently identifies specialist vascular nurses as essential MDT coordinators, facilitating interdisciplinary communication, streamlining patient pathways, supporting outpatient surveillance, providing patient education, and enabling timely escalation of care. Structured nursing involvement contributes to more standardised clinical pathways, improved discharge planning, enhanced continuity of care and more efficient use of healthcare resources. As vascular services become increasingly complex, specialist nursing roles have expanded beyond direct bedside care to encompass leadership, service development, quality improvement, and MDT coordination. Conclusion: The vascular CNC plays a critical role in modern vascular practice. Available evidence suggests that specialist vascular nursing contributes to improved patient experience, supports MDT function and enhances the delivery of high quality vascular care.

9:36 am
Redesigning High-Risk Foot Care: A Unique Multidisciplinary Model of Care for Minor Operative Procedures at Sunshine Coast University Hospital
Maarisha Kumar
Purpose Diabetic foot disease is a leading cause of preventable hospitalisation in Australia, placing significant strain on the healthcare system. While many hospitals offer multidisciplinary high-risk foot services (HRFS), access to timely minor surgical interventions remains a challenge. The Sunshine Coast University Hospital HRFS has established an innovative outpatient Minor Operations and Procedures Service (MOPS). The clinic has bridged the divide between outpatient care and surgery, embedding the multidisciplinary team with surgeons, nursing and podiatry across the continuum of care (1). Methodology This study outlines the development and implementation of the MOPS clinic. Quantitative data has been collected and reports on the numbers and different types of cases undertaken, as well as initial Patient Reported Outcome Measures. Results Early clinical feedback suggests the clinic is achieving its intended goals. The service has been able perform minor amputations, tenotomies and debridement. From the responses available, 90% of patients felt the podiatry presence contributed to better health outcomes, with 97% patients reporting safe care. 100% of patients thus far responded they would feel comfortable with further procedures in MOPS. MOPS has also improved efficiency by reducing reliance on operating theatres and enabling timely interventions. Conclusion MOPS represents a novel and scalable model for addressing access challenges in high-risk foot care. Its strength lies in the integration of the multidisciplinary team at every stage of the patient journey. This approach bridges the traditional disconnect between multidisciplinary high-risk foot care and surgical management, and reflects how surgeons, nurses and podiatrists can work together to support services for high-risk patients. Lazzarini PA, et al. (2018). Diabetes-related lower-extremity complications are a leading cause of the global burden of disability. Diabetic Medicine

9:48 am
Combining AI and Remote Monitoring of Vascular Wounds: The Next Evolution in Wound Management
Haywood Yeung

11 September 2026

8:30 am - 12:00 pm
ANZSVS STEPS Program

Scientific Session - Vascular Surgery - Ripple Room 1

8:30 am - 10:00 am
Venous Disease: DVT & PE

Scientific Session - Vascular Surgery - Bloom Room

8:30 am
Two-Year Outcomes of Mechanical Thrombectomy for Iliofemoral versus Isolated Femoropopliteal Deep Vein Thrombosis: Results From the CLOUT Study
Rajesh Malik
Purpose: To compare outcomes of contemporary mechanical thrombectomy for iliofemoral deep vein thrombosis (IF-DVT) vs isolated femoropopliteal DVT (iFP-DVT). Methodology: The CLOUT study (NCT03575364) evaluated mechanical thrombectomy with the ClotTriever system (Inari, Irvine, CA, US) for proximal lower extremity DVT. Here, outcomes were assessed after grouping subjects by anatomical disease location. The primary effectiveness endpoint was ≥75% postprocedural thrombus removal based on independently adjudicated Marder scores. Additional outcomes, including postthrombotic syndrome (PTS) by Villalta score, were collected through 2-year follow-up. Results: After grouping by DVT location, IF-DVT was present in 389 (78.6%) limbs from 379 subjects, and iFP-DVT was present in the remaining 106 (21.4%) limbs from 105 subjects. In the IF-DVT group, there was a larger proportion of female subjects (53.3% vs 41.6%, P=.0436), but no other significant differences in baseline characteristics were observed. A comparable proportion of limbs in each cohort achieved the primary endpoint of ≥75% thrombus removal (90.5% vs 93.4%, P=.4415). Comparing the IF-DVT and iFP-DVT cohorts, treated limbs demonstrated similar improvements in patency from baseline (18.4% vs 11.8%, P=.1924) through 2-year follow-up (94.9% vs 90.0%, P=.2699). There were no significant differences in Villalta score between the IF-DVT and iFP-DVT groups at any study visit, improving from baseline (median score 9.0 vs 10.0, P=.2732) through 2-year follow-up (median score 1.0 vs 2.0, P=.7186). At the 2-year visit, the distribution of PTS severity was not significantly different in the IF-DVT vs iFP-DVT cohorts (none: 80.6% vs 81.4%, mild: 13.6% vs 8.5%, moderate: 3.7% vs 6.8%, severe: 2.1% vs 3.4%; P=.4695). Conclusion: Mechanical thrombectomy achieved similar outcomes in IF-DVT and iFP-DVT. Additional research is warranted to better understand the benefits and limitations of this intervention for patients with iFP-DVT.

8:38 am
Initial Experience with the Gore VIABAHN FORTEGRA Venous Stent in Acute Iliofemoral DVT
Jessica Green

8:44 am
Venous stenting: inflow, outflow, evidence
Kareem Osman

8:50 am
How Expensive is a Swollen Leg? – A single-centre retrospective review and cost analysis of deep venous thrombosis duplex studies
Michael Na
Purpose Duplex ultrasound presents a quick, non-invasive investigation for deep venous thrombosis (DVT), and its use has expanded over the years with the prevalence of vascular ultrasound laboratories. We assessed the volume of requests, rates of positive scans and surgical intervention at our centre with a cost-analysis to characterise the overall impact on the healthcare system. Methodology We conducted a retrospective cohort analysis of all DVT exclusion requests at our institution from January to May 2026. The primary outcome was scan demonstrating acute DVT, with secondary outcome of referral for consideration of surgery. Results A total of 613 scans were conducted over 5 months, with 350 for inpatients, 194 outpatients and 69 in the emergency department. There were 213 unilateral lower limb, 256 bilateral lower limb and 144 upper limb (unilateral) requests. 99 noted previous DVT (16.3%), 56 had diagnosed pulmonary embolism (PE) (9.1%), and 54 noted recent venous cannulation. 94 scans reported acute DVTs (29 upper and

65 lower limb, 15.3%), with 38 of those in patients with PE. 40 out of 59 acute DVTs involving femoral or upper limb veins were referred for surgical opinion. Notably, 38 requests were for “screening” (6.2% of total requests), 13 of which found a DVT, and 151 requests had no significant clinical information with 19 finding an acute DVT (12.6%). With the current Medicare schedule fee for acute DVT scan being $194.65 and up to 95% rebate for a bulk billed scan, we estimated an overall cost over 110,000AUD over 5 months to Medicare for 5 months of DVT exclusions studies in our centre. Conclusion DVT exclusion duplexes at our institution demonstrated appropriate diagnostic yield (15.3% positive rate), and 42.6% of those with acute DVT were also referred for surgical opinion. Whilst DVT exclusion studies do have a significant cost to the taxpayer, their use at our centre does seem appropriate in the context of a significant pathology.

8:56 am
Discussion

9:01 am
Results From the Completed FLASH Study of Large-Bore Mechanical Thrombectomy for Acute Pulmonary Embolism
Rajesh Malik
Purpose: To present the outcomes of large-bore mechanical thrombectomy (LBMT) for acute pulmonary embolism (PE) from the combined US and European cohorts of the FLASH study. Methodology: FLASH (NCT03761173) prospectively enrolled real-world subjects treated with the FlowTriever system (Inari, Irvine, CA, US) for intermediate-risk or high-risk PE. The composite primary endpoint consisted of independently adjudicated major adverse events (AEs) comprising major bleeding and device-related mortality through 48 hours and intraprocedural device-related or procedure-related AEs. Severe dyspnea was defined as a modified Medical Research Council score of 3 or 4. Subjects were followed for 6 months. Results: The analysis population included 999 subjects enrolled across 69 sites. Mean age was 61.6±14.3 years, and 453 (45.3%) subjects were female. The stratification by PE risk was 14.3% high risk, 72.0% intermediate-high risk, 6.5% intermediate-low risk, and 7.1% intermediate risk without further classification. Immediately after thrombectomy, mean pulmonary artery pressure improved from 32.6±8.8 to 25.0±8.6 mmHg (-22.7% for paired values, P<.0001). Thrombectomy time was 49.8±35.4 minutes, and adjunctive therapy was used in 22 (2.2%) cases. Twenty-four (2.4%) subjects met the primary endpoint, 0 with device-related mortalities, 17 (1.7%) with major bleeds, and 8 (0.8%) with intraprocedural AEs related to the device or procedure. All-cause mortality rates at 48 hours, 30 days, and study exit were 0.6%, 1.8%, and 5.6%, respectively. The proportion of subjects with severe dyspnea improved from 70.9% at baseline to 16.2% (P<.0001) at the 48-hour visit and continued improving to 3.0% (P<.0001) at the 6-month visit. There were low rates of chronic thromboembolic pulmonary hypertension (1.2%) and post-PE syndrome (1.9%) at 6-month follow-up. Conclusion: Data from the FLASH study of acute PE indicate that LBMT is safe and associated with favorable acute and long-term outcomes.

9:09 am
PE/PERT team service at Tertiary hospital
Chris Delaney

9:17 am
Closing the Gap: Mechanical Thrombectomy for Acute Pulmonary Embolism in Regional and Rural North Queensland, Australia
David Sun
Objective To evaluate the feasibility and early outcomes of large-bore mechanical thrombectomy for intermediate-high and high-risk pulmonary embolism (PE) in a regional Australian tertiary referral centre. Methods A retrospective cohort study was conducted at a regional tertiary hospital in North Queensland between January 2022 and June 2025. Consecutive patients undergoing mechanical thrombectomy following multidisciplinary Pulmonary Embolism Response Team (PERT) evaluation were included. Demographic, procedural, and short-term clinical outcomes were analysed descriptively. Results Twenty-three patients underwent mechanical thrombectomy. Technical success was achieved in all cases (100%) with no immediate procedural complications. Eleven patients (47.8%) required post-procedural intensive care unit admission. Mean oxygenation saturation increased modestly following intervention (94.7% to 96.4%), although interpretation is limited by heterogeneity in oxygen support. Among 17 patients with follow-up imaging within 48 hours, 6 (35.3%) demonstrated reduction in right ventricular to left ventricular (RV/LV) ratio to < 0.9. The mean hospital length of stay was 17.9 ± 21.6 days (median 9 days). Thirty-day mortality was 8.7%. Conclusions Large-bore mechanical thrombectomy for acute PE was feasible and safely delivered in a regional Australian centre, with acceptable short-term outcomes in a high-risk cohort. These findings support the potential for appropriately resourced regional centres to provide advanced interventional PE care.

9:23 am
Discussion

9:28 am
Pelvic Venous: the essential role of ultrasound in diagnosis
Jill Sommerset

9:36 am
Durability of Prosthetic Venous Grafts After Major Caval and Iliocaval Reconstruction
Keely Gardiner
Purpose: Major venous resection and reconstruction are frequently required during retroperitoneal sarcoma (RPS) surgery for complete oncological resection. However, concerns remain regarding long-term prosthetic venous graft durability, with limited available data. This study evaluated graft patency and reintervention following venous reconstruction during RPS resection. Methodology: All patients undergoing major venous reconstruction during RPS surgery at Sir Charles Gairdner Hospital, Western Australia, between January 2010 and June 2025 were included. Demographic, operative, and follow-up data were collected retrospectively. Primary outcomes were primary graft patency and graft-related reintervention. Results: 36 venous reconstructions were performed. IVC reconstruction was most common (n=26), followed by iliocaval (n=5) and iliac vein reconstruction (n=5). Polytetrafluoroethylene was the predominant conduit (88.9%). Median caval graft diameter was 20 mm (16-24 mm). Over a median follow-up of 35.8 months, five graft occlusions occurred (13.9%), four (80%) within six weeks postoperatively. Kaplan-Meier estimated freedom from graft occlusion was 88.7% at 1 and 3 years (95% CI 78.9–99.8%), and 79.8% at 5 years (95% CI 63.0–100%). Iliocaval reconstructions had a higher observed occlusion rate than isolated IVC reconstruction (40% vs 11.5%), although this did not reach statistical significance. Four graft-related reinterventions were performed (11.1%), two for thrombosis and two for graft kinking. Discharge anticoagulation included rivaroxaban (n=18), apixaban (n=12) and warfarin (n=2), with no association with graft occlusion. Conclusion: Major venous reconstruction during RPS surgery demonstrates favourable long-term durability, with approximately 80% primary patency at five years. Most occlusions occurred within six weeks postoperatively, indicating an early period of increased risk. These findings highlight early thrombosis prevention as a key target for future research.

9:42 am
Venous TOS thrombolysis and rib resection strategies: Lessons learned over 20 years
Jason Lee

9:50 am
Patient reported outcomes following decompression for Primary Subclavian Venous Thrombosis
Nishanth Wood
Purpose: Primary subclavian venous thrombosis is an uncommon condition that usually affects young and active people. Anticoagulation alone without addressing the underlying pathology may result in post-thrombotic syndrome (PTS) in 40-50% of patients. Decompression with a first rib resection and an endovenous treatment to restore vein patency is recommended to prevent PTS. While the treatment is safer, there is little published data on functional and patient-reported outcomes in this group. Methodology: Patients between February 2020 to May 2026 presenting with primary subclavian venous thrombosis were recruited prospectively. Patients completed the DASH questionnaire and a validated thoracic outlet syndrome survey. All patients had the first rib removed via an infraclavicular incision with an endovascular venous procedure to address the thrombosis. The primary outcome was patient-reported symptoms using validated tools, and the secondary outcome was the clinical result according to Derkash classification. Results: 19 patients were included and 7 were females. The median (range) age was 27 (16-54). The length of the index presentation hospital stay was 4 days, and there were no returns to theatres. 18 patients had a patent vein during follow-up. There was an overall improvement in the DASH score with a 15.8-point difference. 16 patients reported “good” to "excellent" improvement using the Derkash classification. The thoracic outlet syndrome survey improved in all categories (pain, sports, work, emotions, lifestyle) between two and nine points per domain. Conclusion: Patient reported outcomes following endovenous therapy and first rib resection are good, with improvements observed from baseline. Longer-term functional outcomes require further reporting in this young group of patients.

9:56 am
Discussion

11 September 2026

10:00 am - 10:30 am
Morning Tea

Catering - Vascular Surgery, Vascular Nursing - Level 5

11 September 2026

10:10 am - 10:30 am
Cook Medical Morning Tea Symposium: An educational video: REALDES study: drug eluting stent outcomes in PAD

Scientific Session - Vascular Surgery - Bloom Room

10:10 am
An educational video: REALDES study: drug-eluting stent outcomes in PAD
Cook Medical

11 September 2026

10:30 am - 12:30 pm
Kidneys, Reno-Vascular Access & the Environment

Scientific Session - Vascular Surgery - Bloom Room

10:30 am
Two-Year Clinical Outcomes from the WRAPSODY® Arteriovenous Access Efficacy (WAVE) Trial
Manar Khashram

10:38 am
Percutanous AVF- is there still a role/selection
Chris Delaney

10:46 am
DRIL techniques
Carl Muthu

10:54 am
Central Venous Stenosis: Pushing the Boundaries
Asha Malan

11:02 am
Discussion

11:12 am
IMPART-TRIAL: Negative pressure wound therapy versus standard dressings for incision management after renal transplant: a multicentre, partially blinded randomised controlled trial
Michael Na

11:18 am
Renal Access and Patient Care: Delays to Arteriovenous Fistula Haemodialysis
Gabrielle Stratford

11:24 am
Outcomes of a Single Centre Regional Renal Physician-led Dialysis Access Clinic: A Comparative Study
Nima Iranpour
Introduction: Traditionally, renal access clinics have been vascular-led due to the specialist nature of the definitive procedure; however, some rural centres have experimented with a physician-led model as part of a multi-disciplinary approach. This study investigates the impact of rural physician-led renal clinics on patient outcomes, particularly focusing on arteriovenous fistula (AVF) or graft (AVG) at the first session of haemodialysis. The analysis compares outcomes across rural and urban New South Wales (NSW) centres to determine the effectiveness of physician-led care in improving vascular access for dialysis patients. Method: Data was extracted from the Australia and New Zealand Dialysis and Transplant Registry, covering 2020-2023. Data from Dubbo, a rural base hospital with a physician-led model for renal access, was compared to other NSW Hospitals coded as either rural or urban. Statistical analysis was conducted using Pearson's chi-square test to assess the significance of differences in patient outcomes, with a p-value of less than 0.005 considered significant. Results: The analysis demonstrated that the physician-led rural dialysis access clinic at Dubbo achieved significantly higher rates of permanent vascular access at first haemodialysis compared to combined rural and urban centres in NSW. Dubbo reported a rise in permanent access from 40%-75% between 2020 and 2023 (chi-square 20.851 ($p = 0.002$)). In contrast, rural centres averaged 46% and urban centres 41% for permanent access. Conclusion: The findings suggest that rural physician-led renal clinics may contribute to improved patient outcomes in haemodialysis, particularly regarding increasing the use of permanent vascular access. Further research is needed to confirm these results across a broader range of physician-led clinics and to account for potential confounding factors. Future studies should consider retrospective cohort analyses to explore the long-term benefits of this approach.

11:30 am
Establishing Dialysis Access in Parallel: Single-Centre Outcomes of Concurrent PD Catheter and AV Fistula Procedures
Yu Shan Neo

11:36 am
Avoiding Non-Beneficial Treatments
Elizabeth Stallworthy

11:46 am
Discussion

11:56 am
Strategies to increase environmental sustainability and reduce waste relevant to endovascular surgery - A Scoping Review
Aaron Huang
Aim: This scoping review aims to identify, categorise, and evaluate current strategies for increasing environmental sustainability in endovascular theatres, assessing their effectiveness for sites seeking to implement them. Background: Combining the output of healthcare worldwide would rank as the 5th-largest greenhouse gas-producing nation, with a significant contribution from operating theatres. Endovascular and hybrid procedures are resource-intensive environments that generate substantial medical waste, with waste disposal contributing significantly to healthcare's carbon footprint. Multiple strategies have been described as relevant to endovascular theatres, spanning vascular surgery, interventional radiology, cardiology, and neurology. Method: Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) framework, a comprehensive search of Medline, Embase and Cochrane Library was carried out. Studies included in the review were selected by two authors (AH and SL) after a blinded review based on their relevance to waste reduction and environmental sustainability in endovascular surgery. Results: Current findings highlight differing themes for interventions to reduce environmental impact, including optimising waste segregation to increase the recycling of uncontaminated medical waste, educating staff to improve decision-making regarding resource utilisation and waste disposal, and enacting hospital-level policies that promote sustainability. Conclusion: Sustainability initiatives in endovascular surgery require a multifaceted approach. This review will explore themes in the literature relevant to endovascular surgery, including current interventions to increase sustainability and reduce waste, and assess their environmental and clinical impact.

12:02 pm
Small Particles, Big Problems: A Scoping Review of Microplastics in Vascular Surgery

Lucille Vance
Purpose: Microplastics and nanoplastics (MNPs) are increasingly present in the global environment as production of plastics increases despite our understanding of their impact on health remaining limited. This review serves to understand the extent and type of evidence in relation to the role of MNPs relevant to the field of vascular and endovascular surgery. Methodology: Using the PRISMA-ScR guidelines, a search of MEDLINE, Embase and Cochrane Library databases was undertaken from inception to until 24 March 2026. Eligibility criteria included studies published in English, contained human population groups, and examined MNPs in a context relevant to vascular and endovascular surgery. Studies were screened during a blinded review by two authors (LV, AH). Results: 2234 articles were identified from database searches with 28 articles meeting eligibility criteria for review. Most articles identified were reviews and thematically reported on the role of MNPs in cardiovascular risk factors via increased rates of atherosclerosis, thrombosis and reduction in vascular bed integrity. Outcomes-based studies reported higher concentrations of MNPs within vascular and renal tissue correlating with increased severity and complications of cardiovascular disease, including stroke and myocardial infarction, and chronic renal disease. Observational studies identified iatrogenic MNPs associated with therapeutics including percutaneous and endovascular devices, continuous renal replacement therapy and haemodialysis circuits, and extracorporeal membrane oxygenation circuits. Conclusion: The effects of MNPs within the cardiovascular system identifies roles in cardiotoxicity, thrombosis, inflammation and immunomodulation. As such the field of vascular and endovascular surgery is likely to see an increase in disease presentation and severity with effects on management and surgical outcomes not yet revealed.

12:08 pm
Discussion

10:30 am - 12:30 pm
Walking the Patient Path

Scientific Session - Vascular Nursing - Drift Room 1 - Drift Room 2

Focus: Patient perspective, co-morbidities, MDT

10:30 am
Tools to facilitate healing and prevention of vascular leg ulcers in the complex patient
Kathleen Finlayson

11:00 am
Case study: A cascade of events in an older patient
Susan Monaro
Introduction: Older patients in vascular surgery are complex, as they often have multimorbidity. Careful perioperative care is important. Case: An 81-year-old female underwent elective spinal surgery complicated by a postoperative cardiac arrest. Cardiopulmonary resuscitation resulted in rib fractures. After three weeks in acute care and rehabilitation, she represented with chest and jaw pain. On investigation, she was found to have a Type II aortic dissection likely secondary to the trauma from cardiopulmonary resuscitation. She was worked up for an endograft and Thoracic Endovascular Aortic Repair. On follow-up imaging, she had a successful repair of her dissection and no postoperative complications. Discussion: Interdisciplinary care optimised and recovered our patient within our Geriatric Co-management Vascular Model of Care. The perioperative team included Anaesthetics, Operating Room, Radiology, Cardiology, Vascular Surgery, Geriatric Medicine, and Intensive Care. A careful workup was required to control blood pressure, blood glucose, ensure renal protection, and treat iron deficiency. Technical success was improved by mapping access, intraoperative imaging, and device selection. Postoperative risks common among older patients were assessed serially, and prevention strategies were implemented. Conclusion: The older person can experience a cascade of clinical problems. Interdisciplinary care can improve patient outcomes and experience. Reflection on these cases can also deliver important learnings for the vascular surgical team. Keywords: Aortic dissection, Endograft, Thoracic Endovascular Aortic Repair, interdisciplinary

11:12 am
Is Intervention Always the Right Option?
Karen Nixey
Sometimes you get a patient who makes you wonder. Max, pseudonym, was an eighty two year old male who came to the attention of the Waikato Vascular service in 2025. He came with an extensive medical background of chronic autoimmune thrombocytopenia, myelodysplastic syndrome, rheumatoid arthritis,

systemic lupus erythematosus, IHD, gout, lumbar spine degenerative disease, hyperlipidaemia. Fatty liver disease, chronic skin ulcers & bilateral THJRs. He came into hospital initially with a non-healing ulcer on a left pre-tibial site and subsequently had a BTM graft. Discharged home to his retirement village unit but represented in November with his BTM graft infected. Conventional dressings were applied post graft removal. Subsequently had an angioplasty in December. By the end of January, the DNs described the wound as much improved. He represented acutely in April with right limb threatening ischaemia having had a further left leg angioplasty in the interim. By this time, he also had a necrotic toe on the left leg. He had large oedematous legs that were very leaky. Dressings of betadine to the toe & zetuvit with toe to knee crepe bandaging on the legs along with bed rest proving effective. A failed angioplasty to the right leg led to a right femoral anterior tibial artery bypass using reversed spliced GSV. Five days post op I reviewed the right leg that now had extensive necrotic areas and black toes. Not what I was expecting. Discharged four weeks later where the DNs struggled with his dressings. His last admission was on the 10th of June for an evacuation of a right thigh haematoma and repair of the infected graft. Subsequently transferred to HDU from ward after MET call for hypotension, tachycardia and groin bleeding. Taken to OT but no repair possible due to friable tissue. At time of submitting patient was palliative and unfortunately passed away on 23/6/26. In twenty one years, I have never seen a case like this prompting me to ask Is Intervention Always the Right Option?

11:24 am
Outcomes of non-traumatic major lower limb amputation in a tertiary referral centre
Tanghua Chen
Non-traumatic major lower limb (LL) amputation is a devastating complication associated with diabetes and peripheral arterial disease, carrying a high risk of perioperative adverse events and mortality. Previous studies investigated the impact of comorbidities on postoperative outcomes in patients who undergo non-traumatic major LL amputation, highlighting their heightened risk of 30-day mortality and prolonged inpatient stays. However, there remains a lack of research examining inpatient adverse events such as pressure injury, falls, delirium and incontinence. This study aimed to describe the association between pre-operative frailty status and the risk of hospital-acquired complications (HAC) and hospital-acquired infections (HAI). Retrospective study of adult patients admitted to the tertiary centre who underwent non-traumatic major LL amputation between January 2010 to December 2023. All data were extracted from the Admitted Patient Data Collection. Frailty status on admission was estimated using a cumulative deficit approach. During the study period, 642 adults with an average age of 65.5 years (1-SD = 13.2) underwent LL amputation. 40% (n= 254) had 4 or more deficits, and 23% (n = 145) had no deficits at the time of admission. The risk of any HAC increased with the no. of frailty deficit items (4+ items 252/254 99.2%, versus 0-items, 116/145, 80%). A similar association was seen with HAI (4+ items: 33/254, 12.9%, versus 0 items: 9/145, 6.2%). The most common HAC was at least one hospital fall (n = 54), followed by delirium (n = 47). The most common HAI was surgical site infection, followed by acute pneumonia. Among this group undergoing LL amputation, frailty status at the time of hospital admission was observed to be a significant risk factor for hospital adverse events, like HACs and HAI. These results support the need for targeted models of care for frail older adults in the surgical setting.

11:36 am
Innovative Scaffolding Compression Bandaging for Complex Lymphoedema and Chronic Wound Management: A Case Series
Rebecca Aburn

11:48 am
Sleep & Recovery: From Science to Practical Strategies
Jo Gibbs

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11 September 2026

12:30 pm - 1:30 pm
Lunch

Catering - Vascular Surgery, Vascular Nursing - Level 5

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11 September 2026

12:45 pm - 1:15 pm
Gore Lunchtime Symposium: Aortic Arch Repair with an OTS Single Side Branch Device

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Scientific Session - Vascular Surgery - Bloom Room

12:45 pm
GORE LUNCHTIME SYMPOSIUM: AORTIC ARCH REPAIR WITH AN OTS SINGLE SIDE BRANCH DEVICE
Jason Lee, Anastasia Dean

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11 September 2026

1:30 pm - 3:00 pm
Abdominal Aortic Aneurysm & Training Future Aortic Surgeons

Scientific Session - Vascular Surgery - Bloom Room

1:30 pm
The role of women in changing the landscape of Australian Vascular Surgery: Advancements, Challenges and future directions
Pooja Krishnaswamy
Objectives: The proportion of female doctors in surgery is underrepresented when compared to other medical specialties. The Royal Australian College for Surgeons (RACS) and the Australian and New Zealand Society of Vascular Surgery (ANZSVS) have increased awareness in the importance of gender diversity to create an equitable surgical workforce that reflects community. This study explored the current state of women in Vascular Surgery in Australia and New Zealand, including contributions to Vascular Surgery research. Methods: Demographic data was extracted from the ANZSVS Member 2024 database and Health Workforce Data Australia 2024. A PubMed search of each vascular surgeons publications from years 2018 to 2024 was performed by two independent reviewers. Data collected included date of publication, type of study and level of research evidence. Results: Despite 54% women represented in the current medical workforce, only 17% of the current vascular workforce are women. In 2024, 22% of vascular surgical trainees were female. Over 5 years, the proportion of female trainees has slowly increased. During the 2025 Vascular SET intake, there was a significant increase in accepted female applicants of 64%. Compared to other surgical subspecialties general surgery continues to lead in gender diversity. Women vascular surgeons contribute to vascular surgical publications equally to their male counterparts where two of the the top ten publishing vascular surgeons were women. Conclusion: Gender diversity in Vascular Surgery is vital to ensure equitable representation of the community. This study sheds insight into the representation of women in vascular surgery and their contributions to research.

1:38 pm
Open AAA Training: National Decline, Local Success
Adam Beck

1:46 pm
Patient-Specific Aortic Simulation for Training and Procedural Planning
Lucy Guazzo

1:52 pm
Open aortic surgery in Australia over 25 years: an analysis of the trends and its impacts on vascular surgery trainees.
Shawn Ng
Purpose In Australia, peripheral artery disease affects over 20% of the population aged 75 and over, and the prevalence of abdominal aortic aneurysm has remained at 4-6% over the last 20 years. Despite this prevalence of occlusive and aneurysmal disease, rates of open aortic surgery have been decreasing. This could be driven by risk factor modification such as smoking cessation, greater control of hypertension and

hypercholesterolaemia, and a shift towards an endovascular-preferred approach. This study investigates this decreasing trend and its direct impact on vascular surgery trainees. Methodology Medicare Benefits Schedule item numbers for open and endovascular interventions for occlusive and aneurysmal disease were identified. Aggregated data was obtained from the Services Australia Medicare website between 2000 and 2025. Results were tested for statistical significance, and trainee data was extracted from the Australian and New Zealand Society for Vascular Surgery. Results Total abdominal aortic open operations across Australia decreased from 152 in 2000 to 45 in 2025 ($p<0.0001$). Negative binomial regression identified an average yearly decline of 4%. Endovascular aneurysm repairs and aortoiliac stents showed a statistically significant increase over 25 years. These findings were corroborated by data within the Australasian Vascular Audit (AVA). With 45 open operations and 52 trainees in 2025, this represents 0.86 cases per trainee per year. This limited case number, compounded by an uneven distribution of cases among hospitals, results in minimal exposure for trainees and has potential implications for trainee proficiency in open aortic surgery. Conclusion This study highlights the significant decrease in open abdominal aortic operations across Australia and its impact on vascular surgery trainees. Further research into this can contribute to a better understanding of these challenges and guide future improvements to vascular surgery training.

1:58 pm
A Survey of Confidence Performing and Teaching Endovascular and Open Aortic Surgery Among Australasian Vascular Surgery Trainees and Surgeons
Vikram Iyer

2:04 pm
Audience Discussion: Open Aortic Surgery is a Dying Art and Should be Centralised
Irina Baimatova

2:12 pm
Examining the pathophysiological importance of atherosclerotic and non-atherosclerotic arterial wall hypoxia with [18F]Fluoromisonidazole
Nishath Altaf

2:18 pm
The Invisible Threat: Quantifying Missed Opportunities to Diagnose AAA
Anantha Narayanan

2:24 pm
A 12-Year Experience With Aortic Graft and Endograft Infection; The Importance of Identifying a Causative Organism
William Ju

2:32 pm
Crossed-Limb Endovascular Aneurysm Repair: Mid-Term Outcomes from a Multicentre Western Australian Cohort
Tishanthan Pathmarajah
Purpose: Crossed-limb deployment during endovascular aneurysm repair (EVAR) is occasionally required in patients with challenging anatomy to facilitate contralateral gate cannulation. Concerns regarding long-term durability have limited widespread adoption. This study compared graft-related outcomes following crossed-limb and conventional EVAR deployment. Methods: A retrospective multicentre review was performed of all patients undergoing infrarenal EVAR with the Gore Excluder endograft across seven Western Australian hospitals between 2013 and 2018. Patients treated with crossed-limb EVAR were compared with conventional deployment. Primary outcomes included graft limb occlusion, endoleak and reintervention. Secondary outcomes included perioperative and mid-term mortality, with three-year follow-up. Results: A total of 215 patients were analysed, including 83 crossed-limb and 132 conventional EVARs. Mean age was 70.5 years and 86% were male. No graft limb occlusions occurred in the crossed-limb cohort, while three occurred following conventional EVAR (0% vs 2.3%, $p=0.267$). Type I endoleak occurred in one patient in the crossed-limb group and two patients in the conventional group (1% vs 1.5%, $p=0.85$). No Type III endoleaks occurred in the crossed-limb cohort, whereas two occurred in the conventional group (0% vs 1.5%, $p=0.524$). No 30-day mortality occurred in the crossed-limb cohort, compared with one death in the conventional group (0% vs 0.7%, $p=0.427$). No aneurysm-related mortality occurred in either group at three years. Late non-aneurysm-related mortality was comparable between groups (1% vs 3%, $p=0.387$). Conclusion: Crossed-limb EVAR demonstrated durable outcomes comparable to conventional deployment, with no increase in graft limb occlusion, endoleak, reintervention or mortality through mid-term follow-up. These findings support crossed-limb deployment as a safe and effective strategy in patients with

challenging aortoiliac anatomy undergoing EVAR.

2:38 pm
Impact of a Hospital-Wide “Code AAA” Protocol on the Management of Ruptured Abdominal Aortic Aneurysm: A Retrospective Cohort Study
Zaynab Alghurairy
Purpose Ruptured abdominal aortic aneurysm (rAAA) is a time-critical emergency with reported mortality of 30-50%. In June 2019, Northern Health introduced a hospital-wide “Code AAA” protocol to expedite activation, CT imaging, resuscitation and transfer to theatre. We evaluated its impact on process metrics, perioperative morbidity and mortality. Methods Single-centre retrospective cohort study of consecutive patients undergoing emergent repair of rAAA following emergency department presentation. Included patients were stratified by presentation before (Jan 2010 - Jun 2019; n=27) or after (Jun 2019 - May 2026; n=16) protocol implementation. Baseline characteristics, process and operative metrics, and outcome data were extracted and comparative analyses were performed. Results Baseline characteristics were comparable, though the post cohort was older (pre-protocol median age 75 years, post 82.5 years). EVAR use rose markedly (15% pre vs. 75% post, p<0.001). Median triage-to-theatre time trended shorter (251 minutes pre vs. 179 minutes post, p=0.16), and 30-day mortality was similar across the cohorts (pre 41%; n=11/27 vs. post 44%; n=7/16, p=1.0). The post-protocol cohort received significantly less blood product, both intraoperatively (pre-protocol median 4 units vs. post 2 units, p=0.022) and in total (7 pre vs. 4 post, p =0.029). Following the implementation of the protocol, median inpatient stay was lower at 6 days, compared with 8 days prior to implementation (p=0.25). Conclusion: Following implementation of the Code AAA protocol, we observed a non-significant trend towards expedited operating theatre transfer, reduced blood product use and shorter inpatient stay in the emergent management of ruptured AAA. While a shift toward endovascular repair was noted over the same period, this was observational. These findings support the value of coordinated, protocolised pathways for time-critical vascular emergencies and warrant confirmation in larger, multi-centre cohorts.

2:44 pm
A contemporary analysis of small abdominal aortic aneurysm growth patterns
Nishanth Wood
Purpose: The growth patterns of small abdominal aortic aneurysms (AAA) have been the subject of several randomised trials and summarised by level 1 analyses. However, there has been a change in the epidemiology of the AAA population, specifically a reduction in smoking rates, older age at presentation, and better cardiovascular risk management, which might affect AAA growth (1). Furthermore, AAA growth data in the Māori population has not been previously reported. The hypothesis of this study was that the background epidemiological changes and improvements in medical management slow the growth of small AAA. Methods: Retrospective analysis of all patients with a small AAA who were undergoing longitudinal ultrasound surveillance in a tertiary vascular centre. The data were sourced from the Waikato Hospital Vascular Surgery database. There were 5153 scans included, with an average of 4.8 scans per person. Results: 1071 patients were enrolled in the small AAA ultrasound surveillance program, of whom 801 had >1 scan and were included in the analysis. 207 patients underwent AAA repair, and 358 patients died without repair. The median (range) age at the time of the first scan was 74 (45-97). The overall mean growth rate was 2.15mm/year and the median growth rate was 1.7mm/year. There were 224 (28%) women and 83 patients identified as NZ Māori. The median growth rate for men was 1.76mm/year and for women 2.28mm/year. The median growth for Māori men was 1.82mm/year and for Māori women 2.63mm/year. Conclusions: Growth of AAA in contemporary patients appears slower than that reported previously. Growth rates in women were higher, with the fastest growth occurring amongst Māori women, which requires further attention to reduce this disparity. References: 1. Prendes CF, Gouveia e Melo R, Caldeira D, D’Oria M, Tsilimparis N, Koelemay M, et al. Systematic Review and Meta-Analysis of Contemporary Abdominal Aortic Aneurysm Growth Rates. Eur J Vasc Endovasc Surg. 2024;67(1):132-45.

2:52 pm
Discussion

1:30 pm - 3:00 pm
Pushing boundaries – knowing limits

Scientific Session - Vascular Nursing - Drift Room 2 - Drift Room 1

Emerging treatments, wounds, goals of care & palliation

1:30 pm
AAA/ AF Research Programme: Current Outcomes & Future Plans
Chloe Pillay

1:50 pm
Making AAA Surveillance Visible: Transforming Manual Follow-Up into Clinical Insight
Alex Dowds
Abdominal aortic aneurysm (AAA) surveillance is essential to reducing aneurysm-related complications, yet many services rely on manual tracking systems with limited visibility of surveillance activity and population-level trends. Within our service, surveillance was managed using a manually maintained spreadsheet requiring ongoing clinician data entry, annual record migration, manual surveillance calculations, and individual oversight. While functional, the system provided limited audit capability and little ability to understand the wider surveillance population. To address these challenges, a Nurse Practitioner-led AAA surveillance platform was developed using Microsoft Excel. While remaining clinician-managed, the platform incorporates evidence-based surveillance intervals based on aneurysm diameter, automated due date calculations, reminder notifications, overdue surveillance alerts, and visual dashboards. Additional fields capture demographic, clinical, and treatment data including ethnicity, smoking status, intervention history, and geographical location. The platform has transformed surveillance from a static patient register into a practical clinical governance tool. For the first time, the service can visualise its AAA population, identify patients requiring follow-up, monitor equity indicators, support quality improvement initiatives, and better understand future service demand. Visibility of aneurysm size distribution and surveillance status also supports planning for vascular clinic capacity, EVAR workload, and radiology resource allocation. This innovation demonstrates how structured surveillance data can generate meaningful clinical insight. The value lies not simply in the database itself, but in making the surveillance population visible, measurable, and actionable. Patients who are visible can be monitored. Patients who are monitored can be appropriately managed.

2:00 pm
Arterial Pumps for Chronic Limb Threatening Ischaemia
Terra Wilson

2:10 pm
Complex Below Knee Amputation Wound Care – When to Deviate from the Status Quo
Paulina Bruessel
Purpose: Despite advances in the management of complex diabetic foot disease and CLTI, major limb amputation remains common. Post-operative wound care is a key determinant of recovery following below-knee amputation (BKA), influencing infection, wound dehiscence, revision surgery, contracture formation, and chronic pain. While standardised wound care pathways have been proposed, they are often difficult to apply in patients with complex wounds. This review presents a single-centre experience in managing complex BKA wounds, examining outcomes, complications, and alternative wound care strategies when conventional protocols are unsuitable. Methods: A focused literature review was undertaken to evaluate contemporary surgical and post-operative wound management strategies for BKA, including flap design, wound closure, dressing selection, timing and frequency of wound review, and residual limb shaping protocols. This was followed by a review of three complex BKA cases managed at The Canberra Hospital between 2025-2026. Key lessons regarding optimal post-operative wound management were identified. Results: In selected patients with significant post-operative oedema, delayed wound closure may improve healing. Negative pressure wound therapy and compression prior to application of rigid dressings may optimise wound healing and residual limb maturation. Wound products including collagen-based scaffolds may be beneficial in chronic, heavily exudative wounds or where flap tissue quality is poor. Successful management was consistently associated with multidisciplinary care involving surgeons, specialist vascular nurses, allied health practitioners, and prosthetists. Conclusion: Although standardised post-operative wound care pathways offer advantages in streamlining care and education, they are often insufficient for complex BKA wounds. Individualised management within a multidisciplinary framework is essential to optimise healing, preserve function, and improve patient outcomes.

2:20 pm
Outcomes of Calciphylaxis in a tertiary centre – A nursing perspective
Heather Schulz
Outcomes of Calciphylaxis in a tertiary centre – A nursing perspective Heather Schulz,Prakash Balakrishnan ,Paula McKinnel,Lupe Taumoepeau, Elizabeth Suthers , Parth Sheth , Richard Evans ,JK Wickremesekera Purpose Calciphylaxis is a life-threatening disease due to progressive subcutaneous and dermal small vessel calcification resulting in tissue ischaemia ,thrombosis & necrosis mainly in end-stage renal disease patients.

Difficulty in distinguishing it early from peripheral vascular disease led to this study. The focus is on clinical characteristics, diagnosis, early identification and the impact of nursing management on improving patient outcomes. We present a series of successful cases managed in our unit. Methodology A local database search conducted in a tertiary hospital screening for all calciphylaxis cases in the last 10 years. Incidence, demographic patterns, mortality and wound complications were documented. The time to diagnosis and referral pathways were analysed. Results Approximately 24 patients were identified , ranging from 39 to 81 years and 50% were Maori . Majority were end-stage renal failure patients on dialysis at time of onset. Nearly half of the patients had concurrent peripheral arterial disease requiring revascularisation. Around 25% of patients had major limb amputation. Only 12.5 % of patients were on warfarin and there was increasing use of sodium thiosulfate in a third of patients. A case series of 3 patients with calciphylaxis with positive outcomes were presented. Conclusion This study has several limitations, predominantly from the small cohort of patients due to poor electronic coding of disease in hospital electronic databases, the findings were descriptive rather than definitive. Success in managing calciphylaxis within the scope of nursing practice is influenced by increased nursing vigilance with early prompt diagnosis and a robust wound management plan. The hope is to improve local practices through collaboration and increased awareness.

2:30 pm
Integrated High Risk Foot Vascular Clinic: A Service Redesign Model to Improve Access, Efficiency and Limb Preservation in a Tertiary Referral Centre
Grace Manjoro
Purpose Patients with high-risk foot pathology frequently require coordinated vascular and multidisciplinary care coordination, yet traditional models often result in fragmented care and delayed decision-making. We evaluated an integrated vascular–high risk foot clinic model at Royal North Shore Hospital, designed to improve efficiency, streamline care, and optimise surgical triage. Methodology A 13-week prospective service redesign trial was undertaken within a tertiary High Risk Foot Service. Vascular registrar-led consultations were undertaken with podiatric clinicians supported by ambulatory care nursing staff in accordance with defined referral and de-escalation pathways for chronic limb-threatening ischaemia (CLTI), post-revascularisation surveillance, osteomyelitis, and complex ulcerations. Pre- and post-implementation clinic metrics were compared, including overbooking frequency, overtime occurrence, discharge rates, waitlist burden, multidisciplinary engagement and admission avoidance. Results Following implementation, vascular clinic overbooking reduced substantially (92% to 7%), while clinic overtime was eliminated (92% to 0%). Waitlist burden decreased from 217 to 99 patients. Patients required fewer clinic encounters (2.7 to 1.3 clinics per patient) and fewer appointments overall (8.27 to 2.6 appointments). Thirty-three percent of patients were discharged or de-escalated to local services or podiatric-led care. Multidisciplinary input was streamlined, with frequent same-day involvement from Endocrinology, Hospital-in-the-Home, Orthotics and Infectious Diseases. Fifty-six potential admissions were avoided, representing substantial healthcare cost avoidance. Conclusion An integrated vascular–high risk foot clinic improved access, reduced duplication, enhanced multidisciplinary efficiency and supported timely limb salvage decision-making. This model demonstrates a scalable framework for tertiary vascular services managing complex diabetic foot and CLTI presentations.

2:40 pm
EMOLED Evaluation study: assessing blue light therapy in wound healing
Nicholas Tierney
Background Chronic wounds impose a significant clinical burden by increasing morbidity, healthcare costs, and reducing quality of life. Blue light photobiomodulation has emerged as a promising adjunct in wound care, stimulating cellular metabolism, angiogenesis, and antimicrobial action. The EmoLED photobiomodulation device, which has been evaluated in several trials, has intrigued multiple Australian providers. Objectives To evaluate the efficacy of the EmoLED device in aiding the healing of static wounds in vascular and high-risk foot patients. Methods This study is a single-centre, prospective observational study conducted at Sunshine Coast University Hospital. Eligible participants include patients with non-healing wounds under vascular surgery or high-risk foot services. The 12-week study includes a 4-week run-in phase (standard care), 4-week intervention phase (weekly EmoLED plus standard care), and 4-week follow-up phase (standard care). Patients were reviewed 3-months and 6-months post-trial to document wound progress. Healing was assessed weekly through photography and planimetry. The primary outcome is percentage surface area reduction while secondary outcomes include subjective pain and quality of life scores. Results Analysis of 20 participants has been performed. Variable outcomes were achieved during initial phases. Several previously deteriorating wounds showed improvement, whilst others worsened or showed minimal change. The most significant healing occurred 1 to 6 months post-therapy, suggesting a delayed response to treatment. Pain scores consistently improved throughout treatment. Conclusion EmoLED therapy demonstrates variable outcomes during early treatment phases, with possible long-term benefits evident. While most wounds improved, no consistent advantage over standard care was observed

in this short-term study. Future studies with longer observation periods may reveal more significant benefits.

2:50 pm
Discussion

1:30 pm - 3:00 pm
Vascular Ultrasound Workshop

Scientific Session - Vascular Surgery - Ripple Room 1

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11 September 2026

3:00 pm - 3:30 pm
Afternoon Tea

Catering - Vascular Nursing, Vascular Surgery - Level 5

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11 September 2026

3:30 pm - 4:30 pm
Summit Showdown

Scientific Session - Vascular Nursing - Drift Room 2 - Drift Room 1

Expert panel debates: rare, complicated, challenging or novel cases

3:30 pm
Aortic Aneurysm Summit Bid: it's the detail that makes the difference
Frances Horner

3:45 pm
"To heal, or not to heal"
Michael Balladeo

4:00 pm
“It’s on the Leg, So It Must Be Vascular……”
Alicia Sutton

4:15 pm
Panel Discussion
Kathleen Finlayson, Janine Ellison, Carmen Ruiz, Helen Sutton

3:30 pm - 5:30 pm
Trauma, Vascular Foundation & Surgical Training in 2026

Scientific Session - Vascular Surgery - Bloom Room

3:30 pm
Sharp impact: Penetrating Thoracic Trauma at the Northern Territory’s Major Trauma Centre (NT MTC) 2020–2025

Fergus Walsh

Purpose Penetrating thoracic trauma is a major cause of morbidity and mortality in the Northern Territory (NT), where remote geography creates trauma system challenges. This study describes epidemiology, injury patterns, management, outcomes, and vascular injury burden of penetrating thoracic trauma at the NT Major Trauma Centre (NT MTC). Methodology A retrospective cohort study used the Trauma Registry. Adults admitted with penetrating thoracic trauma between 1 January 2020 and 31 December 2025 were included. Demographics, injury patterns, thoracic AIS severity, management, vascular injuries, and outcomes were analysed descriptively. Results 201 patients included; superficial breast injuries excluded. Median age was 33 years; 141 (70%) were male and 170 (85%) Aboriginal and Torres Strait Islander. Assault accounted for 177 (88%), with 148 (74%) presenting after hours. Median ISS was 5, and 38 (19%) sustained major trauma (ISS >13). Thoracic injury severity was minor in 75 (37%), moderate in 47 (23%), serious in 59 (30%), severe in 10 (5%), and critical in 10 (5%). Common injuries were pneumothorax (65), haemopneumothorax (36), lung laceration/contusion (28), and haemothorax (15). Major thoracic vascular injury occurred in seven patients, including six arterial injuries. Although uncommon, these were associated with severe injury patterns and rapid deterioration. Cardiac injury occurred in six patients, all critical. Overall in-hospital mortality was 2.5% (5/201), rising to 20% in critical injuries. Conclusion Penetrating thoracic trauma at NT MTC predominantly affects young Aboriginal and Torres Strait Islander men and is overwhelmingly assault-related. While most injuries are minor to moderate, a small but important subgroup sustains major vascular and cardiac injuries associated with significant morbidity and mortality. This data provides a contemporary benchmark for penetrating thoracic trauma in the NT and support development of dedicated thoracic trauma pathways.

3:38 pm

Vascular access escalation in major trauma: does circulation need a structured algorithm?

Nishath Altaf

Background: Rapid vascular access is essential for haemorrhage resuscitation in major trauma. Pathways for inadequate vascular access are less defined. We investigated access escalation, triggers and mortality in severely injured trauma patients. Methods: Patients were identified from the Royal Perth Hospital trauma registry, and a retrospective review was performed of those requiring vascular access during prehospital or ED resuscitation from January-December 2024. Variables included demographics, injury severity score (ISS), cardiac arrest, access type, massive transfusion protocol (MTP) activation and mortality. IO/CVC escalation was defined as intraosseous access, central venous catheter, MAC line or large sheath. Escalation trigger was MTP activation and/or cardiac arrest. Fisher's exact and Mann-Whitney U tests were used. Results: Thirty-eight eligible patients were identified. Median age 45.5 years, 68.4% male, median ISS 26. Cardiac arrest occurred in 8/38 (21.1%), MTP was activated in 14/37 (37.8%), in-hospital mortality was 10/38 (26.3%) and 24-hour mortality was 8/38 (21.1%). Prehospital PIVC was documented or attempted in 32/38 (84.2%), prehospital IO was used in 2/38 (5.3%). In ED, PIVC was documented in 24/38 (63.2%), IO in 2/38 (5.3%), and CVC/MAC/large sheath in 7/38 (18.4%). IO/CVC escalation occurred in 9/38 (23.7%). All escalations occurred in patients with MTP activation and/or cardiac arrest (9/18 vs 0/20, p<0.001), but only half of trigger-positive patients were escalated. Escalation was more common with MTP activation (6/14 vs 2/23, p=0.035). All cardiac arrest patients died in hospital (8/8 vs 2/30, p<0.001), while ISS did not differ by survival. Conclusion: Mortality clustered around physiological collapse rather than ISS, yet escalation beyond PIVC occurred in only half of patients with MTP activation and/or cardiac arrest. These findings support a structured circulation-access algorithm for major trauma.

3:46 pm

Portal and Superior Mesenteric Venous Injury: Changing Resuscitation and Survival Over Two Decades

Ashton Arthur

3:52 pm

Three phenotypes of inferior vena cava and common iliac vein injuries at a Level 1 Trauma Centre: A ten-year retrospective study

Davina Daudu

Purpose: Central abdominal venous trauma is rare and poorly standardised. We describe phenotypes, management and outcomes after inferior vena cava (IVC) and common iliac vein (CIV) injury at a Level 1 trauma centre. Methodology: IVC/CIV injuries from 2015-2024 were identified using ICD codes, trauma registry and theatre databases. Data included mechanism, associated injuries, physiology, Injury Severity Score (ISS), massive transfusion protocol (MTP), management, discharge antithrombotic strategy, complications and mortality. Fisher's exact and Mann-Whitney U tests explored group differences. Results: Twenty patients were included: 14 blunt and 6 penetrating/iatrogenic; median age 39 years; 15 male. Injuries involved IVC in 18 and CIV in 3. Twelve underwent intervention (11 open, 1 endovascular) and 8 were managed conservatively. Intervention patients had higher lactate than conservative patients (5.0 vs 2.35 mmol/L, p=0.01); median ISS was 19 vs 26.5. Intervention patients were diagnosed intraoperatively in 11/12

with MTP activation in 11/12; all conservative patients were CT-diagnosed with no MTP activation (p<0.001). Hollow viscus/mesenteric injury occurred in 7/12 intervention patients and 0/8 conservative patients (p=0.015). In-hospital mortality was 4/6 after blunt intervention, 1/6 after penetrating/iatrogenic intervention and 0/8 after conservative management. Among 15 survivors, discharge strategy was none in 8, aspirin in 3 and therapeutic anticoagulation in 4. No venous thromboembolism (VTE) or venous injury-related complication was documented during median 44-month survivor follow-up. Conclusion: Blunt polytrauma requiring intervention carried high mortality, while CT-detected stable venous injury was managed non-operatively without VTE despite variable antithrombotic practice. Multicentre data, standardised reporting, surveillance imaging and antithrombotic pathways are needed.

3:58 pm
Fitness to drive and the vascular patient: an update from the ANZSVS Working Group
Simon Vun

4:06 pm
War as a Catalyst for Vascular Innovation: From World Wars to Modern Hybrid Conflict
Paulina Bruessel
Introduction: Armed conflict has driven major advances in vascular surgery, transforming uncontrolled haemorrhage from a fatal event into a survivable injury. From ligation and amputation in World War I to systematic repair strategies in the Vietnam War, conflict has shaped both techniques and systems of care. Registry and military data demonstrate substantial reductions in mortality and limb loss with the evolution of vascular repair, organised evacuation, and damage control principles. Methodology: This study synthesises historical and contemporary evidence from major conflicts. Insights are drawn from modern combat casualty datasets, including reports from the Russo-Ukrainian War, alongside key studies on temporary intravascular shunting, damage control surgery, and haemostatic resuscitation. Vascular and trauma literature informs analysis of changing injury patterns and treatment strategies. Results: Modern warfare involves high-energy blast and fragmentation injuries causing complex, multi-level vascular trauma with severe soft tissue damage. Survival has improved with early haemorrhage control, forward surgical teams, and flexible evacuation systems. The use of whole blood transfusion, “walking blood banks,” and temporary vascular shunts is associated with improved limb salvage and reduced mortality. Emerging technologies such as bioengineered grafts and infection-resistant conduits show promise, though long-term outcomes remain under evaluation. Conclusion: The relationship between war and vascular innovation is cyclical. Advances in haemorrhage control, resuscitation, and reconstruction improve survival but respond to increasingly destructive injuries. As modern conflicts strain evacuation systems and increase mass casualties, there is a need for portable, resilient, and integrated vascular care. Addressing these challenges requires both technical progress and reflection on the human cost driving innovation.

4:12 pm
Long-term TEVAR Aortic Remodelling in Blunt Traumatic Aortic Injury Patients
Omar Ayoub
Purpose Thoracic Endovascular Aortic Repair (TEVAR) is the preferred treatment for blunt traumatic aortic injury (BTAI) due to lower morbidity and mortality than open repair. However, long-term outcomes, particularly in the predominantly young BTAI population, remain poorly understood. Ongoing aortic growth and remodelling may affect stent durability and contribute to late complications. This study evaluated long-term aortic remodelling and stent durability following TEVAR for BTAI. Methodology Patients with acute BTAI treated with TEVAR at Waikato Vascular Surgery Department between 2009 and 2026 were retrospectively reviewed. Computed tomography angiography (CTA) was analysed pre-operatively, immediately post-operatively, and at early (1–2 years), mid-term (3–7 years), and late (8–13 years) follow-up. Aortic diameters were measured at the mid-ascending aorta, pre-lesion/stent, peri-lesion/stented, post-lesion/stent, and celiac artery levels. TEVAR-related complications and reinterventions were recorded. Patients without baseline CTA and 30-day deaths were excluded. Results Thirty-five patients were included, with a median age (range) of 31 years (17–78); 80% were male. Four patients (11%) were lost to follow-up. Median follow-up (range) was 31.8 months (1.3–176.2). Grade III injuries accounted for 77% of cases. Aortic diameters increased over time at all sites, with no significant differences in growth between regions (P>0.05). The stented segment demonstrated less diameter increase than non-stented regions. Three TEVAR-related complications required reintervention at 1, 3, and 6 years; all were successfully managed. Conclusions TEVAR demonstrated durable long-term performance and favourable aortic remodelling following BTAI. Similar growth between the healthy and injured segments supports the biomechanical compatibility of TEVAR. Although limited by sample size, these findings suggest reduced surveillance intensity may be feasible in selected patients and warrant investigation in larger studies.

4:20 pm

Discussion

4:26 pm
SUNDAY trial insights: clinical perspective on medical therapy in uncomplicated type B aortic dissections
Erin Saricilar
Background: Medical therapy is the cornerstone of managing uncomplicated type B aortic dissections (uTBAD), however there are limited guidelines on its implementation. This study aimed to investigate variations in the interpretation and implementation of medical therapy among principal investigators of an ongoing international randomised clinical trial on uTBAD management. Methods: A cross-sectional questionnaire-based study was conducted among all principal investigators participating in the Scandinavian trial of Uncomplicated Aortic Dissection Therapy (SUNDAY) trial across 7 countries. A secure online survey was distributed and entered into REDCap, collecting categorical data on different aspects of medical therapy, including therapy targets, reporting standards, medical management and investigations. Results: A total of 34 of 46 investigators responded (74%). While 31 (91%) agreed upon blood pressure targets of less than 120mmHg, refractory hypertension was defined as blood pressure exceeding 140mmHg by 12 (35%), with 17 (50%) considering the number of antihypertensives used to determine refractory hypertension of which 8 (24%) set this at >3, and 9 (27%) at >5. The upper limit for heart rate was agreed as 60 bpm by 20 (59%). There was no agreement on the definition of refractory pain, with 7 (21%) not even considering it in decision-making. There was notable variation in reporting standards regarding chronicity, with 11 (32%) deeming hyperacute to be <24hrs, 13 (38%) deeming it <48hrs and 5 (15%) not considering it at all. 29 (85%) stated that they have a standardised hospital protocol for medical therapy for acute uTBAD. There was general agreement on escalation of anti-hypertensives in acute uTBAD with 30 (88%) starting with IV labetalol as first line, followed by calcium channel antagonists by 13 (38%) as second- and third-line treatments. Adjunctive medications were used consistently with 20 (59%) commenced statins as part of medical therapy and 22 (65%) commenced life-long single antiplatelets.

4:30 pm
Duplex Ultrasound Surveillance after Endovascular Therapy for Peripheral Arterial Disease: Study Protocol for the SURVEIL Randomised Controlled Trial
Thomas Warburton
Purpose: Duplex ultrasound (DUS) surveillance following femoropopliteal endovascular therapy (EVT) is widely practised to detect restenosis and guide pre-emptive reintervention. An ANZSVS survey confirmed 83% of vascular surgeons perform routine post-EVT DUS surveillance, yet this resource-intensive practice lacks adequately powered randomised evidence. SURVEIL aims to determine whether routine DUS surveillance reduces target vessel occlusion, major adverse limb events (MALE), and death compared to clinical surveillance alone. Methodology: SURVEIL is a multicentre, open-label, superiority randomised controlled trial across vascular surgery units in Australia and New Zealand (HREC: 2025/ETH01129; ACTRN12625000889459). Adults with a patent femoropopliteal target vessel at 4–6 weeks post-EVT for symptomatic PAD are randomised 2:1 to DUS plus clinical surveillance versus clinical surveillance alone. Both arms undergo clinical assessment and ankle-brachial pressure index measurement at 3, 6, 9, 12, 18, and 24 months. The primary endpoint is freedom from a composite of target vessel occlusion, MALE, or death at 24 months, analysed by Kaplan–Meier methods and log-rank test (intention-to-treat). Secondary endpoints include target lesion revascularisation, patency, symptomatic improvement, quality of life, and cost-effectiveness. A sample size of 288 achieves 90% power to detect a 20 percentage-point difference, with an adaptive interim analysis permitting up to 50% sample size increase. Results: Recruitment commenced in 2026. Results are anticipated following 24-month follow-up of all enrolled participants. Conclusion: SURVEIL is the first pre-registered, adequately powered, multicentre RCT evaluating DUS surveillance following femoropopliteal EVT for the full clinical spectrum of symptomatic PAD. Results will directly inform international clinical guidelines and healthcare resource allocation.

4:34 pm
Advancing Patient-Specific Aortic Simulation to Improve Training, Planning, and Outcomes in Complex Aortic Cases
Lucy Guazzo

4:38 pm
NOURISH: Immuno-nutrition-enhanced future foods and digital gastronomy to improve outcomes of peripheral arterial disease: a cost-effective consumer-centered and sustainable approach
Chris Delaney

4:42 pm
Comparison of Rigid Or Conventional/Soft Stump dressings following Below-the-Knee

Anantha Narayanan

4:46 pm
Building the Global Vascular Workforce Through Collaboration
Palma Shaw

4:56 pm
Vascular Surgery Training: The New Program
Sarah Aitken

5:04 pm
ANZ training from a trainee's perspective
James Colbourne

5:12 pm
Challenges of Training in 2026: Panel Discussion
Sarah Aitken

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11 September 2026

4:30 pm - 5:30 pm
ANZSVN AGM

Business Meeting - Vascular Nursing - Drift Room 1 - Drift Room 2

4:30 pm
ANZSVN AGM
Frances Horner

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11 September 2026

7:30 pm - 10:30 pm
Conference Dinner

Speciality Dinner - Vascular Surgery, Vascular Nursing

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12 September 2026

7:00 am - 10:00 am
Wellness Morning - SALVAGE Fun Run

Breakfast Session - Vascular Surgery, Vascular Nursing

From arteries to asphalt—gather your colleagues, family and friends for a healthy dose of cardio as we come together for the SAL-VAGE Fun Run/Walk. The fun run has been organised as an initiative by a group of ANZSVS members (SAL-VAGE). SAL-VAGE aims to advance the prevention, diagnosis, and treatment of chronic limb-threatening ischemia (CLTI). All profits raised will go towards supporting the Vascular Foundation. Tickets can be purchased at the time of registration. If you wish to add a Fun Run ticket to your registration, please email vascular@surgeons.org.

7:00 am

Discussion

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12 September 2026

9:00 am - 10:00 am
Treat Rest and Recovery Session

Scientific Session - Vascular Nursing - Rooftop at QT

This session aims to embed a culture of self-care and promote wellness for clinicians caring for patients with vascular dysfunction

9:00 am
Rest and Recovery

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12 September 2026

10:00 am - 10:30 am
Morning Tea

Catering - Vascular Nursing, Vascular Surgery - Level 5

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12 September 2026

10:30 am - 12:30 pm
Big Data & New Technology

Scientific Session - Vascular Surgery - Bloom Room

10:30 am
The Impact of Registry Participation on Vascular Surgical Quality
Adam Beck

10:38 am
AVA 2.0: An Update
Mark Jackson, Mark Jackson

10:46 am
Sex, size, and survival: rethinking aortic disease in women
Carlota Fernandez Prendes

10:54 am
Contemporary trends in treatment strategies for superficial venous incompetence: A VASCUNET Report from 2016-2022
Manar Khashram
Introduction: Chronic venous disease is a common condition and has a major impact on patients and health resources. The management of superficial venous incompetence has been subjected to level 1 evidence. The aim of this study was to report the contemporary management of superficial venous incompetence within the VASCUNET network. Methods: Vascunet registries were contacted and those that capture data on superficial venous disease were invited to participate. Patients treated with open surgery or endovenous therapy (radiofrequency/laser) between 2016-2022 were included and the data was harmonised. Eight

countries (Australia, New Zealand, Finland, Germany, France, Malta, Sweden, Switzerland) contributed to the dataset. The outcomes of interest included variation in treatment options over time, proportion of CEAP 6 and anaesthesia use. Results: 127,047 patients were included and the mean (standard deviation) age was 54.9 (14.6) and 65.8% were females. The proportion of endovenous therapy (compared to open surgery) ranged from 18-100% of cases. The most common endovenous therapy use was radiofrequency, followed by laser then glue. The great saphenous vein was the most common location of surgery/intervention, with proportions ranging between 60% and 80% for all countries. The proportion of general anaesthetic use reported ranged from 9.9% to 84.3%. Of those patients with CEAP 6 New Zealand had the highest reported group with 12.6% compared to France with 0.8%. There was an overall decline in open surgery with most of the change seen in Australia. There were no changes in the reported procedures performed during the pandemic (2020-2021). Conclusion: There are major variations in the management of patients with superficial venous disease across countries and such data might help and understand this variation and standardise patient care.

11:02 am

Transatlantic management and outcomes of zone 2 TEVAR in type B aortic dissection

Erin Saricilar

Background: Surgical management of type B aortic dissections (TBAD) remains significantly technically challenging to obtaine an adequate proximal landing zone in the descending thoracic aorta. With increasingly more options to manage TBAD to seal in zone 2 with a thoracic endovascular aortic repair (TEVAR) the risk profile needs to be identified. Methods: Data was collected by centralised centres in Sweden, New Zealand, Hungary, USA, Serbia and Switzerland using a standardised database template. These were then passed through a turn-key R script that allowed for data federation without identifiable data leaving the local region. Analysis included patient characteristics, case mix analysis, peri-operative outcomes for acute and subacute/chronic TEVAR, predictors of outcomes with multivariate analysis for per-operative mortality and neurological events as well as a sensitivity analysis. Results: A total of 3666 (68%) men and 1720 (32%) women are included in the total analysis. There was a statistically significant decrease in zone 3 TEVAR from 2014 to 2025 (p = 0.0083). Acute TEVAR had a pooled mortality of 10.0%, while occluding the LSA for zone 2 TEVAR was 12.4% and zone 3 TEVAR alone was 11.6%. Acute TEVAR had an acute kidney injury rate of 19.6% with a stroke rate of 7.2%. However subacute/chronic TEVAR had an acute kidney injury rate of 6.9% and a stroke rate of 2.1%. Occlusion of the LSA in zone 2 TEVAR carried higher mortality in subacute/chronic (7.2%) and higher stroke rates in acute treatment (10.1%). Older patients had worse outcomes in open LSA zone 2 treatment and in pooled analysis, but no difference in zone 3 treatments. Conclusions: This is the largest dataset comparing zone 2 and zone 3 TEVAR using a first-of-its-kind turnkey R analysis for true data federation while protecting data residence. Acute TEVAR carries significant additional risks, while coverage and occlusion of the LSA does not increase stroke rates but has elevated mortality rates in TEVAR of any chronicity.

11:10 am

Variation in abdominal aortic surgery outcomes in Aotearoa New Zealand: ‘capacity to rescue’ drives differences in mortality and ‘days alive and out of hospital’

Anastasia Dean

Introduction: Days Alive and Out of Hospital within 90 days of surgery (DAOH90) is a composite outcome that integrates death, hospital length-of-stay and hospital readmissions. The aim of this study is to investigate postoperative mortality, DAOH90, and ‘failure to rescue’ (FTR) following abdominal aortic (AAA) surgery across AoNZ. Methods: Population-based retrospective cohort study of all AAA interventions performed in AoNZ between 2010 and 2024, identified from National Minimum Dataset. Patients categorised using ACHI procedure codes: non-ruptured open repair, ruptured open repair, and endovascular repair. Outcomes included 90-day mortality, post-operative complications, FTR and DAOH90. National procedural coding data identified AAA intervention in public hospitals between January 2010 and December 2024. Results: 6,978 patients had aortic repair across nine hospitals, of whom 2,721 had open repair, 4,257 endovascular intervention. Overall 90-day mortality was 6.7% non-ruptured open repair, 35.7% ruptured open repair, and 3.9% endovascular intervention. There was marked inter-hospital variation in 90-day mortality in both intact open (OR 2.0, 1.3-3.0) and endovascular repair (OR 10.4, 2.6-42.2). Differences in post-operative complication rates were less pronounced in both intact open (OR 1.1; 0.9-1.3) and endovascular (OR 1.7; 1.3-2.2), however, this re-appeared when comparing post-operative mortality following a complication for both intact open (OR 2.1, 1.4-3.3) and endovascular intervention (OR 7.9, 1.9-32.6), suggesting hospital variation in mortality was primarily driven by differences in ‘rescue’ from complications (Spearman correlation coefficient = 0.82), rather than complication incidence (correlation coefficient = 0.45). Conclusion: Variation in outcomes after aortic surgery in AoNZ is driven by hospitals’ capacity to rescue, rather than frequency of complications, suggesting the importance of postoperative monitoring and critical care access.

11:18 am
Discussion

11:26 am
Moving the monitor: wireless Apple Vision Pro display of live angiography in the hybrid theatre
Daniel Thompson
Purpose: During endovascular procedures, live imaging may not be equally visible to all members of the team. For assistants, trainees or operators at alternate access sites, visibility may be limited by room layout, C-arm position, equipment, monitor orientation or operator height. We used Apple Vision Pro as an augmented-reality headset to display live angiography as a movable spatial display without changing the standard monitor setup. Methodology: Multiple secondary imaging outputs from the hybrid theatre were routed through signal-normalisation and wireless video hardware to display live angiography on Apple Vision Pro. The headset was used as an additional display while standard theatre monitors remained primary. We describe the setup, practical use, advantages and limitations identified during bench and theatre testing. Basic feasibility data including case type, duration, technical issues and device battery use were collected. A video demonstration will be presented. Results: Live angiographic imaging was displayed wirelessly in the headset without a cable to the operator. The image could be moved and resized within the user's visual field while the standard theatre display remained unchanged. Technical issues were minimal, with signal compatibility and wireless network setup the main practical barriers during implementation. Battery life was identified as an important limitation for longer procedures. Conclusion: We describe a functional method for displaying live angiography on Apple Vision Pro using off-the-shelf hardware, as an adjunct to standard hybrid-theatre monitors. This approach will improve with dedicated software, full hybrid-lab input integration and partnership with imaging vendors. Further evaluation is required to determine reliability, practical value and integration into endovascular workflow.

11:32 am
Computer-Assisted Arterial Thromboaspiration in Acute Limb Ischaemia and Beyond
Alan Rossman

11:38 am
Percutaneous VA-ECMO Decannulation: Faster Procedural Times and Fewer Groin Complications Compared with Surgical Cutdown
Dushan Miladinovic

11:44 am
Decoding the Dotted Line: Mitigating Medicolegal Risk and Socioeconomic Inequity in Vascular Consent via Next-Generation AI.
Mina Mikhael
Purpose: Informed consent requires equitable health literacy. Standard vascular consent forms induce cognitive fatigue through excessive length and medical jargon, disenfranchising lower socioeconomic and culturally diverse patients. While artificial intelligence simplifies text, its ability to translate medicolegal risks without critical omission remains a literature gap. This study evaluates next-generation AI (ChatGPT-5.5) in democratising surgical consent, balancing accessibility with strict medicolegal safety. Methodology: Institutional consent texts for ten major vascular procedures (including EVAR and amputation) were sourced. Baseline word counts, jargon density, and readability (Flesch-Kincaid Grade Level [FKGL]) were calculated. Texts were processed by ChatGPT-5.5, prompted to enhance health literacy to an eighth-grade target. AI outputs were reassessed. Vascular clinicians graded AI outputs (1-5 scale) to ensure severe medicolegal risks (e.g., mortality, limb loss, stroke) were rigorously retained. Results: Baseline texts were highly inefficient (mean 1,678 words) and saturated with jargon, presenting a severe cognitive burden. ChatGPT-5.5 drastically improved accessibility, reducing the mean word count by 74% (to 435 words) and eliminating 88.8% of complex terminology. Readability was further optimised from a baseline FKGL of 5.75 to 5.10. Crucially, clinical grading confirmed 100% of severe medicolegal risks were safely preserved in the AI translation (Mean Clinical Safety Score 5.0/5). Conclusion: Verbose, jargon-heavy institutional consent protocols systemically disadvantage vulnerable populations, risking uninformed consent and medicolegal exposure. ChatGPT-5.5 provides a safe, highly efficient solution, reducing patient cognitive load by 74% while maintaining perfect medicolegal integrity. Clinicians in high-acuity environments can utilise this tool to generate accessible, patient-specific consent documents, fostering true shared decision-making.

11:50 am
Discussion

10:30 am - 12:30 pm
Workshop - Wound Management - ASSESSMENT & NIVT

Scientific Session - Vascular Nursing - Ripple Room 1

Moleculight - shed some light to your wound - Matt Kerr, Tea, Medical Supplies Sonography - Martin Necas, Sonography Waikato

10:30 am - 12:30 pm
Wound Management - CLEANSING & DEBRIDEMENT

Scientific Session - Vascular Nursing - Ripple Room 2

Wound Cleansing with Granudacyn and NPWT with Advance Solo Adapt for cavities, tight spaces NPWT with installation for cleansing and debridement with Veraflow Compression bandaging with Coban Complex compression bandaging with scaffold technique - Rob Heath Compression bandaging measured with Feeltect "tight alright" - Babrielle McMullan and Alexandra Sim

10:30 am
Discussion

10:30 am - 12:30 pm
Wound Management - Negative Pressure Wound Therapy & Compression bandaging

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Scientific Session - Vascular Nursing - Notch

Surgical debridement with Versajet Sharp/Mechanical Debridement & Pain Management - Karen Nixey Mechanical Wound bed preperation with Debrisoft Duo Dressings aiding with wound bed preparation

10:30 am
Discussion

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12 September 2026

12:30 pm - 1:30 pm
ANZSVS Supervisors and Trainers Meeting

Scientific Session - Vascular Surgery - Drift Room 1 - Drift Room 2

12:30 pm - 1:30 pm
Lunch

Catering - Vascular Surgery, Vascular Nursing - Level 5

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12 September 2026

1:30 pm - 3:00 pm
Thoracic Aorta, Dissection & Spinal Cord Ischaemia

Scientific Session - Vascular Surgery - Bloom Room

1:30 pm
Global seasonal variation in prevalence and outcomes of acute aortic syndrome: A systematic review, meta-analysis, and comparison with a nationwide cohort study
Sameer Bhat

1:36 pm
Aortic dissection incidence, management and outcomes: a national population-based study
Erin Saricilar
Background and Aims: Aortic dissection (AD) management requires early medical therapy and surgical intervention in applicable patients with type A aortic dissection (TAAD) or complicated type B dissection (TBAD). We aimed to assess incidence trends of AD in Sweden, and sex-based differences in management and outcome over 25 years. Methods: Swedish National Patient Register and Cause of Death Register were used to identify new AD between 1999 and 2023. Incidence, management and survival outcomes were analysed with relative survival comparing general population matching age, sex and year. Results: 15946 individuals had AD, 12225 admitted alive, and 6595 (53.9%) treated medically. Of 5630 surgically treated, 4141 (73.6%) represented TAAD; 1489 (26.4%) represented TBAD. Incidence increased significantly to 9.32/100,000, annual percentage change (APC) 1.4% (95%CI 1.2-1.6%). Incidence was lower for women (6.25/100,000) than men (10.52), but incidence increased threefold in women (APC 2.3% 95% CI 1.9-2.6%) than men (0.8% 95% CI 0.5-1.0%). Women presented older (mean 71.9 years; men 67.5 years, $p < 0.001$), had less surgical treatment (37.8% AD; 33.6% of surgical TAAD; 29.3% of surgical TBAD, $p < 0.001$) and poorer 10 year relative survival (medical: women 70.9%; men 84.1% $p = 0.0041$, surgical TAAD: women 86.6% men 94.9% $p < 0.0001$, surgical TBAD: women 70.9%; men 87.5% $p = 0.027$). Conclusion: This nationwide population-based study confirms increasing incidence of AD in Sweden, with persisting sex disparities in management, short- and long-term outcomes. These findings underscore needs for targeted interventions improving diagnosis, management and prognostication of AD, especially in women.

1:40 pm
Long term outcomes of optimal medical therapy in aortic dissection within the Swedish population
Erin Saricilar
Background: While established clinical guidelines provide foundational recommendations for managing aortic dissection (AD), there is a significant lack of recent, large-scale evidence to definitively delineate optimal medical therapy, particularly concerning specific medication choices and dosages in the chronic period of the disease. Methods: Swedish National Patient Register and Cause of Death Register were used to identify new AD between 2006 and 2021. The impact of pre-dissection medications on survival was analysed. Landmark analysis of 10 year failure of medical therapy, aorta-related death and all-cause mortality was investigated with subgroup analysis of beta-blocker, antihypertensive and the role of adjunctive medications. All analyses controlled for age and sex. Results: A total of 12,223 patients were included, of which 4853 (39.7%) were females. Patients who were on metformin, an antiplatelet, statin or anticoagulant did not have a protective benefit to survival following AD, however metformin had a significant protective effect for 10 year failure of medical therapy ($p = 0.00622$). In patients with diagnosed diabetes, those on metformin also had a significant survival benefit ($p = 0.0362$). Non-selective beta-blockers had the poorest mortality compared to selective or alpha and beta-blockers ($p = 0.089$) though this wasn't significant for aortic death ($p = 0.52$) and a trend to more failure of medical therapy ($p = 0.072$). Being commenced on an anticoagulant and antiplatelet significantly increased all cause mortality while commencing a statin trended towards poorer all cause and aortic death. Conclusions: This is the largest analysed cohort focussing on optimal medical therapy for AD. The role of metformin having a protective aortic effects is demonstrated but requires more focussed investigation. Antihypertensive choice did not impact outcomes, though selective beta-blockers provide the best mortality and failure of medical therapy outcomes.

1:44 pm
What's new in the 2026 ESVS Guidelines on Descending Thoracic and Thoraco-Abdominal Disease: Thoracic aorta, dissections and spinal cord ischaemia
Carlota Fernandez Prendes

1:54 pm
Real-World Outcomes of Thoracic Branch Endoprosthesis Repair for Aortic Arch Pathology: A Bi-Centre New Zealand Experience
Summer Hassan
Introduction Thoracic branch endoprosthesis (TBE) is an endovascular alternative to hybrid and open arch reconstruction, allowing preservation of supra-aortic branch perfusion. We report the first bicentre New Zealand experience evaluating the safety and effectiveness of TBE across a broad spectrum of aortic arch pathology. Methods A retrospective review of all patients undergoing TBE at two tertiary New Zealand

vascular centres from June 2023 to April 2026. Outcomes included technical success, perioperative mortality, neurological complications, branch patency, reintervention and survival. Results Forty-eight patients underwent TBE. Median age was 70 years (IQR 63–77), and 60% were male. Indications included thoracic aortic aneurysm (43%), aortic dissection (31%), penetrating aortic ulcer or intramural haematoma (22%), and traumatic aortic injury (4%). Thirty-five procedures (71%) were elective, 13 (27%) urgent, and one (2%) emergent. Zone 2 proximal sealing was utilised in 65% of procedures, while 35% required zones 0–1 repair. The left subclavian artery was the target branch vessel in 86% of cases. Median intensive care stay was 1 day (IQR 1–2), and median hospital length of stay was 5 days (IQR 3–6). Median clinical follow-up was 14.5 months (IQR 4.5–23.0). Technical success was achieved in all patients. Thirty-day mortality was 2.0%. Stroke occurred in 4.1% and spinal cord ischaemia in 2.0%. Despite the inclusion of complex arch pathology and urgent presentations, there was no retrograde type A dissection, device failure, or loss of target vessel patency observed during follow-up. Secondary interventions occurred in ten patients and were related to distal progression of underlying aortic pathology, endoleak management, or staged aortic repair rather than branch device failure. Conclusions TBE provides a safe and effective endovascular solution for a wide range of aortic arch pathologies in contemporary practice.

2:02 pm
Building up from below: Endograft migration after TEVAR
Jun Cheul Park
Objective: This study aimed to investigate the incidence, risk factors, and clinical significance of endograft migration (EM) following thoracic endovascular aortic repair (TEVAR). Methods: Consecutive patients undergoing TEVAR at a tertiary aortic referral centre between February 2004 and January 2025 were reviewed, with clinical and radiological follow-up until April 2026. Patients with at least 6 months of computed tomography angiography surveillance were included. EM was defined as endograft displacement ≥10 mm relative to fixed anatomical landmarks, or any displacement associated with symptoms or requiring treatment. Predictors of proximal endograft distal migration and distal endograft proximal migration were evaluated using univariable and multivariable logistic regression. Time to first EM was analysed using Kaplan–Meier methods. Results: Of 125 patients, 91 were male (72.8%), with mean age 59 years (range 15–87). The most common indications were type B aortic dissection (n = 41, 32.8%) and thoracic aortic aneurysm (n= 41, 32.8%). EM occurred in 33 patients (26.4%) over median follow-up of 73.7 months (IQR 37.0-109.0). Freedom from EM was 88.2% at 1 year, 75.2% at 3 years, and 68.4% at 5 years. Aortic elongation was associated with proximal endograft distal migration (OR 2.08, 95% CI 1.46–3.27; p < .001) and distal endograft proximal migration (OR 2.59, 95% CI 1.77–4.21; p < .001). Proximal-first deployment was independently associated with proximal endograft distal migration (OR 12.08, 95% CI 2.11–230.76; p = .022). Prompted by imaging surveillance, six patients with EM (18.2%) underwent EM-related reintervention; there was no EM-related mortality. Conclusion: EM after TEVAR was common on imaging surveillance, most occurring within the first two years. Aortic elongation was the most consistent anatomical predictor, while a proximal-first deployment in multi-device repairs was a strong, modifiable procedural risk factor.

2:08 pm
Early and late Vascular surgery interventions in patients undergoing acute Stanford type A aortic dissection repair: an 11-year single institutional experience
Michael Zhu
Purpose: Data on the incidence, indications, and outcomes of Vascular interventions after acute Type A aortic dissection (ATAAD) repair are limited. Methods: We reviewed all patients undergoing ATAAD repair from 2015-2025 who subsequently needed vascular intervention. Interventions were classed as acute (≤14 days after index ATAAD repair), subacute (15–90 days), or late/chronic (>90 days). Multidisciplinary consensus guided intervention decisions. Results: Among 128 ATAAD repairs, median age was 64.1 years, and 75.8% (97/128) were male. Index dissection extended beyond zone 2 in 62.5% (80/128). Median follow-up was 2.2 years (IQR 0.4-4.7). Overall, 24 patients (18.8%, 24/128) underwent vascular intervention: 12 acute, 3 subacute, and 9 late/chronic. 30-day mortality was 50% (6/12), 0% (0/3), and 0% (0/9). There were no late deaths. Acute indications were: lower limb (N=3), mesenteric (N=3), renal (N=2) or cerebral malperfusion (N=2), and symptomatic distal anastomotic new entry tear (DANE: N=2, treated with conformable thoracic stent graft (cTAG)). Subacute interventions were for symptomatic DANE (N=3, thoracic branched endoprosthesis (TBE)). Late/chronic interventions were for: progression of DANE and/or residual type B dissection (N=6; TBE (N=3), cTAG (N=3)), mesenteric ischaemia (N=1), aorto-iliac aneurysm (N=1) and leg claudication (N=1). Four patients underwent late cardiothoracic aortic reoperation for pseudoanuerysm. Cumulative incidence of vascular and aortic interventions, with death as a competing risk, at 14days, 90days, 1, 3 and 5 years was 8.6%, 12.0%, 17.7%, 22.9%, and 29.9%. Conclusion: After ATAAD repair, vascular intervention was needed in almost 10% of patients acutely, and over 20% by 3 years. Acute interventions for refractory malperfusion carried high early mortality, whereas late interventions, principally for residual dissection progression, had no observed mortality. These findings support multidisciplinary decision-making, early malperfusion recognition and

lifelong aortic surveillance.

2:14 pm
A Kaupapa Māori qualitative study of young Aortic Dissection in Aotearoa New Zealand
Meg Beaumont

2:20 pm
Discussion

2:30 pm
Spinal cord ischaemia - an anaesthetist perspective
Helen Lindsay

2:40 pm
United States Aortic Research Consortium Insights on Spinal Cord Ischemia in Endovascular TAAA repair
Adam Beck

2:50 pm
Discussion

1:30 pm - 3:00 pm
Workshop - Wound Management - ASSESSMENT & NIVT

Scientific Session - Vascular Nursing - Ripple Room 1

Moleculight - shed some light to your wound - Matt Kerr, Tea, Medical Supplies Sonography - Martin Necas, Sonography Waikato

1:30 pm - 3:00 pm
Wound Management - CLEANSING & DEBRIDEMENT

Scientific Session - Vascular Nursing - Ripple Room 2

Wound Cleansing with Granudacyn and NPWT with Advance Solo Adapt for cavities, tight spaces NPWT with installation for cleansing and debridement with Veraflow Compression bandaging with Coban Complex compression bandaging with scaffold technique - Rob Heath Compression bandaging measured with Feeltect "tight alright" - Babrielle McMullan and Alexandra Sim

1:30 pm - 3:00 pm
Wound Management - Negative Pressure Wound Therapy & Compression bandaging

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Scientific Session - Vascular Nursing - Notch

Surgical debridement with Versajet Sharp/Mechanical Debridement & Pain Management - Karen Nixey
Mechanical Wound bed preperation with Debrisoft Duo Dressings aiding with wound bed preparation

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12 September 2026

3:00 pm - 3:30 pm
Afternoon Tea

Catering - Vascular Surgery, Vascular Nursing - Level 5

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12 September 2026

3:30 pm - 5:05 pm
Trainees Challenge the Experts: experts dissect some of their most challenging cases

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Scientific Session - Vascular Surgery - Bloom Room

3:30 pm
The Aortic Case I wish I had Not Started
Jason Lee

3:40 pm
Multiple Visceral Aneurysms
Michael Zhu

3:50 pm
Pruning a tree of unwanted fruit
Hamish Tso

4:00 pm
Complex Inferior Pancreatico-Duodenal Aneurysm with occluded coeliac artery
James Kellie

4:10 pm
A traumatic transection
Angie Arnold

4:20 pm
Aneurysm Beyond the Aorta
Abhishekh Srinivas

4:30 pm
Atrial Appendage Occlusion Device in Distal Aorta
Lucas Hendy

4:40 pm
How not to do an endo conduit
Carlota Fernandez Prendes

4:50 pm
3rd Time Lucky
Kay Hon

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12 September 2026

5:30 pm - 6:30 pm
ANZSVS Annual General Meeting

Scientific Session - Vascular Surgery - Bloom Room

5:30 pm
Discussion

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13 September 2026

8:30 am - 10:00 am
Complex Aortic: Arch, TAAA

Scientific Session - Vascular Surgery - Bloom Room

8:30 am
Real World Outcomes Compared with Trial Data for TAMBE: the USA Experience
Jason Lee

8:40 am
Complex aortic management & outcomes: A perspective from Asia
Rajesh Dharmaraj

8:50 am
Early Clinical and Technical Outcomes of Inner-Branched Endografts in Complex Aortic Repair
Haywood Yeung

8:56 am
Thoracic Branch Endoprosthesis (TBE) zones 0-2 tips and tricks
Jason Lee

9:04 am
Zone 0 TBE:Undertaking an ANZ Multi-centre Collaboration
David Herlihy

9:10 am
False lumen management: old and new options
Anastasia Dean

9:16 am
Discussion

9:24 am
Aortic arch and ascending aortic interventions: indications, evidence, and ethical considerations
Carlota Fernandez Prendes

9:34 am
Survey on provision of complex aortic services
Conor Marron

9:42 am
Aortic peri-operative management in ANZ
Helen Lindsay

9:46 am
Impact of multidisciplinary team meetings on management and outcomes for aortic disease: A scoping review of the literature
Sameer Bhat
Purpose: Multidisciplinary team (MDT) meetings have enhanced shared decision-making in the oncology setting due to the complexity of available treatments. In view of the expanding endovascular and hybrid interventions, their evaluation in the vascular surgery setting is warranted.[1] This scoping review summarised the current evidence on MDT meetings in patients with any aortic disease. Methodology: The conduct of this study adhered to PRISMA methodology. Comprehensive systematic searches of the MEDLINE, EMBASE, Scopus, Web of Science, CINAHL and Google Scholar databases were independently performed by two investigators in December 2025. Studies implementing MDT meetings for consensus on management strategies among patients with any aortic disease were included. Data were synthesised thematically. Results: A total of 2,244 patients with aortic conditions were discussed at MDT meetings within six studies. All were retrospective cohort studies and reflected both contemporary and historic management practices (2010 until 2024). Aortic aneurysms were most frequently reviewed. MDT

composition, meeting structure and processes were inconsistent and lacked standardisation. After MDT meetings were instituted, significant increases in aortic case volume and complexity were observed, together with reductions in time to definitive treatment and mortality. Conclusion: MDT meetings are emerging as a means of facilitating complex decision-making across a range of aortic conditions, and particularly among patients with aneurysmal disease. Despite the substantial variability in MDT frameworks, several improvements in clinical outcomes were recognised. Future efforts should aim to standardise MDT meeting processes and validate these systems-level changes through larger studies capturing a uniform set of outcomes. References: 1. Yates MT, Lopez-Marco A, Lee M, Adams B, Yap J, Uppal R, et al. Decision making of a specialist Aortovascular multidisciplinary team meeting. AME Surg J. 2022 Mar;5:2–2.

9:52 am
Discussion

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13 September 2026

10:00 am - 10:30 am
Morning Tea

Catering - Vascular Nursing, Vascular Surgery - Level 5

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13 September 2026

10:20 am - 10:30 am
Boston Scientific Symposium: ENROUTE TCAR: who benefits and how to select the right patients. Indications, evidence and case selection including imaging and learned tips and tricks

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Scientific Session - Vascular Surgery - Bloom Room

10:20 am
ENROUTE TCAR: who benefits and how to select the right patients. Indications, evidence and case selection including imaging and learned tips and tricks
Enis Kocak

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13 September 2026

10:30 am - 12:00 pm
Carotid Artery Disease

Scientific Session - Vascular Surgery - Bloom Room

10:30 am
The asymptomatic carotid stenosis patient: What have we learned from CREST 2
Wesley Moore

10:40 am
40 Years of Carotid Bifurcation Intervention: Is there a place for TCAR?
Bernard Bourke
INTRODUCTION: Carotid bifurcation intervention (CBI) remains controversial and highly scrutinised (ref 1). The Crest 2 trial arguably helps guide treatment of asymptomatic high-grade stenotic disease. CBI in Australia and NZ has been CEA or TFCAS. The ENROUTE reverse-flow TCAR System introduced into Australia in March 2026 allows an additional method. METHODS: CEA commenced 20/2/86 evolving from GA /

obligatory shunting through LA / selective shunting (LASS)/ vein patching through LASS / eversion CEA (LASSeCEA). TFCAS commenced 2/9/05 evolving to primary carotid stenting (PCS) avoiding a balloon. TCAR commenced 3/3/26 (choosing only high-grade asymptomatic stenoses). RESULTS: 2792 CBI (to 20/6/26). CEA: 2250; TFCAS: 531; TCAR: 11. LASSeCEA DWI rate of 3% is the lowest recorded and in the largest series published (ref 2). PCS: zero CVA/death (CD). TCAR: 10GA;1LA; zero CD. 5 TCAR stayed more than 1 night {2 persistent hypotension, 1 persistent bradycardia (BC), 1 random BC, 1 social reason}. CEA: 76% and TFCAS: 84% overnight, OPINIONS/CONCLUSIONS: TCAR is a safe, valuable addition for CBI. In our practice it will expand options, particularly for high carotid bifurcations. For high grade lesions stenting has a significantly increased rate of haemodynamic compromise compared to CEA.TCAR had a shallow learning curve for us. It will be steeper for those without stent experience but not as steep as TFCAS. It should be embraced by the ANZSVS to increase our “skin in the stent game”. In our practice CEA remains the gold standard for symptomatic patients but TCAR will challenge this with time. 1.Bourke BM. Intervention on the carotid bifurcation—75 years on, still not nailed. Editorial ANZ Journal of Surgery. 2025 Oct;95(10):1979 -1981 2.Bourke VC, Bourke BM, Beiles CB. Operative factors associated with the development of new brain lesions during awake carotid endarterectomy. European Journal of Vascular and Endovascular Surgery. 2016; 51:167–173.

10:48 am
Optimizing Carotid Revascularization: Selecting Between CEA, TCAR, and TF-CAS
Bobby Mendes

10:56 am
A liberal carotid artery stenting strategy is safe in Australia
Enis Kocak
Purpose/Aim Carotid artery stenting has historically been associated with a higher risk of perioperative stroke as compared to carotid endarterectomy (CEA), especially in the symptomatic population. After adopting a more liberal strategy to selecting patients for carotid artery stenting, we sought to evaluate the safety of this approach in Australia with modern techniques and technology. Methods We conducted a retrospective analysis of all patients undergoing transfemoral carotid artery stenting (tfCAS) and transcarotid artery revascularisation (TCAR) at our institution within the 36 months to September 2025. Patients were selected for tfCAS/TCAR where there was clinical equipoise between these and CEA, or a relative contraindication to CEA. The primary outcome was the 30-day ipsilateral stroke rate. All interventions were performed by two experienced operators. All patients were given dual antiplatelet therapy preoperatively and for at least 30 days postoperatively. Results 37 patients in total underwent carotid artery stenting procedures with a 100% technical success rate. 35 patients underwent tfCAS (95%) and 2 underwent TCAR with flow reversal (5%). Only 1 tfCAS patient did not have an embolic protection mechanism employed (due to severe distal tortuosity). 21 patients (57%) were symptomatic and 16 (43%) were asymptomatic. 23 lesions (62%) were high grade (80-99% stenosis). 18 patients (49%) received a dual-layer/micromesh stent. The ipsilateral stroke rate at 30 days and composite stroke/death rate at 30 days were both 0%. Conclusion A liberal carotid artery stenting strategy is safe in Australia with modern techniques and a reasonable case volume to maintain proficiency.

11:04 am
Discussion

11:10 am
TCAR: Critical Steps Flatten the Learning Curve
Victor Bourke
Background: Transcarotid artery revascularisation (TCAR) is a hybrid technique that reduces embolic risk by avoiding aortic arch manipulation and using direct carotid access with flow reversal cerebral protection. For the Vascular Surgeon it may offer a shorter learning curve than transfemoral carotid artery stenting (TF-CAS), with outcomes comparable to carotid endarterectomy (CEA) in selected patients. Methods: We report the introduction of a TCAR service within an Australian health service, focusing on proctoring, regulatory approval, and governance, contextualised by prior institutional outcomes with CEA and TF-CAS. Critical technical and pharmacological steps are outlined. Implementation aligned with Australian requirements for new interventional procedures. Author experience includes TF-CAS (n=270), TCAR (n=11; 5 primary operator), and CEA under local anaesthesia (n=173). Results: Eleven patients underwent TCAR (7 male), aged 62–91 years (mean 76). Comorbidities included ischaemic heart disease (n=7), diabetes (n=4), hypertension (n=7), and smoking (n=9). All lesions were asymptomatic high-grade stenoses (80–99%); 7 had St Mary’s ratio >30. Technical success was 100%. All cases required pre-dilation; 5 required post-dilation. Ten stents were tapered and 40 mm in length. There were no perioperative strokes, deaths, or myocardial infarctions. Six patients were discharged the next day; five had delayed discharge due to hypotension (n=2), bradycardia (n=2), or social factors (n=1), requiring selective ICU and cardiology input. Conclusions: TCAR can be safely introduced

by the Vascular Surgeon with appropriate proctoring, multidisciplinary planning, prior carotid experience, structured haemodynamic monitoring, and clear escalation pathways. Contemporary data support low stroke and mortality rates, and TCAR may play an increasing role in asymptomatic high-grade disease as trials such as CREST-2 further define revascularisation.

11:18 am
Early TCAR experience with the ENROUTE System in Australia
Enis Kocak
Purpose/Aim Transcarotid artery revascularisation (TCAR) is an established technique for carotid revascularisation in the USA, utilising a proprietary neuroprotection and stent system which, until recently, has not been available overseas. Select centres in Australia have adopted an “off-the-shelf approach” to establish flow reversal using existing non-proprietary equipment with satisfactory results. As one of the centres historically performing off-the-shelf TCAR, we sought to evaluate our TCAR results following the availability of the ENROUTE Neuroprotection and Stent Systems in Australia. Methods We conducted a retrospective analysis of all patients undergoing TCAR with the ENROUTE Neuroprotection and Stent Systems (Boston Scientific) at our institution from March to May 2026. Patients were selected for TCAR where they were considered high surgical risk under historical Centers for Medicare and Medicaid Services (CMS) carotid stent criteria, where they had risk factors making either CEA or TFCAS higher risk, or where there was clinical equipoise between techniques. The primary outcomes were the 30-day ipsilateral stroke rate and 30-day composite stroke/death rate. Results 10 patients in total underwent TCAR with the ENROUTE system during this period. 7 patients (70%) were symptomatic and 3 (30%) were asymptomatic. 5 lesions (50%) were high grade (80-99% stenosis). 7 patients received clopidogrel (70%) and 3 patients received ticagrelor (30%) as the P2Y12 inhibitor for their pre-operative and post-operative antiplatelet regimen. 3 patients (30%) were standard risk and 7 patients (70%) were high risk according to CMS carotid stent criteria. Technical success rate was 100%. The flow reversal time during the procedures was 10.8 minutes. The ipsilateral stroke rate at 30 days and composite stroke/death rate at 30 days were both 0%. Conclusion Our early experience with the ENROUTE Neuroprotection and Stent Systems suggests that it is a safe means of performing TCAR in Australia.

11:26 am
Advancing TCAR: Contemporary Clinical Outcomes in the Era of Integrated Embolic Protection
Bobby Mendes

11:34 am
Intravascular Lithotripsy During Transcarotid Artery Revascularization: A Retrospective Analysis
Marisa Doran
Purpose: Severe carotid artery calcification is a technical challenge during carotid revascularization and has been associated with suboptimal stent expansion and residual stenosis. Intravascular lithotripsy (IVL) has emerged as an adjunct for plaque modification; however, clinical experience in conjunction with transcarotid artery revascularization (TCAR) is limited. This study evaluated the safety and perioperative outcomes of IVL-assisted TCAR compared with TCAR alone. Methodology: A retrospective review was performed of patients undergoing TCAR at two affiliated hospitals between 2018 and 2024. Baseline demographics, comorbidities, procedural characteristics, and 30-day postoperative outcomes were analyzed. Patients undergoing IVL-assisted TCAR were compared with those undergoing standard TCAR. Results: Among 723 patients undergoing TCAR, 19 (2.6%) underwent adjunctive IVL. Patients treated with IVL were older than those undergoing standard TCAR (median age 78 vs 73 years; p=0.036). Baseline comorbidities, symptom status, medication use, and degree of stenosis were similar between groups. IVL-assisted procedures required longer operative times (84 vs 70 minutes; p=0.006) but no increase in length of stay. No strokes, myocardial infarctions, deaths, cranial nerve injuries, reoperations, or other major perioperative complications occurred in the IVL cohort, compared with stroke, myocardial infarction, and mortality rates of 1.7%, 0.4%, and 0.1%, respectively, in the standard TCAR group. Conclusion: IVL during TCAR appears safe and feasible for the treatment of heavily calcified carotid lesions, achieving perioperative outcomes comparable to standard TCAR despite treatment of an older patient population. These findings support IVL as a useful strategy in selected patients with severe carotid calcification. Future studies incorporating CT imaging based calcium burden scoring and propensity-matched comparisons with carotid endarterectomy are underway.

11:42 am
Prospective Study and Cost Analysis of Off-The-Shelf Transcarotid Artery Revascularisation - A Safe and Cost-Effective Solution?
Michael Na
PURPOSE Transcervical Carotid Artery Revascularization (TCAR) combines the benefits of endovascular

carotid stenting with cerebral protection through flow reversal, offering an alternative to conventional carotid endarterectomy (CEA) and to transfemoral carotid artery stenting (TF-CAS). Current TCAR protocols rely on a dedicated flow reversal device which carries considerable costs. This study aimed to demonstrate the feasibility and safety of TCAR performed with an off-the-shelf setup as an option for treatment of carotid disease. METHODOLOGY This prospective, open-label, multi-center study consecutively enrolled patients requiring carotid revascularization for internal carotid artery disease from July 2023 onwards. All procedures were performed under general anesthesia using an off-the-shelf flow reversal circuit comprising a standard 8 Fr sheath in the common carotid artery (CCA) and an 11 Fr sheath in the common femoral vein (CFV), connected by a wide-bore extension tube. No proprietary flow reversal or neuroprotection device was used. The primary endpoint was procedural success at 30 days (stent patent and without cerebrovascular accident, myocardial infarction, or death). RESULTS 26 patients were included, with a median age of 73 and 42% (11/26) having both anatomical and physiological high-risk factors. 73% (19/26) of the cohort had symptomatic disease. Median procedural time was 1h:21m, median flow reversal time 10m:48s. Procedural success was achieved in 96%. Material cost of the off-the-shelf setup (including stent) was 1,741 AUD, compared to 10,010 AUD for the dedicated flow-reversal device setup. CONCLUSION Off-the-shelf TCAR is technically feasible and appears safe, with 96% 30-days procedural success. The setup offers a dramatic cost reduction compared to dedicated flow-reversal device, and if confirmed in larger studies could offer a viable and cost-effective alternative to conventional CEA and TF-CAS.

11:48 am
Declining Carotid Endarterectomy Volume with Preserved Safety and Guideline Adherence: A 15-Year Single-Centre Experience
Dushan Miladinovic

11:54 am
Discussion

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13 September 2026

12:00 pm - 1:00 pm
Lunch

Catering - Vascular Surgery, Vascular Nursing - Level 5

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13 September 2026

1:00 pm - 2:30 pm
The Final Word

Scientific Session - Vascular Surgery - Bloom Room

1:00 pm
When the Diagnosis doesn't fit: Looking beyond the obvious
Asha Malan

1:12 pm
Vascular Oncosurgery
Mamoun Albasheer

1:24 pm
Developing an Oncovascular Service for Complex Retroperitoneal Tumours: A Twelve-Year Experience
Keely Gardiner
Purpose: Retroperitoneal sarcomas (RPS) are rare, aggressive malignancies often requiring radical en bloc multivisceral resection. Major vascular involvement is a key determinant of resectability and may

necessitate vascular reconstruction. This study describes patterns and outcomes of vascular reconstruction in RPS surgery at a high-volume sarcoma centre. Methodology: A retrospective review of primary RPS resections (2010–2022) was conducted at the State Sarcoma Service, Sir Charles Gairdner Hospital, Western Australia. Data included tumour type, vascular reconstruction, operative duration, length of stay, reoperation, readmission, mortality, and graft patency. Analyses included chi-squared testing and binary logistic regression. Results: A total of 129 patients underwent resection (mean age 58.6 years; 51% female). Vascular surgeons were involved in 76% of cases, and 30 patients (23%) required vascular reconstruction. Venous reconstruction was more common than arterial (20.2% vs 10.9%), most frequently associated with leiomyosarcoma and dedifferentiated liposarcoma, respectively. ECMO bypass was used in 22 cases (17.1%), exclusively for venous reconstruction. Inpatient and 1-year mortality were 2.3% and 9.3%, respectively. Increasing age was associated with higher 1-year mortality (OR 1.1 per year, p=0.009). Vascular reconstruction was associated with longer operative time (623 vs 360 minutes, p<0.001) and longer hospital stay (15 vs 12.5 days, p=0.02), but not with increased reoperation, readmission, or 1-year mortality. Conclusion: Vascular reconstruction is required in approximately one in five RPS resections and increases operative complexity and length of stay without adversely affecting short-term morbidity or 1-year mortality. These findings support the safety of aggressive oncovascular resection in a high-volume setting and highlight the role of multidisciplinary vascular involvement and adjuncts such as ECMO bypass in selected cases.

1:32 pm
Global Vascular Surgery in Low and Middle Income Countries: An Analysis of Surgical NGO Representation
James Lockhart
Objective: The 2015 Lancet Commission on Global Surgery highlighted a critical shortage of surgical care in low and middle-income countries (LMICs). Since then death and morbidity from surgical vascular disease in particular has grown in LMICs as life expectancy increases. Despite this, the role of surgical non-governmental organisations (s-NGOs) in addressing vascular surgical need in LMICs has not been characterised. Design: A cross-sectional survey of international s-NGOs operating in LMICs was conducted. Multiple search strategies were employed to engineer redundancy and increase sensitivity. Search strategies included literature review via PubMed and Google Scholar, a review of national charity registries, and searching independent NGO databases. NGOs were included if they demonstrated current activity and a commitment to delivering or expanding access to surgical care. Surgical specialties were identified and compared by frequency. Results: Of 1,242 organisation names identified, 398 unique s-NGOs met inclusion criteria. A plurality of s-NGOs provided multiple specialties (n = 120, 30.2%). The most common surgical specialties offered were ophthalmology (n = 98, 24.6%), paediatric surgery (n = 84, 21.1%) and plastic and reconstructive surgery (n = 77, 19.3%). The least commonly delivered specialty was vascular surgery (n = 5, 1.3%). Only two s-NGOs (the Global Vascular Companionship and the World Federation of Vascular Societies) were dedicated exclusively to vascular surgery. Conclusions: Vascular surgery remains critically underrepresented among international s-NGOs relative to other surgical specialties, despite a growing global burden of vascular disease in LMICs. Efforts to address this gap focus mainly on local capacity building and training rather than direct care provision as recommended by the Lancet Commission, though investment in global vascular surgery remains substantially lower than in other specialties.

1:40 pm
A Qualitative Exploration of the Perceptions of Music Use by Healthcare Professionals in the Operating Theatre
Anantha Narayanan
Background: In this abstract we present the final chapter on a thesis journey investigating the effect that background music has on the operating surgeon. Studies from this thesis have been presented at ANZSVS conferences prior, including the BRAHMS study (an ANZSVS survey), the MOSART Study (field investigation) the STRAUSS Study (laboratory investigation). In this paper we use these previous studies to contextualise a final study where healthcare professionals' (HCPs) experiences of intra-operative music are explored qualitatively. Methods: Semi-structured interviews with seven HCPs (surgeons, anaesthetists, nurses) were analysed using qualitative content analysis with an abductive, critical realist approach. Results: Five themes emerged: (1) music reflects team cohesion; (2) contributes to therapeutic space; (3) is not a panacea; (4) enacts power and protection; and (5) serves as an environmental cue. Music fostered camaraderie and calm but could cause tension, reinforce hierarchy, and disproportionately affect some staff. Conclusions: Music plays a nuanced, multifaceted role in theatre. Team-led, flexible frameworks may best support inclusive, situationally appropriate use.

1:48 pm
Left Common Carotid–Subclavian Transposition: A Native-Vessel Solution to Arch Debranching Before TEVAR
Abram Poznanski

Purpose: Off-the-shelf and custom thoracic endovascular aortic repair (TEVAR) solutions for aortic arch and descending aortic pathologies have transformed contemporary treatment landscape. However, consideration must be given to arch and supra-aortic vessel anatomy to ensure both antegrade perfusion is maintained, as well as satisfactory proximal seal zones can be obtained. This study aims to compare left common carotid to left subclavian artery (LCCA-LSCA) transposition with conventional carotid–subclavian bypass/debranching for supra-aortic revascularisation in patients undergoing thoracic endovascular aortic repair (TEVAR). Methods and Materials: A single-centre case-control study was performed including consecutive patients undergoing TEVAR with supra-aortic reconstruction prior. Patients underwent either LCCA-LSCA transposition or conventional debranching with bypass. Primary outcomes included stroke, technical success, immediate LSCA patency, and 30-day mortality. Secondary outcomes included proximal landing zone length increase and reintervention rates. Results: 32 patients were included (Bypass/debranching n = 27; transposition n = 5). Technical success and immediate LSCA patency were achieved in 100% of cases in both groups, with no 30-day mortality. Stroke occurred in one patient (3.7%) in the bypass group and none in the transposition group. Reintervention was required in one bypass patient (3.7%) and none in the transposition cohort. Both techniques enabled equivalent proximal landing zone extension lengths to facilitate TEVAR. Conclusion: LCCA-LSCA transposition provides equivalent technical and anatomical outcomes to conventional bypass for LSCA revascularization and optimizing proximal landing zone length in TEVAR, while avoiding prosthetic graft use and additional anastomoses. It represents a safe and potentially more durable alternative in appropriately selected patients.

1:56 pm
A contemporary evaluation of early and late aortic and non-aortic mortalities after dissection repair.
Shantel Chang

2:04 pm
The Stella Chart: Pilot Experimental Evaluation of Sheath-Sized Bovine Pericardial Conduits Using Intravascular Ultrasound
Tin Yau Ngan
Background Back-table bovine pericardial conduits may be fashioned for small-calibre arterial reconstruction when autologous vein is unavailable. Their final pressurised diameter cannot be assumed from nominal introducer sheath size. We evaluated a pragmatic intravascular ultrasound-based sizing method and developed the Stella Chart. Methodology Bovine pericardial conduits were fashioned around 7, 8, 10 and 12 Fr Cook introducer sheaths using continuous 6-0 polypropylene with locking knots at 1-cm intervals. Each construct was submerged in saline, statically pressurised to 150 mmHg and assessed using intravascular ultrasound at three predefined locations. Measured luminal diameter was compared with sheath outer diameter, and longitudinal dimensional variation was calculated. Results Twelve intravascular ultrasound measurements were obtained across four constructs. Mean luminal diameters for the 7, 8, 10 and 12 Fr constructs were 2.9, 2.9, 4.1 and 5.3 mm, respectively. Within-construct variation was 0.1–0.3 mm. Relative to sheath outer diameter, achieved conduit diameter differed by −0.1 mm for 7 Fr, −0.4 mm for 8 Fr, +0.1 mm for 10 Fr and +0.7 mm for 12 Fr. The 7 and 8 Fr constructs converged at approximately 2.9 mm, while the 12 Fr construct expanded beyond its mandrel diameter. Conclusion Nominal sheath size did not demonstrate a linear relationship with final pressurised conduit diameter. Intravascular ultrasound enabled direct back-table verification and identified size-dependent behaviour not predicted by geometric calculation alone. The Stella Chart provides an empirical framework for constructing small-calibre bovine pericardial conduits when standard options are unavailable.

2:12 pm
Impact of a dedicated multi-disciplinary aortic team on survival after uncomplicated type B acute aortic syndrome
Sameer Bhat
Purpose: Acute aortic syndromes (AAS) are associated with high mortality. While existing evidence suggests improved outcomes for type A AAS managed within specialised multidisciplinary aortic teams, it is unclear whether this association is also found for patients with type B AAS. This study assessed the impact of a multidisciplinary management approach on outcomes among patients with type B AAS. Methodology: This prospective cohort study included all consecutive adult patients aged □18 years old presenting with or referred to Waikato Hospital in Aotearoa New Zealand with type B or non-A/non-B AAS between January 2010 and December 2024. The primary outcome was mortality measured at 30-days and 1-year after presentation. Secondary outcomes included length of stay (LOS), unplanned 30-day readmission, and aortopathy panel testing. Variables were compared between patients presenting prior to (phase 1) and following the introduction of a multidisciplinary aortic team in mid-2020 (phase 2). Results: A total of 141 patients with type B AAS were included (phase 1, n=69; phase 2, n=72). The majority of presentations were aortic dissections (68.8%) and were uncomplicated in nature (73.0%). Baseline demographics and

comorbidity profiles were similar between the two cohorts. Rates of 30-day (14.5% vs. 8.3%; p=0.38) and 1-year (26.1% vs. 12.5%; p=0.066) mortality trended towards an improvement after the introduction of a multidisciplinary aortic team. Hospital LOS (median 8 vs. 8.5 days; p=0.18) and 30-day readmission rates (17.4% vs. 6.9%; p=0.10) were not significantly different. Overall rates of genetic aortopathy testing increased significantly (10.1% vs. 44.4%; p<0.0001). Conclusion: This study suggests that a dedicated multidisciplinary aortic team may result in an improvement in medium-term survival among patients with type B AAS. Further work is in-progress to determine whether this survival benefit persists in the long-term and how genetic results may guide type B AAS management.

2:20 pm
Discussion
