Outcomes of Patients with CLI in a Large Urban Safety Net Hospital: What Are the Results in This Setting?

Vincent L. Rowe M.D., FACS

Professor of Surgery

Division of Vascular and Endovascular Surgery

Keck School of Medicine at USC

USC University of Southern California

DISCLOSURE

Vincent Rowe, MD

- **No relevant financial relationship reported**

Questions?

- Should outcomes be the same in private and non-private hospitals?
- What results should we expect with CLI?
- Are these results feasible in the “real world”?

Questions?

- Should outcomes be the same in private and non-private hospitals?
- What results should we expect with CLI?
- Are these results feasible in the “real world”?

USC University of Southern California

USC University of Southern California

Results - Demographics

	Af-Am (n=43)	Hispanic (n=148)	Other (n=17)	White (n=28)	p-value
Age	68±1.4	65±0.9	61±2.6	53±2.3	NS
Female	23 (53)	84 (57)	6 (35)	9 (32)	NS
DM	31 (72)	139 (94)	15 (88)	18 (64)	NS
HTN	34 (79)	108 (73)	7 (41)	15 (54)	0.06
Smoking	24 (56)	44 (30)	9 (53)	20 (71)	0.03
CAD	14 (33)	39 (26)	2 (12)	8 (29)	NS
Dyslipidemia	3 (7)	14 (10)	1 (6)	3 (11)	NS
Renal dysfn	4 (9)	14 (10)	2 (12)	2 (7)	NS

Vascular and Endovascular Surgery
2007;41: 397-401

*Renal Dysfn: 9.3%

USC University of Southern California

Results - Presenting symptoms

	Af-Am (n=43)	Hispanic (n=148)	Other (n=17)	White (n=28)	p-value
Claudication	4 (9)	7 (5)	3 (18)	5 (18)	NS
Rest pain	8 (19)	14 (10)	4 (24)	6 (21)	NS
Tissue loss	31 (72)	127 (86)	10 (59)	17 (61)	NS

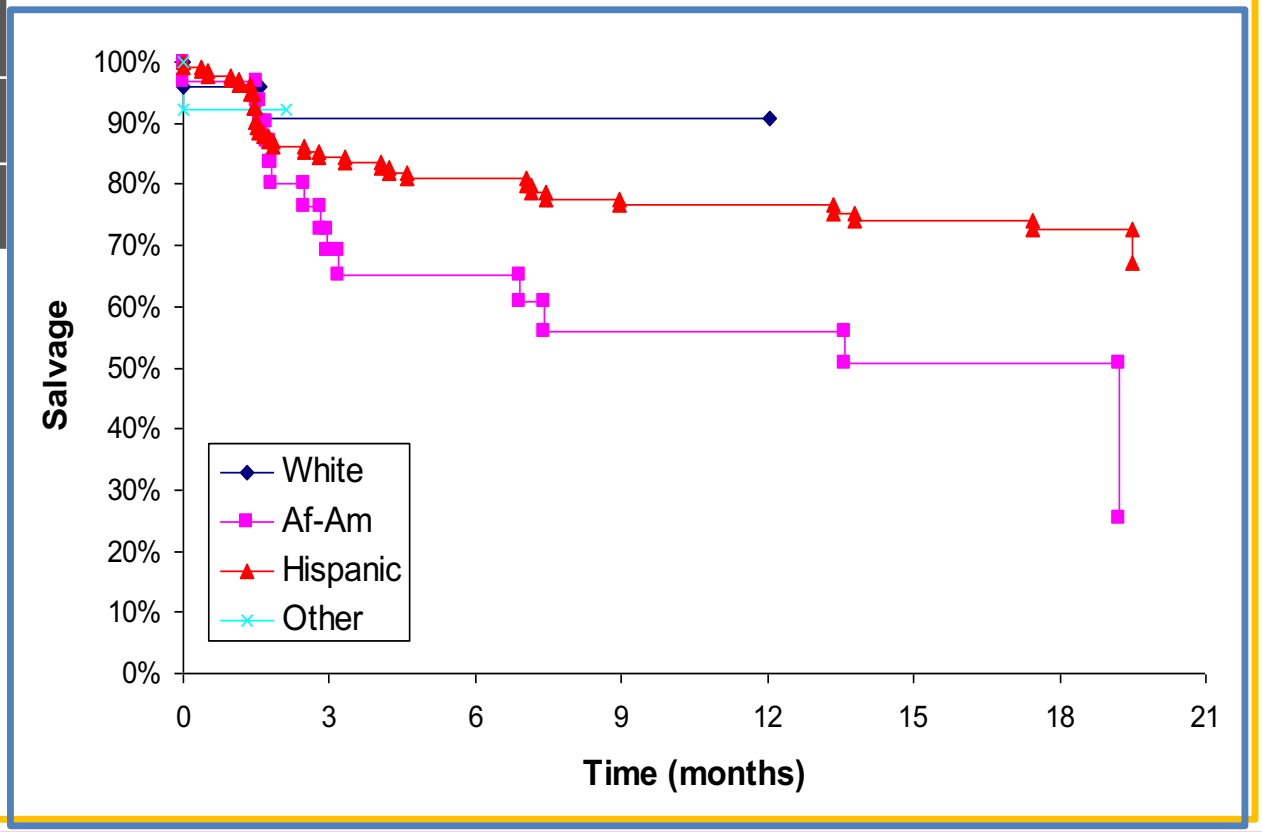
*Tissue Loss: 78.3%

Vascular and Endovascular Surgery
2007;41: 397-401

Results - Limb salvage

Race	Salvage (18-mo %)
Af-Am	50.8
Hispanic	72.6
Other	92.3
White	90.8

Hazard ratio = 8
p = 0.006

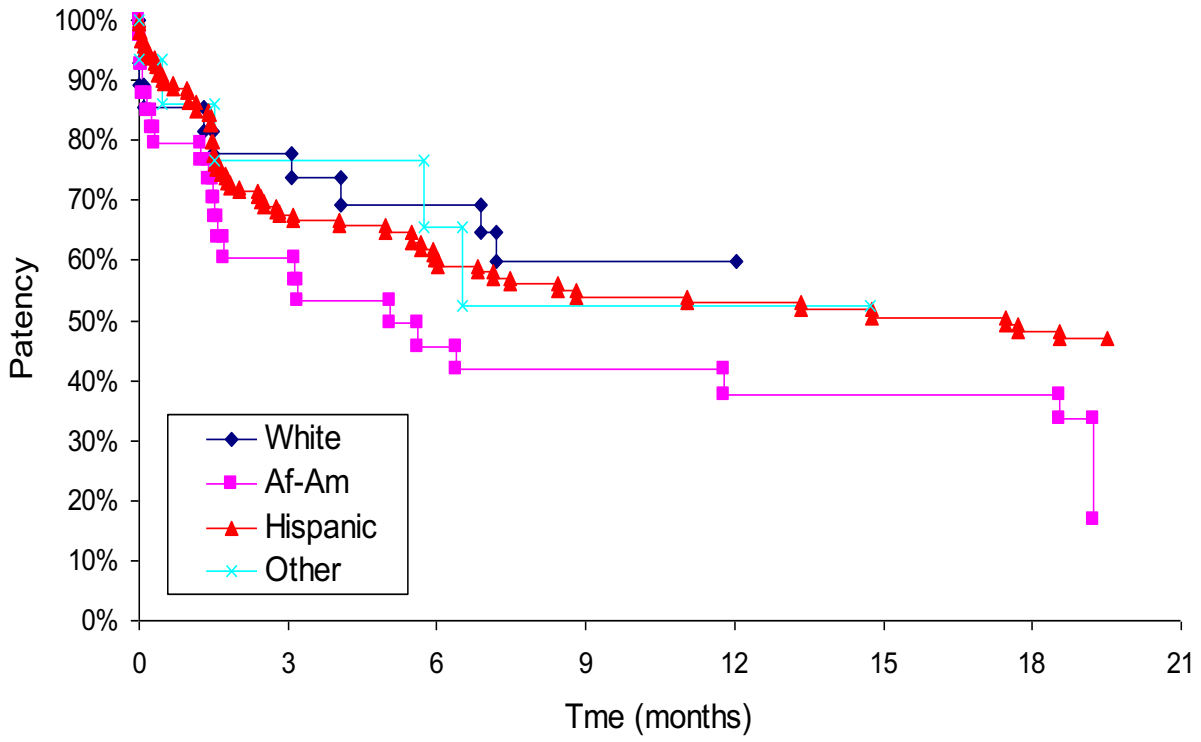


Vascular and Endovascular Surgery
2007;41: 397-401

Results - Primary patency

Race	Patency (18-mo %)
Af-Am	33.5
Hispanic	46.9
Other	52.5
White	59.9

Hazard ratio = 1.95
p = 0.08



Vascular and Endovascular Surgery
2007;41: 397-401

Results of PREVENT III: A multicenter, randomized trial of edifoligide for the prevention of vein graft failure in lower extremity bypass surgery

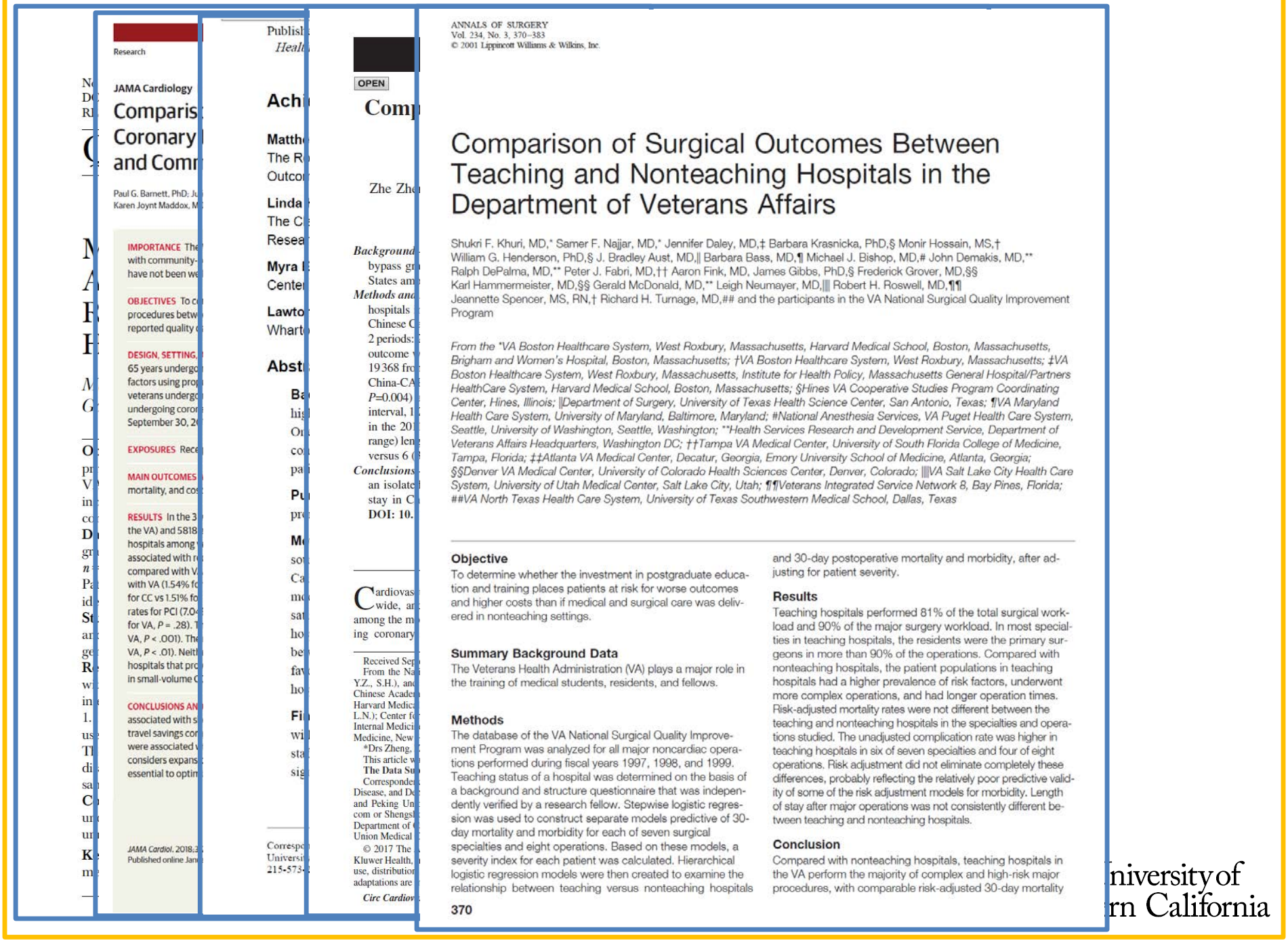
Michael S. Conte, MD,[a] Dennis F. Bandyk, MD,[b] Alexander W. Clowes, MD,[c] Gregory L. Moneta, MD,[d] Lynn Seely, MD,[c] Todd J. Lorenz, MD,[c] Hamid Namini, PhD,[c] Allen D. Hamdan, MD,[f] Sean P. Roddy, MD,[g] Michael Belkin, MD,[a] Scott A. Berceli, MD,[h] Richard J. DeMasi, MD,[i] Russell H. Samson, MD,[j] and Scott S. Berman, MD,[k] for the PREVENT III Investigators, *Boston, Mass;*

- Randomized, Double Blinded
- Multicenter – 83 centers (US and Canada)
- Efficacy of edifoligide (EF2 decoy)
  - Competitive inhibitor of EF2
  - Inhibit SMC proliferation and reduce intimal hyperplasia

J Vasc Surg 2006;43:742-51.

Ethnic origin		
White	526 (74.4%)	491 (70.4%)
Black	116 (16.4%)	133 (19.1%)
Asian	3 (0.4%)	7 (1.0%)
Hispanic	53 (7.5%)	54 (7.7%)
Other	9 (1.3%)	12 (1.7%)
CLI criterion (worst)		
Rest pain	184 (26.0%)	169 (24.2%)
Nonhealing ulcer	273 (38.6%)	280 (40.2%)
Gangrene	247 (34.9%)	246 (35.3%)
Comorbidities		
Hypertension	577 (81.6%)	569 (81.6%)
Diabetes	461 (65.2%)	439 (63.0%)
CAD	353 (49.9%)	324 (46.5%)
CVD	144 (20.4%)	140 (20.1%)
Smoking*	520 (73.5%)	513 (73.6%)
Dyslipidemia	393 (55.6%)	373 (53.5%)
Dialysis	84 (11.9%)	86 (12.3%)
Inflow	146 (20.7%)	147 (21.1%)
Infrainguinal (either limb)	190 (26.9%)	193 (27.7%)

Variable	*Edifoligide*	*Placebo*	P *value*
Protocol-specified end points			
Primary trial end point (nontechnical failure)	25.2	25.5	.69
All clinical failures	34.8	36	.51
Freedom from clinically significant stenosis	44.3	46.1	.62
Amputation/ reintervention-free survival	50.1	48.6	.47
Conventional end points			
Primary patency	61.5	59.5	.38
Primary assisted patency	78.6	74.7	.10
Secondary patency	82.6	77.5	.02
Limb salvage	87.7	89.2	.37
Survival	83.2	84.4	.55



Research

JAMA Cardiology

Comparis
Coronary
and Comr

Paul G. Barnett, PhD; Ju
Karen Joynt Maddox, M

IMPORTANCE The
with community-
have not been we

OBJECTIVES To c
procedures betw
reported quality

DESIGN, SETTING,
65 years undergo
factors using prop
veterans undergo
undergoing coron
September 30, 2

EXPOSURES Rece

MAIN OUTCOMES
mortality, and cos

RESULTS In the 3
the VA) and 5818
hospitals among
associated with r
compared with V
with VA (1.54% fo
for CC vs 1.51% fo
rates for PCI (7.04
for VA, P = .28). T
VA, P < .001). The
VA, P < .01). Neith
hospitals that pro
in small-volume C

CONCLUSIONS AN
associated with s
travel savings cor
were associated v
considers expans
essential to optim

JAMA Cardiol. 2018;3
Published online Jan

Publish
Healt

Achi

Matth
The R
Outco

Linda
The C
Resea

Myra
Center

Lawto
Wharto

Abst

Ba
hig
Or
co
pa

Pu
pr

M
so
Ca
m
sa
ho
be
fa
ho

Fi
wi
st
sig

Correspo
Universi
215-573-

OPEN

Comp

Zhe Zhe

Background
bypass gr
States am
Methods and
hospitals
Chinese C
2 periods:
outcome v
19 368 fro
China-CA
P=0.004)
interval, 1
in the 201
range) len
versus 6 (
Conclusions
an isolate
stay in C
DOI: 10.

Cardiovas
wide, ar
among the m
ing coronary

Received Sep
From the Na
Y.Z., S.H.), an
Chinese Acade
Harvard Medic
L.N.); Center fo
Internal Medici
Medicine, New
*Drs Zheng,
This article w
The Data Su
Correspondenc
Disease, and De
and Peking Un
com or Shengsl
Department of
Union Medical
© 2017 The
Kluwer Health,
use, distributio
adaptations are
Circ Cardiov

ANNALS OF SURGERY
Vol. 234, No. 3, 370–383
© 2001 Lippincott Williams & Wilkins, Inc.

Comparison of Surgical Outcomes Between Teaching and Nonteaching Hospitals in the Department of Veterans Affairs

Shukri F. Khuri, MD,* Samer F. Najjar, MD,* Jennifer Daley, MD,‡ Barbara Krasnicka, PhD,§ Monir Hossain, MS,†
William G. Henderson, PhD,§ J. Bradley Aust, MD,‖ Barbara Bass, MD,¶ Michael J. Bishop, MD,# John Demakis, MD,**
Ralph DePalma, MD,** Peter J. Fabri, MD,†† Aaron Fink, MD, James Gibbs, PhD,§ Frederick Grover, MD,§§
Karl Hammermeister, MD,§§ Gerald McDonald, MD,** Leigh Neumayer, MD,‖‖ Robert H. Roswell, MD,¶¶
Jeannette Spencer, MS, RN,† Richard H. Turnage, MD,## and the participants in the VA National Surgical Quality Improvement Program

*From the *VA Boston Healthcare System, West Roxbury, Massachusetts, Harvard Medical School, Boston, Massachusetts, Brigham and Women's Hospital, Boston, Massachusetts; †VA Boston Healthcare System, West Roxbury, Massachusetts; ‡VA Boston Healthcare System, West Roxbury, Massachusetts, Institute for Health Policy, Massachusetts General Hospital/Partners HealthCare System, Harvard Medical School, Boston, Massachusetts; §Hines VA Cooperative Studies Program Coordinating Center, Hines, Illinois; ‖Department of Surgery, University of Texas Health Science Center, San Antonio, Texas; ¶VA Maryland Health Care System, University of Maryland, Baltimore, Maryland; #National Anesthesia Services, VA Puget Health Care System, Seattle, University of Washington, Seattle, Washington; **Health Services Research and Development Service, Department of Veterans Affairs Headquarters, Washington DC; ††Tampa VA Medical Center, University of South Florida College of Medicine, Tampa, Florida; ‡‡Atlanta VA Medical Center, Decatur, Georgia, Emory University School of Medicine, Atlanta, Georgia; §§Denver VA Medical Center, University of Colorado Health Sciences Center, Denver, Colorado; ‖‖VA Salt Lake City Health Care System, University of Utah Medical Center, Salt Lake City, Utah; ¶¶Veterans Integrated Service Network 8, Bay Pines, Florida; ##VA North Texas Health Care System, University of Texas Southwestern Medical School, Dallas, Texas*

Objective
To determine whether the investment in postgraduate education and training places patients at risk for worse outcomes and higher costs than if medical and surgical care was delivered in nonteaching settings.

Summary Background Data
The Veterans Health Administration (VA) plays a major role in the training of medical students, residents, and fellows.

Methods
The database of the VA National Surgical Quality Improvement Program was analyzed for all major noncardiac operations performed during fiscal years 1997, 1998, and 1999. Teaching status of a hospital was determined on the basis of a background and structure questionnaire that was independently verified by a research fellow. Stepwise logistic regression was used to construct separate models predictive of 30-day mortality and morbidity for each of seven surgical specialties and eight operations. Based on these models, a severity index for each patient was calculated. Hierarchical logistic regression models were then created to examine the relationship between teaching versus nonteaching hospitals and 30-day postoperative mortality and morbidity, after adjusting for patient severity.

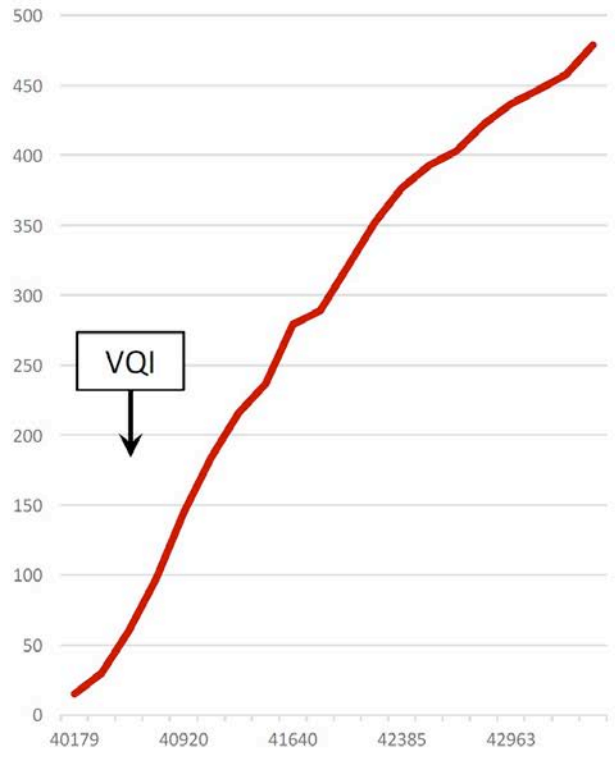
Results
Teaching hospitals performed 81% of the total surgical workload and 90% of the major surgery workload. In most specialties in teaching hospitals, the residents were the primary surgeons in more than 90% of the operations. Compared with nonteaching hospitals, the patient populations in teaching hospitals had a higher prevalence of risk factors, underwent more complex operations, and had longer operation times. Risk-adjusted mortality rates were not different between the teaching and nonteaching hospitals in the specialties and operations studied. The unadjusted complication rate was higher in teaching hospitals in six of seven specialties and four of eight operations. Risk adjustment did not eliminate completely these differences, probably reflecting the relatively poor predictive validity of some of the risk adjustment models for morbidity. Length of stay after major operations was not consistently different between teaching and nonteaching hospitals.

Conclusion
Compared with nonteaching hospitals, teaching hospitals in the VA perform the majority of complex and high-risk major procedures, with comparable risk-adjusted 30-day mortality

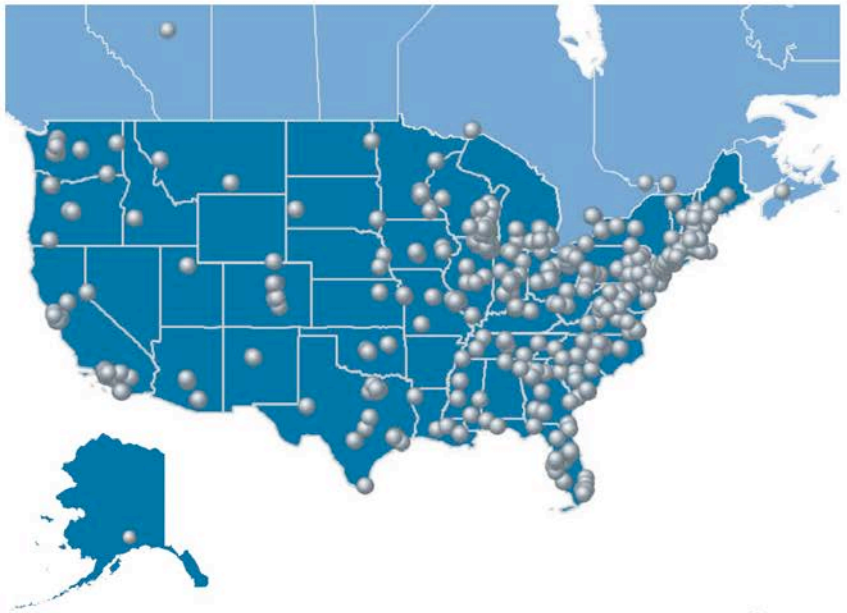
niversity of
rn California

SVS | VQI

Number of Participating Centers



Location of VQI Participating Centers



479 Centers, 46 States + Canada

SVS Society for Vascular Surgery | m2s | Society for Vascular Medicine | VASA

USC University of Southern California

Questions?

- Should outcomes be the same in private and non-private hospitals?
- What results should we expect with CLI?
- Are these results feasible in the “real world”?

USC University of Southern California

Suggested objective performance goals and clinical trial design for evaluating catheter-based treatment of critical limb ischemia

Michael S. Conte, MD,[a] Patrick J. Geraghty, MD,[b] Andrew W. Bradbury, MD,[c] Nathanael D. Hevelone, MPH,[d] Stuart R. Lipsitz, ScD,[e] Gregory L. Moneta, MD,[f] Mark R. Nehler, MD,[g] Richard J. Powell, MD,[h] and Anton N. Sidawy, MD,[i] *San Francisco; Calif; St. Louis, Mo; Birmingham, United Kingdom; Boston, Mass; Portland, Ore; Aurora, Colo; Hanover, NH; and Washington, DC*

- SVS LEB objective performance goals (OPG)
- Prevent III, BASIL, Circulase II Trials
- Benchmark for future CLI therapies (including endovascular)
- Excluded prosthetic grafts and ESRD patients

J Vasc Surg 2009;50:1462-73

Suggested objective performance goals and clinical trial design for evaluating catheter-based treatment of critical limb ischemia

Michael S. Conte, MD,[a] Patrick J. Geraghty, MD,[b] Andrew W. Bradbury, MD,[c] Nathanael D. Hevelone, MPH,[d] Stuart R. Lipsitz, ScD,[e] Gregory L. Moneta, MD,[f] Mark R. Nehler, MD,[g] Richard J. Powell, MD,[h] and Anton N. Sidawy, MD,[i] *San Francisco; Calif; St. Louis, Mo; Birmingham, United Kingdom; Boston, Mass; Portland, Ore; Aurora, Colo; Hanover, NH; and Washington, DC*

Table Va. Summary of safety outcomes for overall CLI cohort

Outcome	*30 day events (%; 95% CI)*	*Maximum allowable events (trial N = 392)*	*Safety OPG*
MACE	6.2% (4.7-8.1)	20 (5.1%, 3.1-7.8%)	8%
• Death	2.7%		
• MI	3.1%		
• CVA	1.0%		
MALE	6.1% (4.6-7.9)	18 (4.6%, 2.7-7.2)	8%
Amputation	1.9% (1.1-3.1)	5 (1.3%, 0.4-3.0)	3%

ia

Suggested objective performance goals and clinical trial design for evaluating catheter-based treatment of critical limb ischemia

Michael S. Conte, MD,[a] Patrick J. Geraghty, MD,[b] Andrew W. Bradbury, MD,[c] Nathanael D. Hevelone, MPH,[d] Stuart R. Lipsitz, ScD,[e] Gregory L. Moneta, MD,[f] Mark R. Nehler, MD,[g] Richard J. Powell, MD,[h] and Anton N. Sidawy, MD,[i] *San Francisco; Calif; St. Louis, Mo; Birmingham, United Kingdom; Boston, Mass; Portland, Ore; Aurora, Colo; Hanover, NH; and Washington, DC*

Table Vb. Summary of efficacy outcomes (one year) for overall CLI cohort and suggested OPG for each endpoint

Outcome	*Point (95% CI)*	*Efficacy OPG*
MALE + POD	76.9% (74.0-79.9)	71%
AFS	76.5% (73.7-79.5)	71%
RAS	46.5% (42.3-51.2)	39%
RAO	61.3% (58.0-64.9)	55%
Limb salvage	88.9% (86.7-91.1)	84%
Survival	85.7% (83.3-88.1)	80%

Suggested objective performance goals and clinical trial design for evaluating catheter-based treatment of critical limb ischemia

Michael S. Conte, MD,[a] Patrick J. Geraghty, MD,[b] Andrew W. Bradbury, MD,[c] Nathanael D. Hevelone, MPH,[d] Stuart R. Lipsitz, ScD,[e] Gregory L. Moneta, MD,[f] Mark R. Nehler, MD,[g] Richard J. Powell, MD,[h] and Anton N. Sidawy, MD,[i] *San Francisco; Calif; St. Louis, Mo; Birmingham, United Kingdom; Boston, Mass; Portland, Ore; Aurora, Colo; Hanover, NH; and Washington, DC*

- Negative factors:
  - Age > 80 years old with tissue loss
  - Poor quality saphenous vein
    - Prosthetic conduit
  - Infrapopliteal level

Questions?

- Should outcomes be the same in private and non-private hospitals?
- What results should we expect with CLI?
- Are these results feasible in the “real world”?

USC University of Southern California

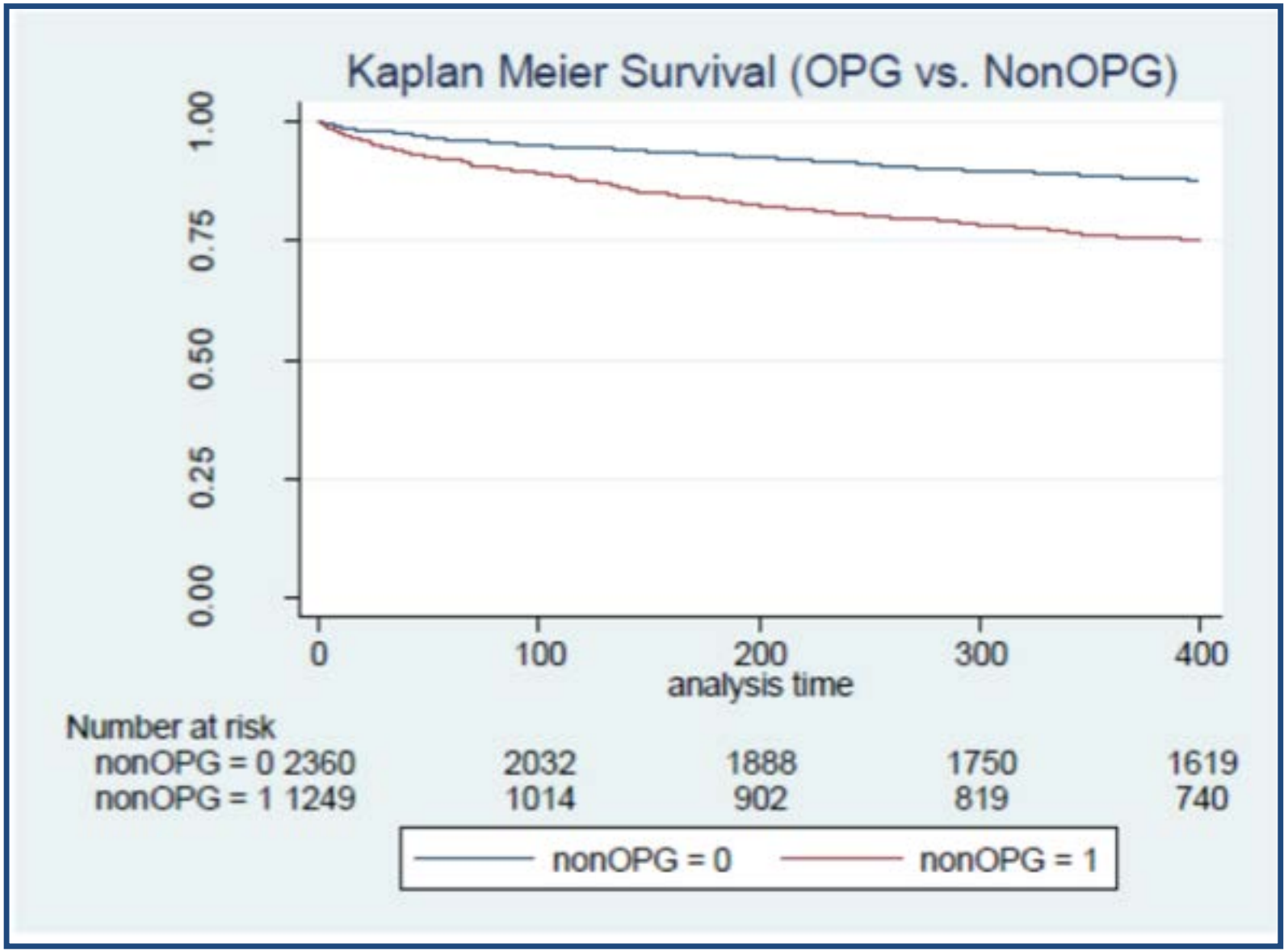
The Society for Vascular Surgery's objective performance goals for lower extremity revascularization are not generalizable to many open surgical bypass patients encountered in contemporary surgical practice

Julia T. Saraidaridis, MD,[a] Emel Ergul, MS,[a] Virendra I. Patel, MD, MPH,[a] David H. Stone, MD,[b] Richard P. Cambria, MD,[a] and Mark F. Conrad, MD, MMSc,[a] *Boston, Mass; and Lebanon, NH*

- All LEB in VSGNE for CLI
- 2003 -2013
- SVS Objective Performance Goals (OPG)

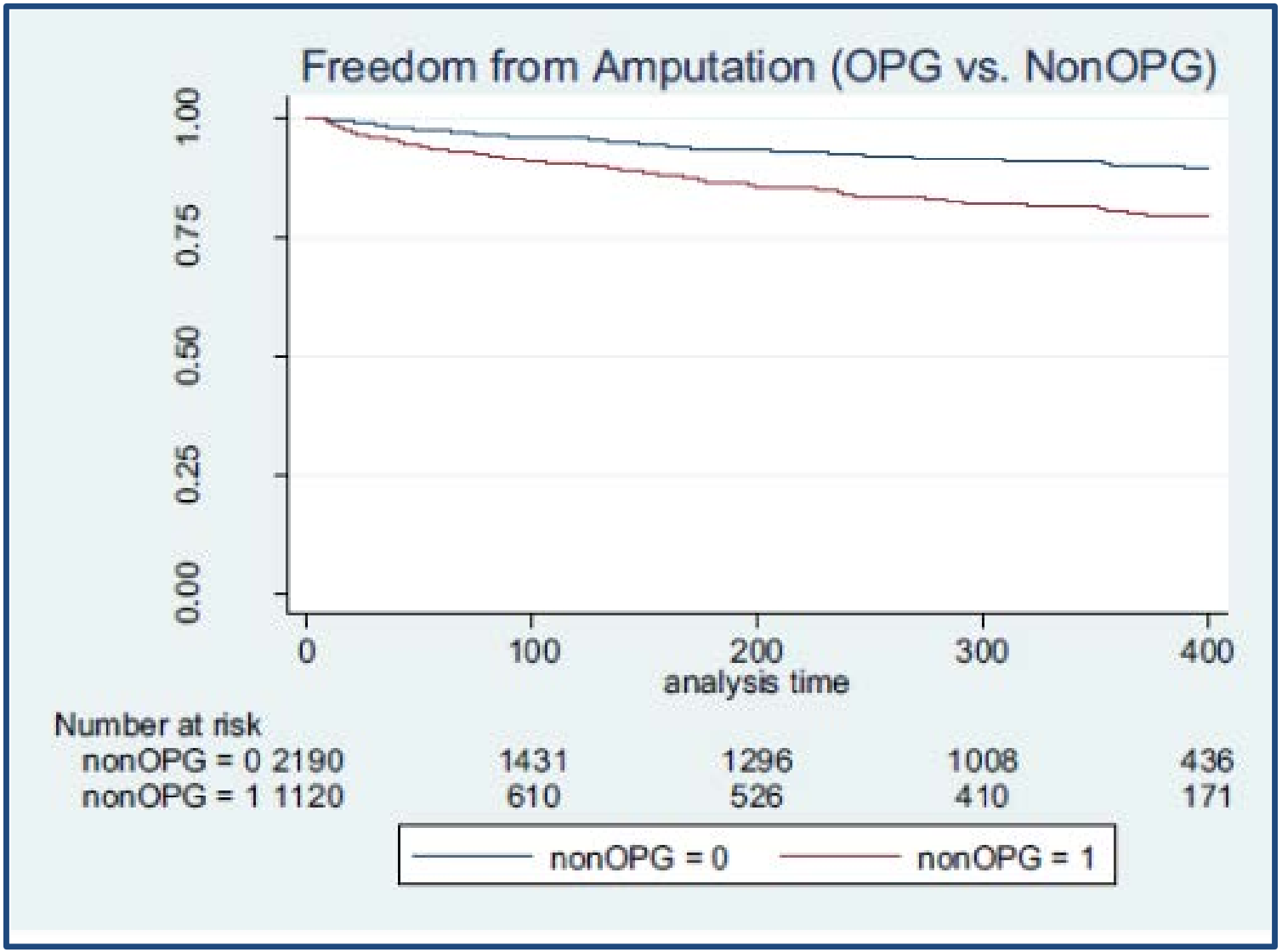
J Vasc Surg 2015;62:392-400.

USC University of Southern California



J Vasc Surg 2015;62:392-400.

USC University of Southern California



J Vasc Surg 2015;62:392-400.

USC University of Southern California

Demographic	*Non-OPG (n = 1249), No. (%)*	*OPG (n = 2360), No. (%)*	P *value*
Age, years	69.2	68.8	.34
Female sex	502 (40.2)	788 (33.4)	<.001
Nonwhite	99 (7.9)	159 (6.4)	.19
Any smoking	1030 (82.5)	1915 (81.0)	.33
Current smoking	423 (33.9)	887 (37.6)	.03
Hypertension	1142 (91.4)	2054 (87.0)	<.001
Diabetes	771 (61.7)	1328 (56.3)	.002
Diabetes requiring insulin	483 (38.7)	691 (29.3)	<.001
CAD	560 (44.8)	783 (33.2)	<.001
History of coronary artery bypass grafting	73 (5.8)	68 (2.9)	<.001
Congestive heart failure	323 (25.9)	414 (17.5)	<.001
Chronic obstructive pulmonary disease	372 (29.8)	593 (25.1)	.003
History of previous			
Ipsilateral bypass	220 (17.6)	240 (10.2)	<.001
Ipsilateral PVI	171 (13.7)	358 (15.2)	.23
Carotid endarterectomy/carotid artery stenting	147 (11.8)	209 (8.9)	.005
Major amputation	86 (6.9)	104 (4.4)	.002
Preoperative aspirin	930 (74.5)	1779 (75.4)	.54
Preoperative statin	865 (69.3)	1601 (67.8)	.38
Popliteal distal target			
Above the knee	441 (35.3)	233 (9.9)	<.001
Below the knee	323 (25.9)	768 (32.5)	<.001
Tibial distal target	328 (26.3)	991 (42.0)	<.001
Pedal distal target	117 (9.4)	349 (14.8)	<.001
Prosthetic conduit	1001 (80.1)	–	–
ESRD	343 (27.5)	–	–

CAD, Coronary artery disease; *ESRD*, end-stage renal disease; *PVI*, peripheral vascular intervention.

J Vasc Surg 2015;62:392-400.

Results

Outcome measures	*Non-OPG group (n = 1249)*	*OPG group (n = 2360)*	P *value*	*SVS OPG, %*
Safety outcomes at 30 days, No. (%)				
MALE	69 (5.5)	113 (4.8)	.34	<8
MACE	115 (9.2)	147 (6.2)	.001	<8
Myocardial infarction	67 (5.4)	110 (4.7)	.35	
Death	65 (5.2)	46 (2.0)	<.001	
Amputation	32 (2.6)	21 (0.9)	<.001	<3
Efficacy outcomes at 1 year, % (SE)				
Survival	75.9 (1.3)	88.3 (.7)	<.001	>80
Freedom from amputation	80.9 (1.6)	90.1 (.8)	<.001	>84

MACE, Major adverse cardiovascular event; *MALE*, major adverse limb event; *SE*, standard error; *SVS*, Society for Vascular Surgery.

J Vasc Surg 2015;62:392-400.

USC University of Southern California

MALE 30: Risk factor	*OR*	*P value*
Age	0.98	.01
Female	1.46	.02
Nonwhite	0.96	.87
ESRD	0.98	.94

MACE 30: Risk factor	*OR*	*P value*
Age	1.03	<.001
Female	1.21	.17
Nonwhite	1.57	.13
ESRD	1.70	.004
noking	0.64	.01
iabetes	1.42	.02
osthetic	1.28	.10
rapopliteal target	1.35	.03
AD	2.17	<.001

end-stage renal disease; *MACE*, E, major adverse limb event; *OR*,

Survival: risk factor	*HR*	*P value*	*Amputation: Risk factor*	*HR*	*P value*
Age	1.05	<.001	Age	0.99	.10
Female	0.87	.02	Female	1.08	.54
Non-white	1.72	.002	Nonwhite	1.13	.57
ESRD	3.41	<.001	ESRD	2.94	<.001
Diabetes	1.26	<.001	Diabetes	1.16	0.28
Prosthetic	1.26	<.001	Prosthetic	2.15	<.001
Smoking	1.20	.01	Infrapopliteal target	2.17	<.001
CAD	1.40	<.001	Previous ipsilateral bypass	1.54	.004
			Previous PVI	1.69	<.001

CAD, Coronary artery disease; *ESRD*, end-stage renal disease; *HR*, hazard ratio; *PVI*, peripheral vascular intervention.

J Vasc Surg 2015;62:392-400.

USC University of Southern California

Recommended Changes

End point	*SVS OPG, %*	*Non-OPG, %*	*ESRD, %*	*Prosthetic, %*
Safety outcomes at 30 days				
MALE	<8	<8	<8	<8
MACE	<8	<11	<16	<11
Amputation	<3	<4	<6	<4
Efficacy outcomes at 1 year				
Survival	>80	>70	>52	>73
Limb salvage	>84	>73	>56	>75

ESRD, End-stage renal disease; *MACE*, major adverse cardiovascular event; *MALE*, major adverse limb event; *SVS*, Society for Vascular Surgery.

J Vasc Surg 2015;62:392-400.

Changing Era

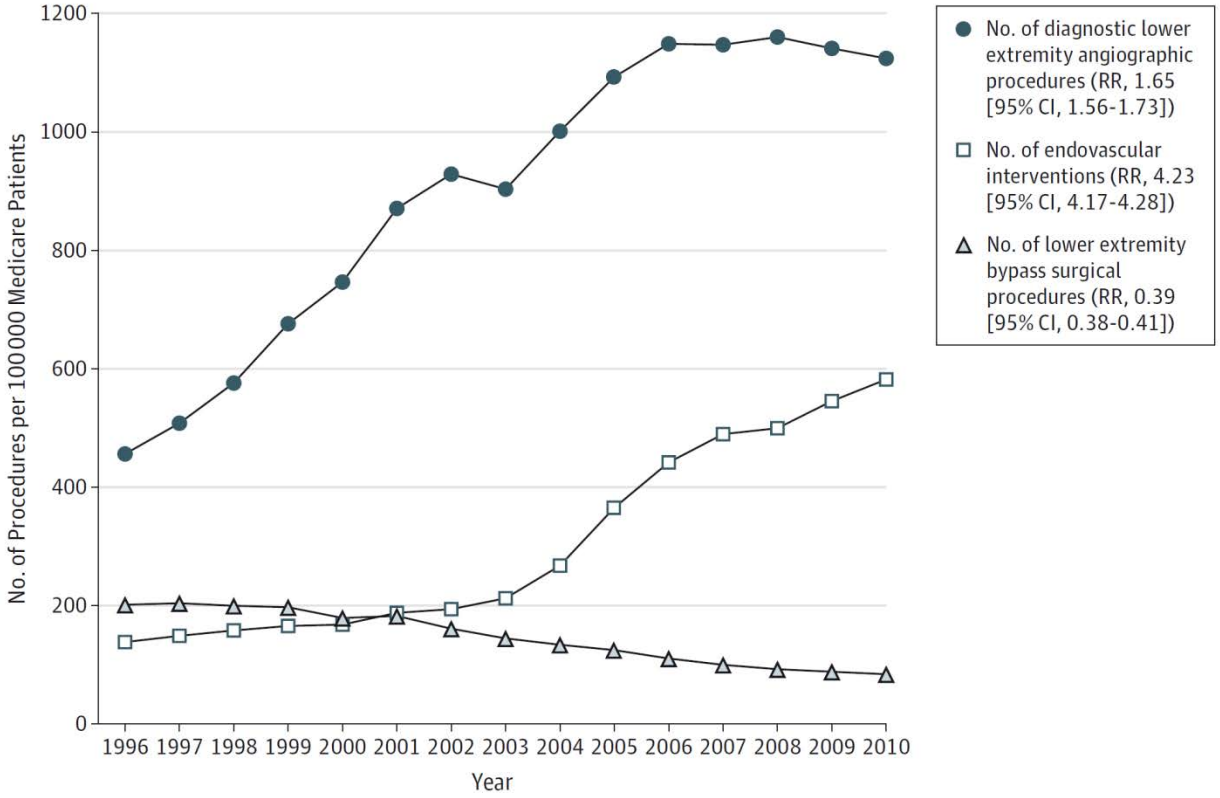
- Medications
  - Statins
  - Oral anticoagulants
  - Antiplatelet agents
- Endovascular
  - Lower profile systems
  - Drug delivery interventions
  - Retrograde access
  - Atherectomy

Changing Era

- Surgery
  - Are we as good as we used to be?

Trends in PAD Therapy

Figure 2. Trends in Diagnostic Angiography, Therapeutic Endovascular Interventions, and Lower Extremity Bypass Surgery, 1996-2010



Goodney et al. JAMA Surg 2015;150:84-86

USC University of Southern California

Resident Experience

	2010 Mean	2010 Std Dev	2017 Mean	2017 Std Dev
Femoral, Profunda Endarterectomy	**10.8**	6	**15.2**	9
Femoral-Popliteal Bypass, Vein	**10.3**	6	**10.5**	6
Femoral-Popliteal Bypass, Prosth	**8.6**	6	**7.0**	6
Translum balloon angio femoral-popl	**18.8**	13	**40.5**	22
Translum atherectomy femoral-popliteal	**4.7**	7	**4.6**	6
Endarterectomy, superf femoral, popl	**2.1**	2	**2.6**	3
Infrapopliteal Bypass, Vein	**15.5**	9	**15.9**	10
Infrapopliteal Bypass, Prosthetic	**4.2**	4	**4.2**	4
Translum ballon angio, tibioperoneal	**11.2**	9	**17.8**	12
Translum atherectomy, tibioperoneal	**2.2**	4	**3.0**	5

USC University of Southern California

Resident Experience

	2010 Mean	2010 Std Dev	2017 Mean	2017 Std Dev
Femoral, Profunda Endarterectomy	**10.8**	6	**15.2**	9
Femoral-Popliteal Bypass, Vein	**10.3**	6	**10.5**	6
Femoral-Popliteal Bypass, Prosth	**8.6**	6	**7.0**	6
Translum balloon angio femoral-popl	**18.8**	13	**40.5**	22
Translum atherectomy femoral-popliteal	**4.7**	7	**4.6**	6
Endarterectomy, superf femoral, popl	**2.1**	2	**2.6**	3
Infrapopliteal Bypass, Vein	**15.5**	9	**15.9**	10
Infrapopliteal Bypass, Prosthetic	**4.2**	4	**4.2**	4
Translum ballon angio, tibioperoneal	**11.2**	9	**17.8**	12
Translum atherectomy, tibioperoneal	**2.2**	4	**3.0**	5

USC University of Southern California

Changing Era

- Surgery
  - Are we as good as we used to be?
- Patients
  - Distal disease
  - Diabetes/Obesity
  - ESRD

Recent Public Hospital Experience

	2006 (Avg. %)	Last 100 (Avg. %)
Age > 80	6.7	13
Race - Hispanic	62.7	76
Race – Af. American	18.2	7
Diabetes	86.0	81
ESRD/Renal Insuff.	9.3	25

Recent Public Hospital Experience

	2006 (Avg. %)	Last 100 (Avg. %)
Age > 80	6.7	13
Race - Hispanic	62.7	76
Race – Af. American	18.2	7
Diabetes	86.0	81
ESRD/Renal Insuff.	9.3	25

Recent Public Hospital Experience

	2006 (Avg. %)	Last 100 (Avg. %)
Age > 80	6.7	13
Race - Hispanic	62.7	76
Race – Af. American	18.2	7
Diabetes	86.0	81
ESRD/Renal Insuff.	9.3	25

Recent Public Hospital Experience

	2006 (Avg. %)	Last 100 (Avg. %)
Age > 80	6.7	13
Race - Hispanic	62.7	76
Race – Af. American	18.2	7
Diabetes	86.0	81
ESRD/Renal Insuff.	9.3	25

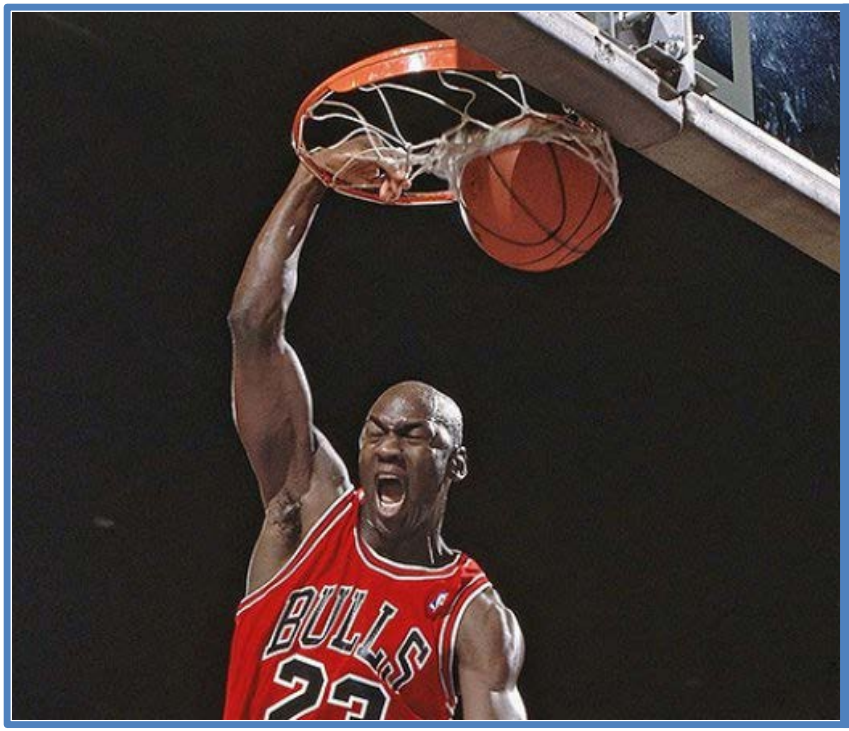
Recent Public Hospital Experience

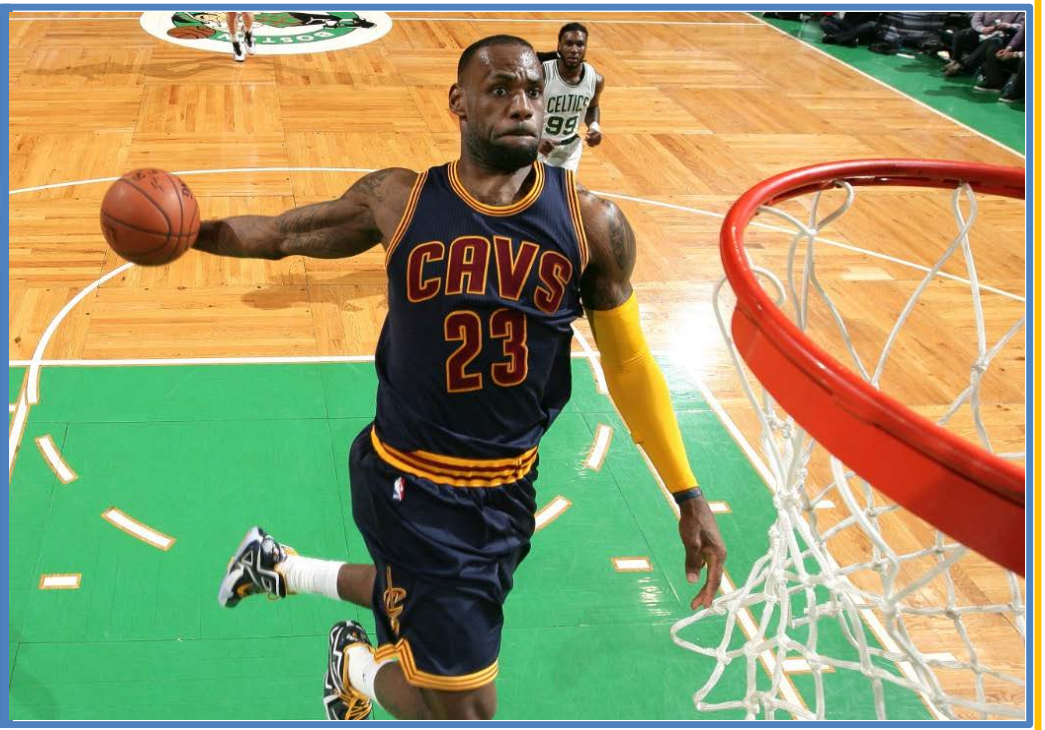
	2006 (Avg. %)	Last 100 (Avg. %)
Age > 80	6.7	13
Race - Hispanic	62.7	76
Race – Af. American	18.2	7
Diabetes	86.0	81
ESRD/Renal Insuff.	9.3	25

USC University of Southern California

USC University of Southern California

Hard to compare!!!





USC University of Southern California

BEST-CLI

Best **E**ndovascular vs. Best **S**urgical **T**herapy in Patients with **C**ritical **L**imb **I**schemia

Sponsored by the National Heart Lung and Blood Institute

BWH

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

MGH 1811

neri
New England Research Institutes

Conclusion

- Should outcomes be the same in private and non-private hospitals?
  - For the most part, Yes
- What results should we expect with CLI?
  - SVS Guidelines provide great starting point
- Are these results feasible in the “real world”?
  - Yes, but with risk adjustments
  - Revisions of guidelines every 5 years

THANK YOU

USC University of Southern California