“What's past is prologue,”

From ***The Tempest***, (act 1, scene 1)
~ William Shakespeare

*Shakespeare observed that the experience of the **past** is but an introduction to that **which is to come**. In many ways, history repeats itself.*

- **Nothing to disclose**

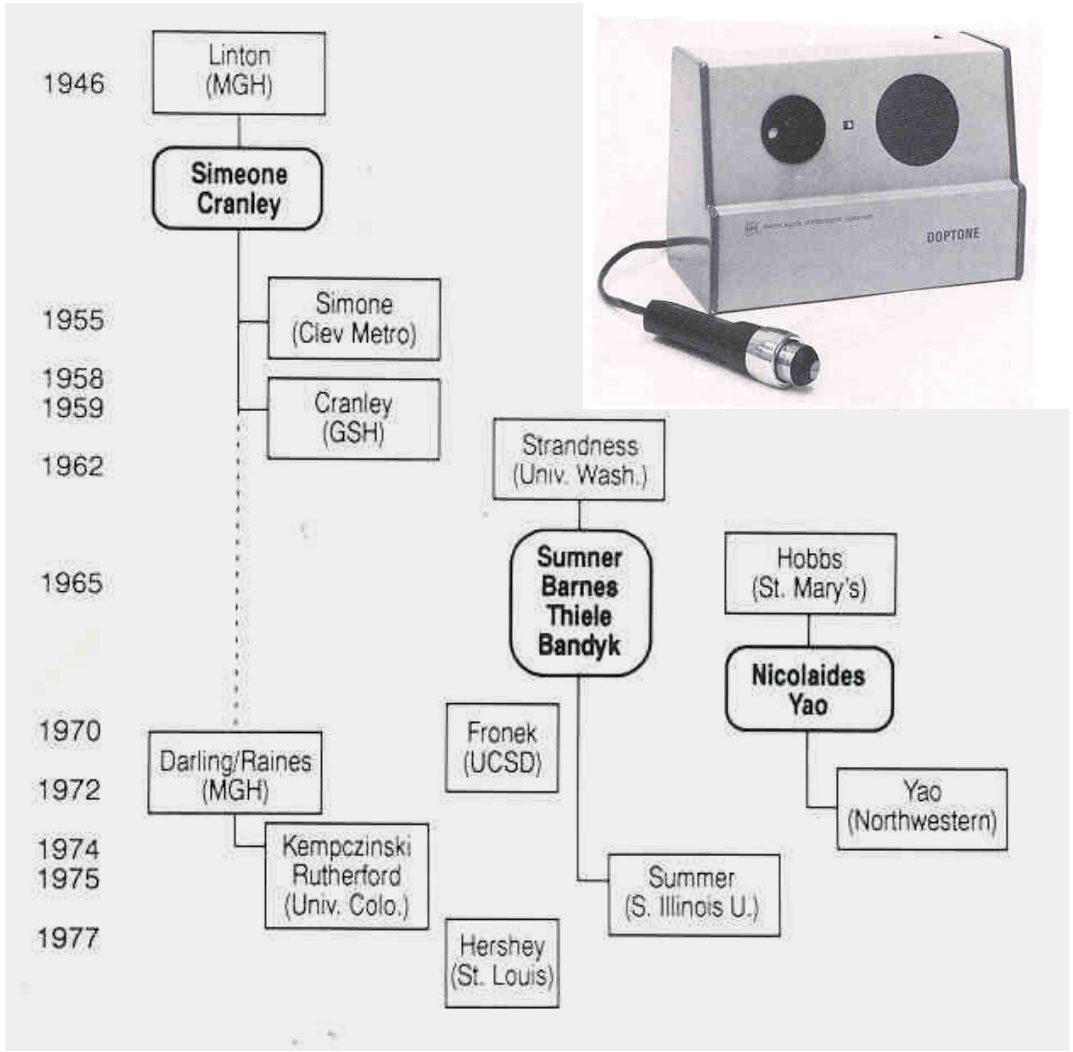
Acknowledgment to Eileen D’Alba

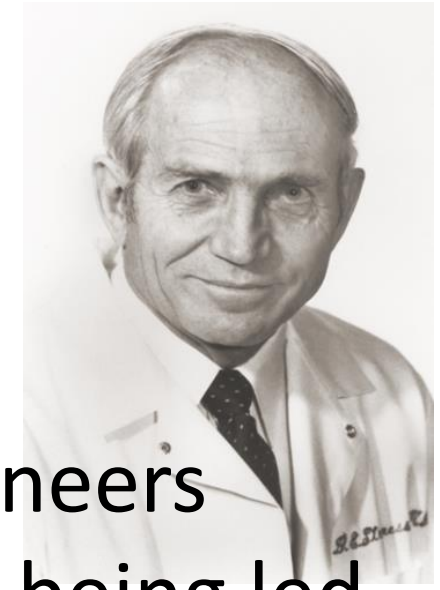
Evolution of Vascular Testing and the Vascular Ultrasound Professional

George Berdejo, BA, RVT, FSVU
White Plains Hospital Center
White Plains, NY

In the beginning…

- Pioneers



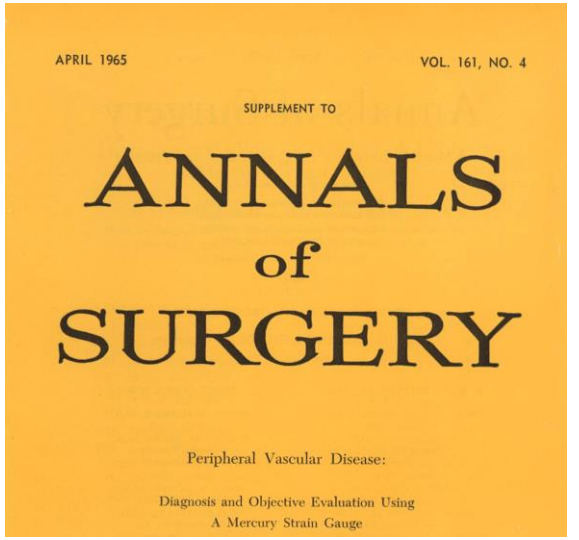


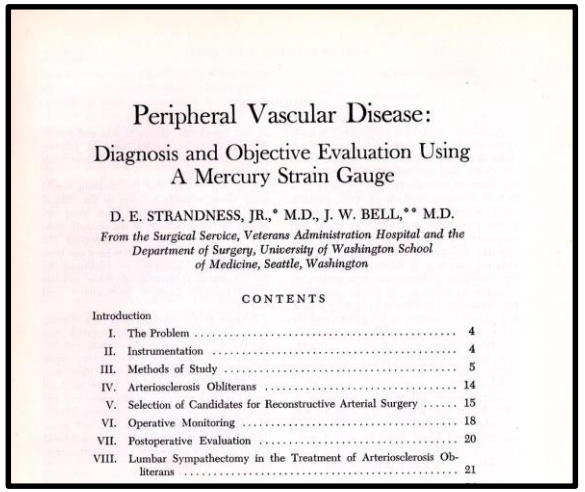
- In the early 60's heavily involved with Doppler devices built by bioengineers at the U of W, the team being led by ***Robert Rushmer***, ***Dean Franklin*** and ***Donald Baker***.
- Responsible for most of the early clinical trials using these pioneering equipment.

Strandness demonstrating the use of a small directional CW Doppler

History of Vascular Testing –

- 1965 Gene Hokanson (physicist), used his knowledge and electronics to develop and build various non invasive instruments.
- 1966 David Sumner and Strandness wrote a short booklet called "Hemodynamics for Surgeons".
- Evolved into an important guide for applied vascular physiology.
- Strandness, Sumner and Hokanson hosted display at the American College of Surgeons Conference in San Francisco in the same year.




Peripheral Vascular Disease:
Diagnosis and Objective Evaluation Using
A Mercury Strain Gauge

D. E. STRANDNESS, JR.,* M.D., J. W. BELL,** M.D.

From the Surgical Service, Veterans Administration Hospital and the Department of Surgery, University of Washington School of Medicine, Seattle, Washington

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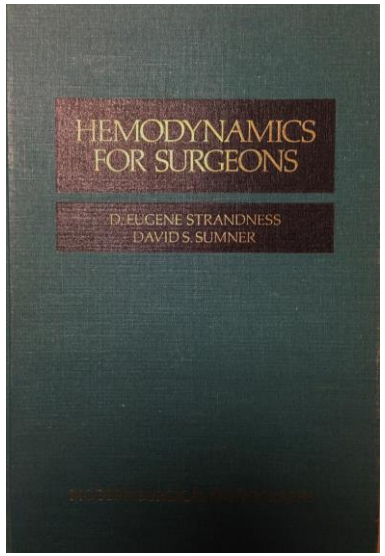

Organizational Meeting - San Diego, California
March, 1977

At the fourth annual San Diego Vascular Symposium, eight technologists met several times to discuss the structure of a proposed organization for those working in vascular laboratories:

Barton Bean, San Francisco, CA
Donna Blackburn, Chicago, IL
Mitzi Andrews Clark, Columbus, OH
Valerie Crain, Tucson, AZ
Andrew Hayes, Maywood, IL
Michael McCloy, Phoenix, AZ
Cindy Ramirez, Cincinnati, OH
Victor Wedel, Palo Alto, CA

They decided on a name:

The Society Of Non-Invasive Vascular Technology

During the year, the officers made plans for the fledgeling society.

- They wrote a code of regulations to be approved at the first annual meeting.

- They met in September, 1977.
  It was decided that the first annual meeting would be in Los Angeles in June, 1978.

- The first issue of BRUIT was published.

- Formed in 1977 in Columbus, OH, as SNIVT
- Moved in 1986 from Columbus, OH, to Washington, DC
- Name changed from SNIVT to SVT in 1988
- SVT moved to Lanham, MD, in Dec. 1994 as an independently managed 501 (c) (3) non-profit professional medical society
- Name changed from SVT to SVU in Sept. 2002

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- Name changed from SVT to SVU in Sept. 2002

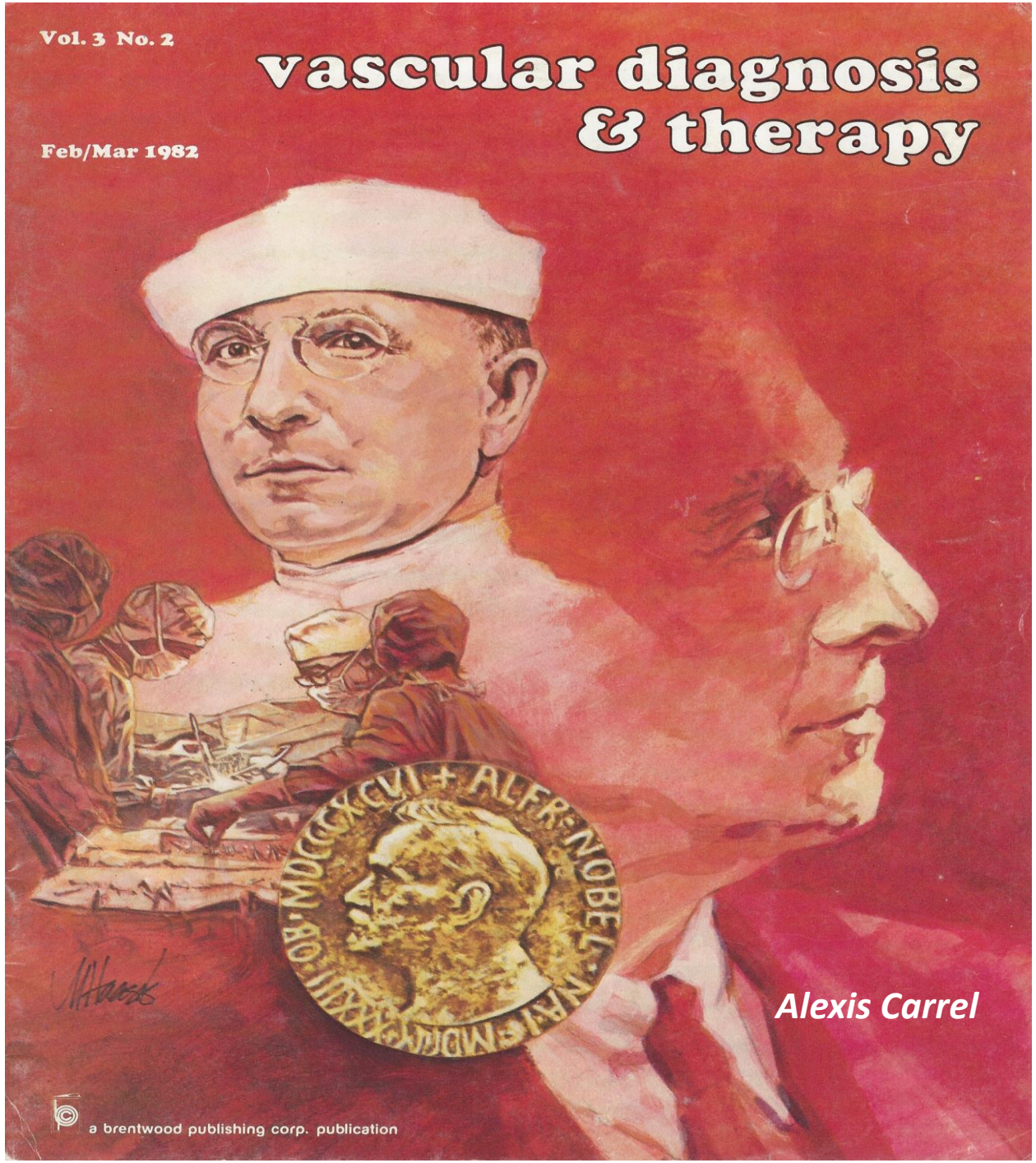
Executive Directors

- ***Pat Horner***
- ***Suzanne Stone***
- ***Robert Van Hook****
- ***Steve Haracznak***
- ***Thomas Stefaniak***
- ***James Wilkinson***

Vol. 3 No. 2

vascular diagnosis & therapy

Feb/Mar 1982



Alexis Carrel

a brentwood publishing corp. publication

Patient walks on treadmill to determine functional disability of claudication.

which deal with technique and laboratory management. A fairly large data base and documentation of our observations have made this possible.

No attempts have been made to establish a formal training program here owing to our limited space, but we have tried to make ourselves available to technicians and physicians from other institutions who call with questions or wish to visit.

Some of our future plans include computerization of records and establishment of a better system of gauging test accuracy, possible expansion of our staff to accommodate growth, and attempts to extend our influence in the medical community while remaining a self-sufficient and cost-effective unit. ■

editorial

Keep us informed

D.E. Strandness, Jr, MD

As a new publication, *VD&T* is attempting to find its proper place in a field which we feel has been neglected to some degree. Since it is not a peer review journal in the traditional sense, it will succeed only if we fulfill the needs of our readers. This is not an easy task, and we will on occasion stumble and appear to be less than totally responsive to this goal.

Those of us on the editorial board badly need your input. It is coming, but we want to encourage it even further. We appreciate plaudits, but since these only lead to complacency, we want criticism—not only with regard to journal content but also in terms of quality of the papers published.

Further, it is one of the goals of *VD&T* to encourage rational discourse between readers and authors. This requires that you let us know when you disagree so that this type of dialogue can become a regular part of each issue.

While we can't please everyone, we certainly will attempt to make the reading of *VD&T* an educational experience. When we don't meet your expectations, let us know! You have an opportunity for input to a large audience, one which is rarely possible in publications dealing with problems of the type covered in ours.

Dr Strandness, chairman of the Editorial Advisory Board of Vascular Diagnosis & Therapy, *is professor of surgery, University of Washington School of Medicine, Seattle.*

Advertisers

During the year, the officers made plans for the fledgeling society.

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- They met in September, 1977.
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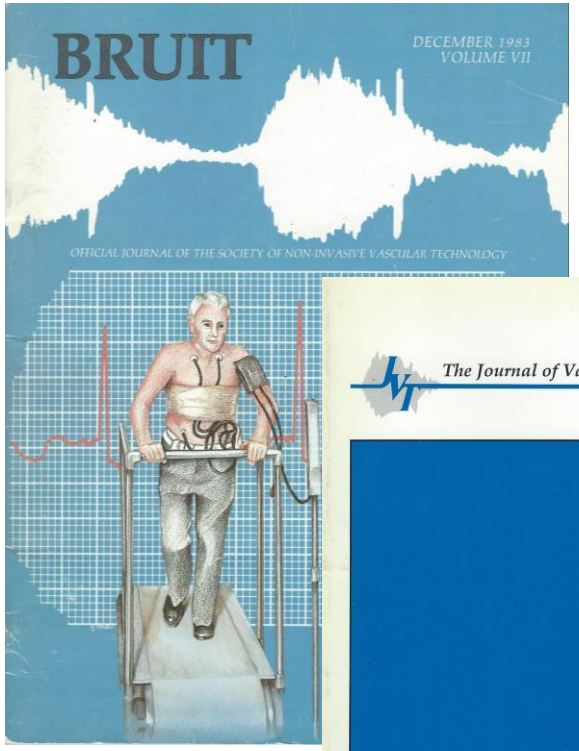
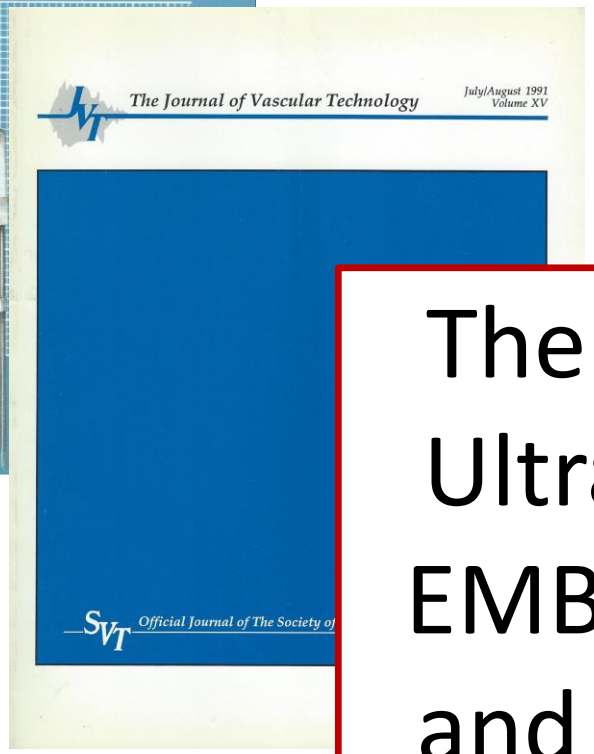
Evolution of the Journal

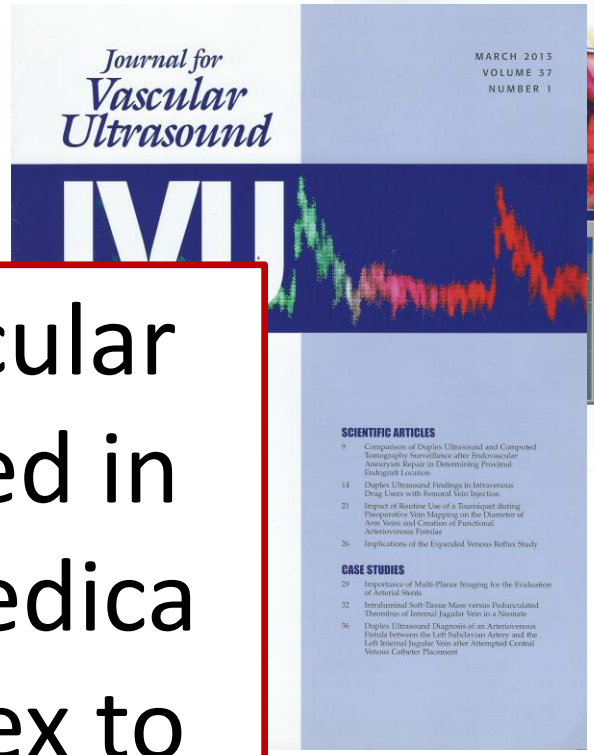
Current Co-Editors

Steven R. Talbot

Barton A. Bean







The Journal for Vascular Ultrasound is indexed in EMBASE/Exerpta Medica and Cumulative Index to Nursing and Allied Health Literature

Editors Emeriti

Cynthia Burnham

Paul Cardullo

Ann Marie Kupinski

Barbara Rhodes

SOCIETY OF NON-INVASIVE VASCULAR TECHNOLOGY

BRUIT

Vol. IV, June 1980

The Noninvasive Vascular Laboratory: A Personal Opinion

James S. T. Yao, M.D., Ph.D.

During the last decade, noninvasive testing has emerged as the standard diagnostic technique for patients with vascular problems related to arterial or venous disorders. Because of rapid expansion of technology, vascular laboratories are now a common sight in many hospitals in the United States. As we all know, many of these laboratories provide valuable diagnostic information regarding cerebral ischemia, occlusive disease of the upper and lower extremities, and acute deep venous thrombosis.

The role of the vascular laboratory in the delivery of care to vascular patients is now undisputed, but new adventures always bring challenges. In addition to keeping up with new developments in technology, we face issues including administrative responsibility, quality control, budget and financial arrangements which are an integral part of the success of running a vascular laboratory. The abuse of noninvasive tests must be addressed by us. This editorial is intended to express my personal opinion on these issues.

Ideally, the vascular laboratory should be hospital based with administrative responsibility placed under the umbrella of the hospital diagnostic service. Similar to other diagnostic laboratories, budgetary and financial arrangements including proper charges must be dealt with by the hospital on a yearly basis. Noninvasive tests must be cost effective, and their cost must not be allowed to approach the charges for direct, invasive procedures. Finally, the laboratory should aim at providing service to all physicians, rather than catering to a special group of physicians or surgeons.

Who should be in charge of the vascular laboratory? Those who are not familiar with noninvasive tests or unable to interpret the tests must be banned from running the laboratory. Those who are interested in financial gain rather than in quality of testing are poor persons to direct laboratories. The director, either an M.D., Ph.D., or a vascular technologist, must be well versed in knowledge of vascular problems and in biomedical instrumentation. He or she must have a keen interest in noninvasive testing. Although the day-to-day running of the laboratory and performance of testing is in the hands of the vascular technologist, the director must be responsible for interpretation of tests. Such interpretation of testing is best done with input from the technician doing the examinations. Participation of the technician is essential if quality of laboratory performance is to be improved. This cooperative input provides valuable feedback information, especially on diagnostic accuracy when invasive tests such as arteriograms and venograms are available to compare with the noninvasive tests.

For quality control, it appears that there is a need to maintain a constant surveillance of diagnostic accuracy of each noninvasive test. They must be compared with invasive testing whenever such studies are available for analysis. The review of diagnostic accuracy is essential to improvement of laboratory performance and is of use to referring physicians. Regardless of the type of instruments used, each laboratory must establish its own diagnostic accuracy compared with invasive testing. Such comparative study must be done yearly in order to upgrade diagnostic accuracy

SOCIETY OF NON-INVASIVE VASCULAR TECHNOLOGY

BRUIT

Vol. IV, December 1980

THE ROLE OF THE VASCULAR TECHNOLOGIST

The phenomenal growth of SNIVT is ample evidence of the interest being shown in this emerging field. We should all be proud of this development but at the same time be cognizant of the fact that rapid growth always leads to problems many of which will tax the ingenuity and patience of the membership. Some of these problems are self evident while others are more subtle but no less important to the credibility of the entire field.

The most obvious problem faced by all of us is a lack of acceptance by certain segments of the medical community. These critics, some of whom are prominent, find noninvasive testing as not only unnecessary but wasteful of money, resources and personnel. Those who in general complain the loudest have little or no experience in the field. They will be forced to be quiet or at least tone down their rhetoric only if the leaders in the field maintain their credibility and are willing to also be critical of certain practices that are emerging. Let us examine some of these issues more completely.

The laboratory must be able to provide a useful clinical service of high quality. There is no place for the "total body screen" which has been advocated by some people and actively put into practice. While there may be a time when mass screening could be of benefit, there is no evidence that detecting arterial disease early can, in fact, protect the patient against some future catastrophic event. For example, there has been a steady decline in the mortality from coronary artery disease over the past decade. This has not come about by routine EKG's, other testing or the widespread use of coronary arteriography. It has probably come about by gradual changes in the lifestyle of Americans which include diet, reduction in cigarette smoking, and more efficient control of hypertension. Although the data are not yet in, the same may apply to the problem of peripheral arterial disease and stroke as well.

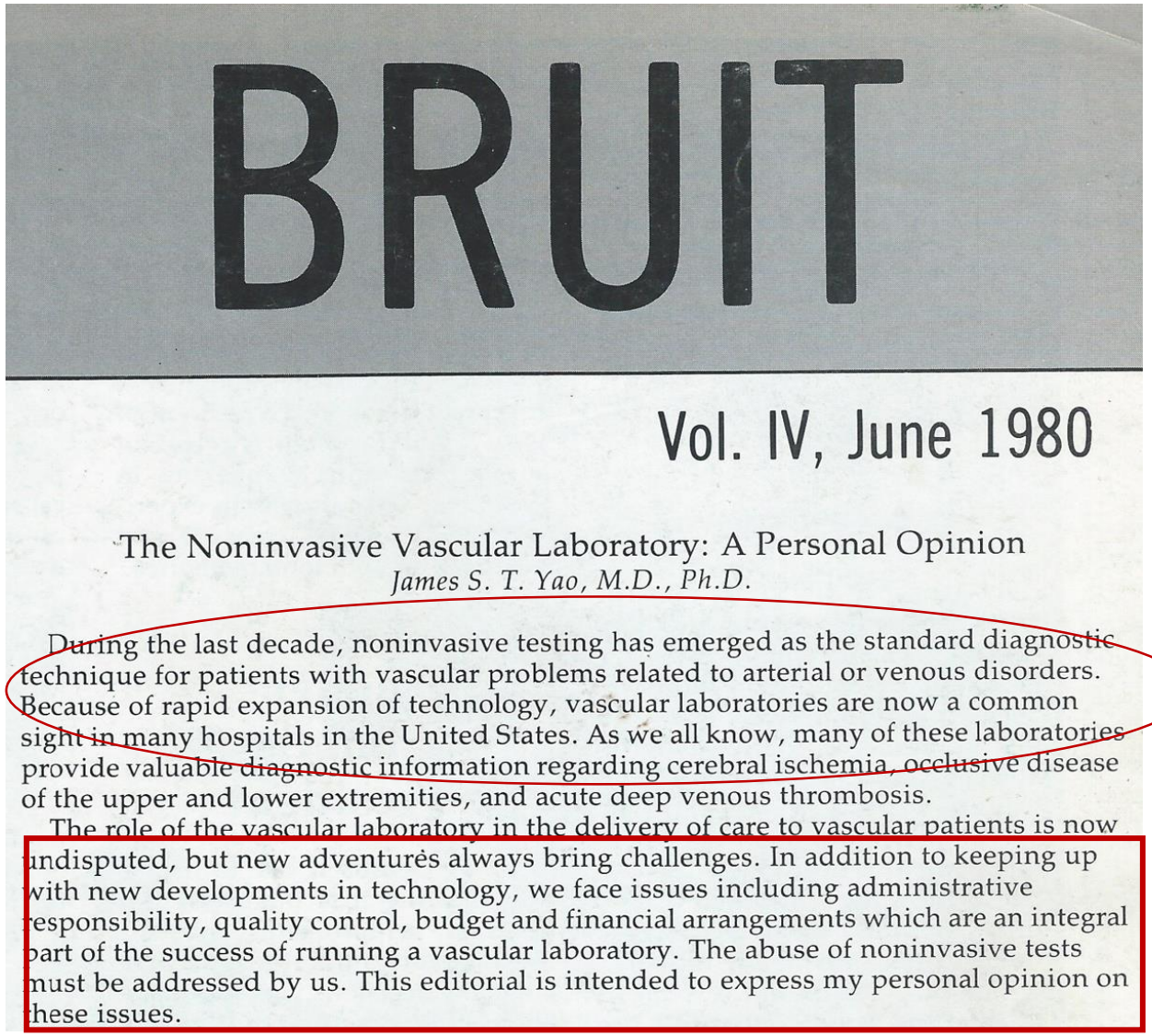
A good vascular laboratory can and should be directed at obtaining accurate clinical data which may be helpful in solving clinical problems. This means by definition that it should be used in a setting where physicians request and utilize the information effectively and efficiently. Numbers accurately obtained which are supplemented by clinical information are always more useful than impressions alone. One only has to do a retrospective review of hospital records to appreciate the problems involved.

The laboratory must not be used to screen or sort out, if you will, patients who will then be subjected to unacceptable forms of therapy. This pernicious practice is already occurring and is, in fact, on the increase. It must be soundly condemned by the leadership and members of SNIVT. This leads to the important question of the role of SNIVT in controlling the practices in the field.

This Society was in large part conceived and organized by technologists. It does not, in fact, take its marching orders from physicians but has usually sought counsel from the leaders in the field with regard to its direction. This trend must continue but be accompanied by a realization of the responsibilities that are involved. You, the membership, will have to make some difficult decisions with regard to the practices which are occurring in this field.

This leads to the important question of the roles of the physician and the technologist in this venture. The technologist is not an "extender" which [illegible]

Evolution of Vascular Testing and the Vascular Ultrasound Professional



BRUIT

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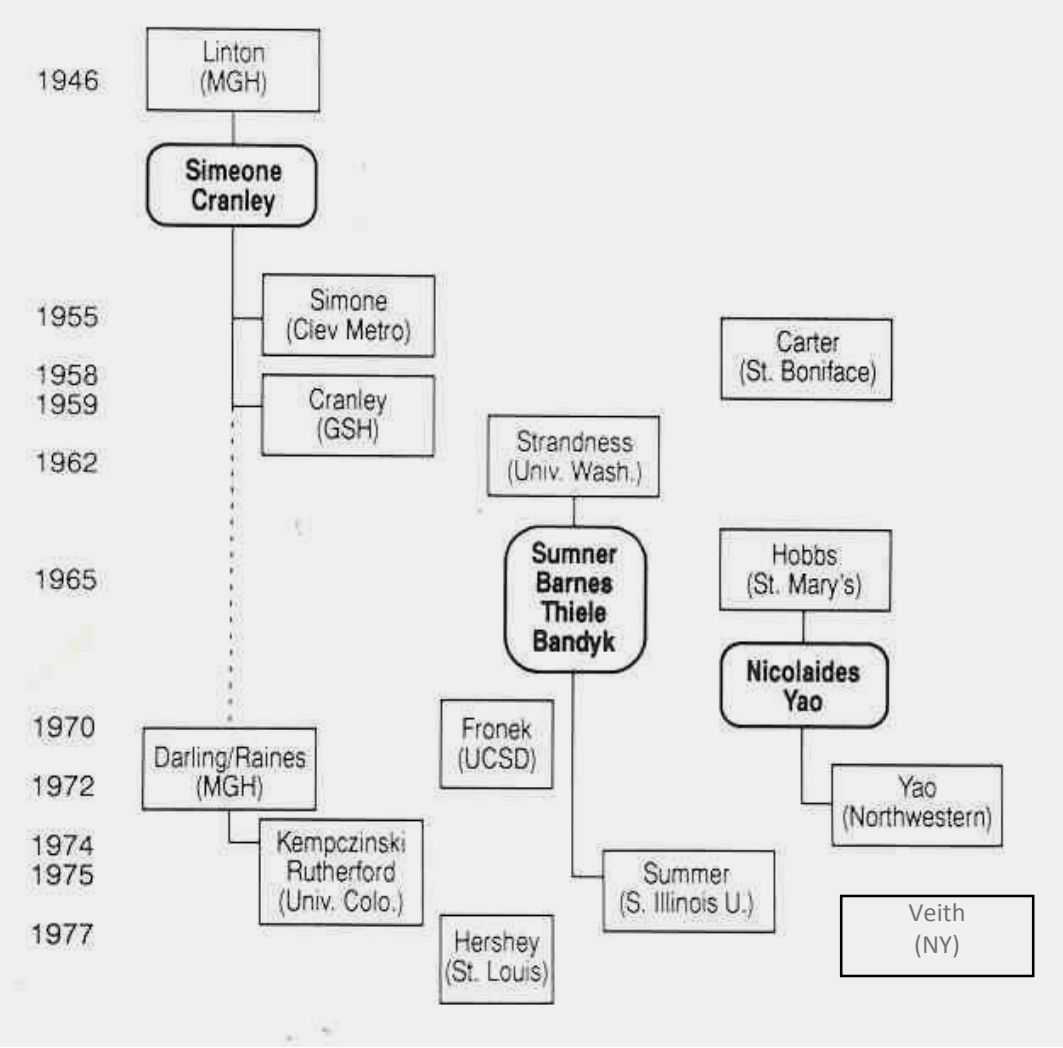
37 years later the Vascular Lab remains the standard for diagnostic evaluation! We have evolved the technology, how we use it and how we look…

Yet we still face many of the same challenges!

Montefiore Experience



Evaluation of graft patency utilizing the ankle-brachial pressure index and ankle pulse volume recording amplitude.

Samson RH, Gupta SK, **Veith FJ**, Scher LA, Ascer E. Am J Surg. 1984 Jun;147(6):786-7.

Inadequacy of the noninvasive hemodynamic evaluation of percutaneous transluminal angioplasty.

Samson RH, Sprayregen S, **Veith FJ**, Gupta SK, Ascer E, Scher LA. Am J Surg. 1984 Feb;147(2):212-5.

Montefiore Experience

Preoperative saphenous venography in arterial reconstructive surgery of the lower extremity. **Veith FJ**, Moss CM, Sprayregen S, Montefusco C. Surgery. 1979 Mar;85(3):253-6.

Preoperative localization of the greater saphenous vein: use of the portable Doppler ultrasound flow detector. Samson R, Gupta S, **Veith FJ**. Arch Surg. 1980 Nov;115(11):1402.

Comparison of duplex ultrasonography and ascending contrast venography in the diagnosis of venous thrombosis. Montefusco-von Kleist CM, Bakal C, Sprayregen S, Rhodes BA, **Veith FJ**. Angiology. 1988 Mar;44(3):169-75.

St. Luke's Sept. 82

Pamela Clauss
930 5th Avenue
New York, NY 10021
Home: 737-1919

OPG, Arterial, Venous, IPG, Spectrum analysis, B-mode, Doppler imaging

Length of experience: 6 years

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Chester NY
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Bus: 914 948-6633

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Home: 212 679-5647

OPG-G Sonicaid B7 381, Buffington cuff,

Length of experience: 2 years

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Length of experience: 5 years

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Roosevelt Hospital
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Barbara Rhodes
Monteflore Hospital
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Bronx NY 10467
Home: 212 777-7075
Bus: 212 920-6603

Medasonics Vascular Lab, Life Science PVR Zira OPG, Arterial, Venous, OPG Penile

Length of experience: 6 years

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*N*E*W*S*L*E*T*T*E*R*
Local New York SNIVT Chapter August, 1982 Vol. I No. 2

NEW YORK LOCAL CHAPTER MEETING

September 23, 1982

St. Luke's Hospital

NEW YORK SNIVT LOCAL CHAPTER MEETING

October 13, 1982

New York University Medical Center

THE BROOKLYN HOSPITAL
121 DeKalb Avenue, Brooklyn, New York 11201

December 27, 1982

To: All members of the New York S.N.I.V.T. Local Chapter Meeting

Re: Our January 22, 1983 meeting at The Brooklyn Hospital, Brooklyn, New York

Dear Member,

As your hosts for the January 22nd meeting, I wish to welcome you to our first meeting of the new year and remind you that it will be held at The Brooklyn Hospital, on January 22, 1983, in Conference Room K-l on the third floor of the main building, at 1:00 p.m.

The main theme of the meeting will be Cerebrovascular Insufficiency and Associated Non-Invasive Laboratory Studies. The program will consist of the following presentations:

Barbara Rhodes --- Pulse Volume Recordings

Debbie Breen --- Venous Pathophysiology

Coffee Break

Dr.Constantin D.Papadopoulos --- Carotid Artery Occlusive Disease and Associated Non-Invasive Vascular Studies

EASTERN SOCIETY FOR THE ADVANCEMENT OF VASCULAR TECHNOLOGY

Volume 1, Number 6 January 31, 1989

*****Chapter Minutes*****

First of all I wish you all a very happy and healthy New Year! After speaking with many of you it seems that it hasn't been too healthy so far for a lot of us. The flu seems to be wiping out a lot of vascular labs including the one here at Montefiore.

The ESAVT meeting held on January 28 was very successful. Over thirty people attended and I was happy to see several physicians attend. From the reviews I received it seems that everyone found the meeting very educational. All attendees will receive 2 CMEs for the meeting.

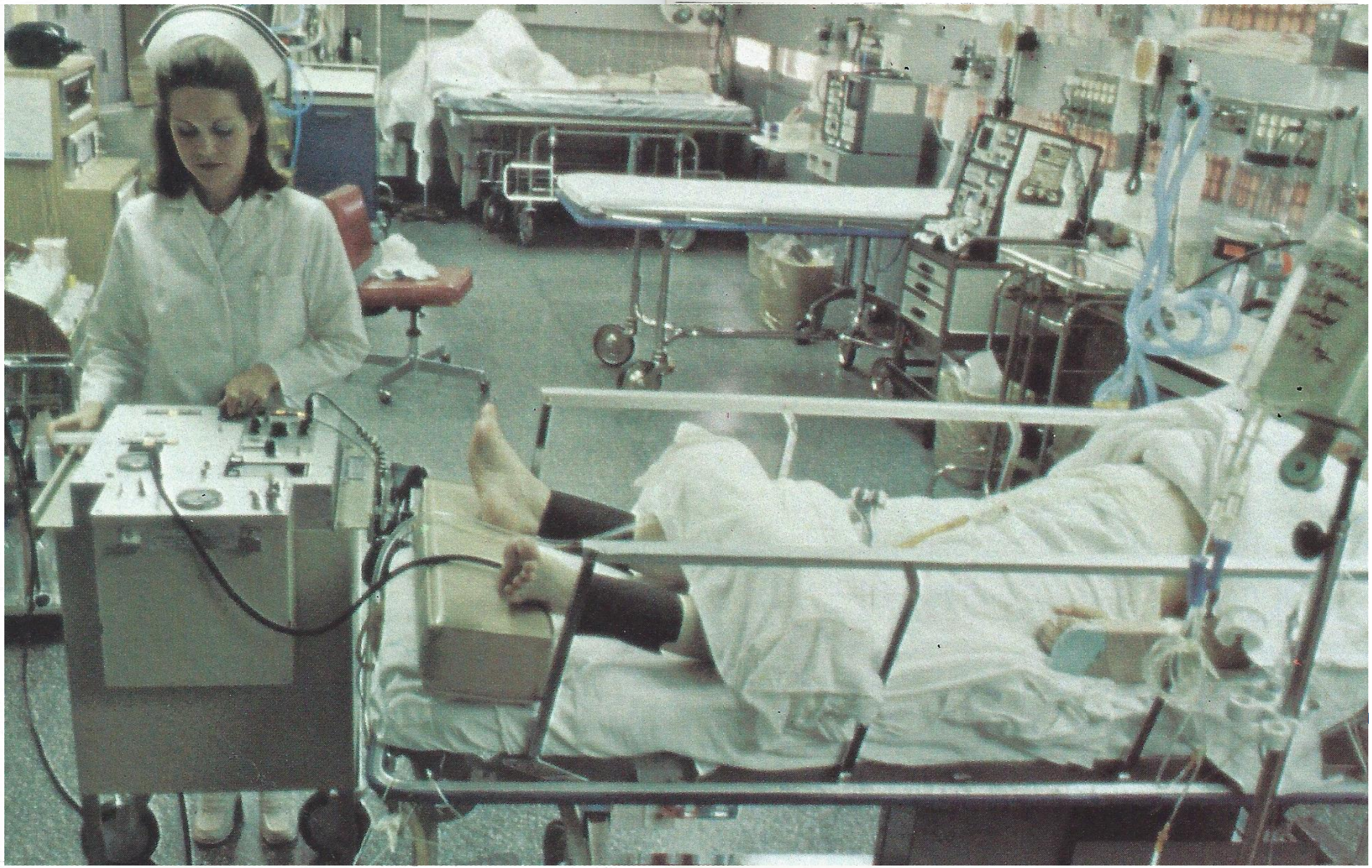
I would like to take this opportunity to thank Drs. Bakal, Dietzek and Montefusco as well as Mr. Naughton for their excellent presentations and for sacrificing part of their weekend in order to impart their knowledge to us. Their efforts were appreciated by all who attended.

I would also like to thank Mr. Naughton of the Kendall Company for providing the splendid lunch for us.

This was the first meeting in which we attempted to approach a topic from different aspects. We tried to cover the anatomy of veins as well as the invasive and noninvasive diagnosis of venous disease. We also covered the treatment and possible prevention of the disease as well. Those in attendance seemed to like this approach so we will try to keep to the same format whenever possible.

I would like to give you a summary of the meeting for those of you who were not able to attend but there was so much information presented that it will take time to put it in a reasonable format for the newsletter. If I can do it, I will.

Tentatively, our next meeting will be in April and will be held at Stony Brook University Hospital. The proposed topic will be on carotid disease. So all of you members from LI will have no excuse not to attend this one! Our host will be Annette Pitzele. I will let you know in the next newsletter the specifics of date, time and place.



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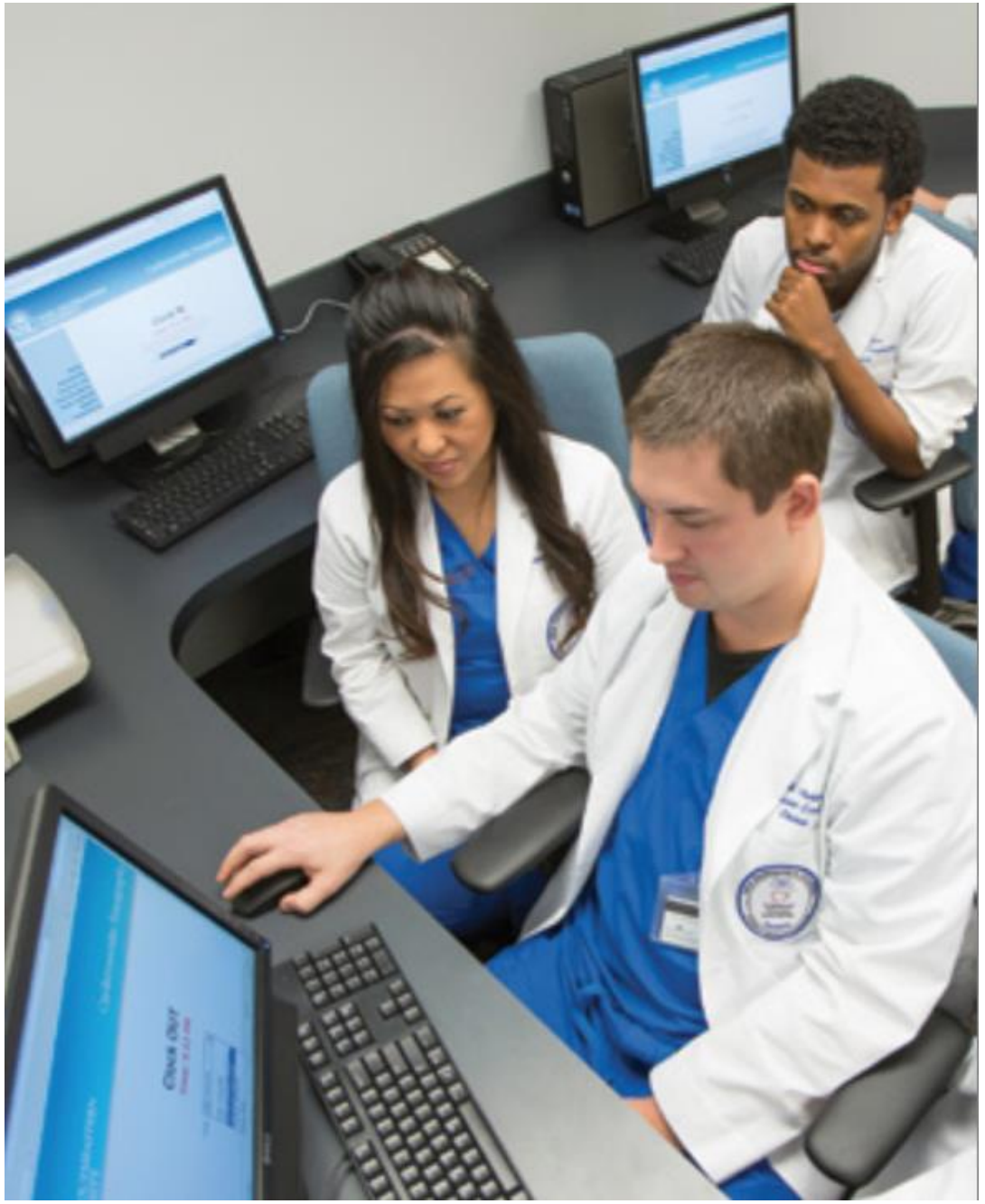
TJU

…also a trend towards the multi-credentialed tech who works in a non dedicated vascular lab



SOCIETY OF NON-INVASIVE VASCULAR TECHNOLOGY
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Last First Middle Title (R.N., M.D.)

Birth Date: ___ ___ ___ Sex: __M __F Soc Sec #: _____ - _____ - _____
Mo Da Yr

Indicate Highest Level of Education:
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B __Some College
C __Diploma Program
D __Assoc Deg
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H __M.D.
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Major Area of Study: _____ Years in Non-Invasive Testing: _____

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- ☐ **Resident/Fellows Membership** $95/yr

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☐ RPhS ☐ RTR ☐ CRT ☐ RRT ☐ PA-C
☐ Other: _____

Highest Degree earned:
☐ High School ☐ Some College
☐ Diploma Program ☐ AS ☐ AA ☐ BS
☐ BA ☐ BSN ☐ MS ☐ MA ☐ MSN
☐ Med ☐ MBA ☐ MD ☐ DO ☐ PhD
☐ ScD ☐ JD ☐ Other: _____

Work setting (check one):
☐ Hospital/Institution
☐ Private Lab/Physician's Office
☐ Equipment Company

Other organizations of which you are a member:
☐ SDMS ☐ SVS ☐ SVM ☐ ASE ☐ ACP
☐ ASN ☐ ACC ☐ SIR ☐ SVN ☐ ACR
☐ ASRT ☐ AIUM ☐ Other: _____

Year you began work in a noninvasive field: _____

Specialty of the Physician Medical Director (check one):
☐ Vascular Surgery ☐ Cardiology
☐ Cardiovascular Surgery
☐ Radiology ☐ Neurology
☐ General Surgery
☐ Other: _____

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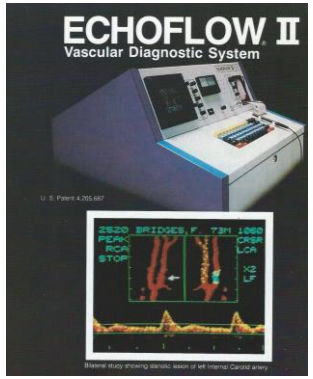
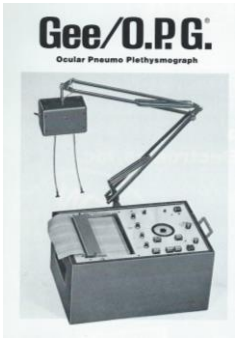
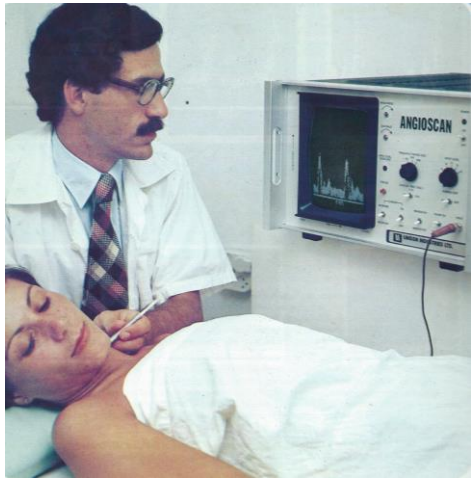
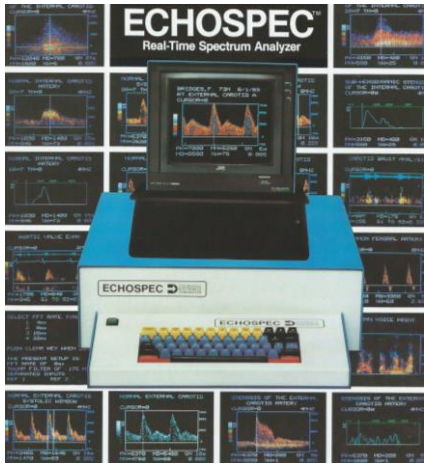


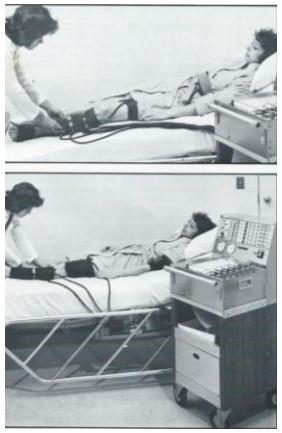


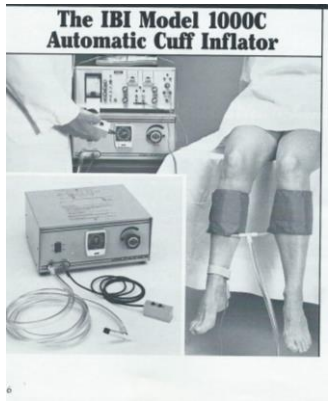
ATL Mk500, 1981

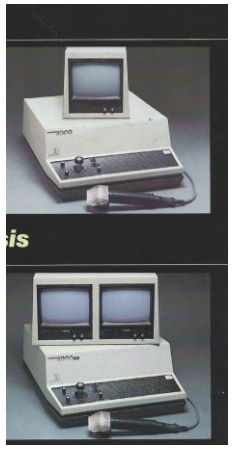
The ATL Mark V marketed in 1978

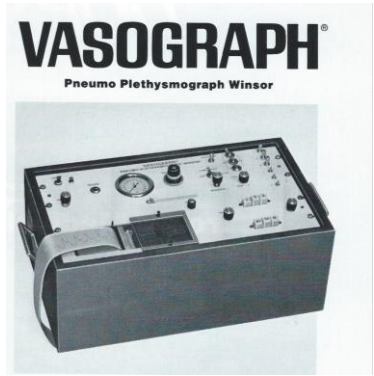












Structural markers of plaque vulnerability and regression

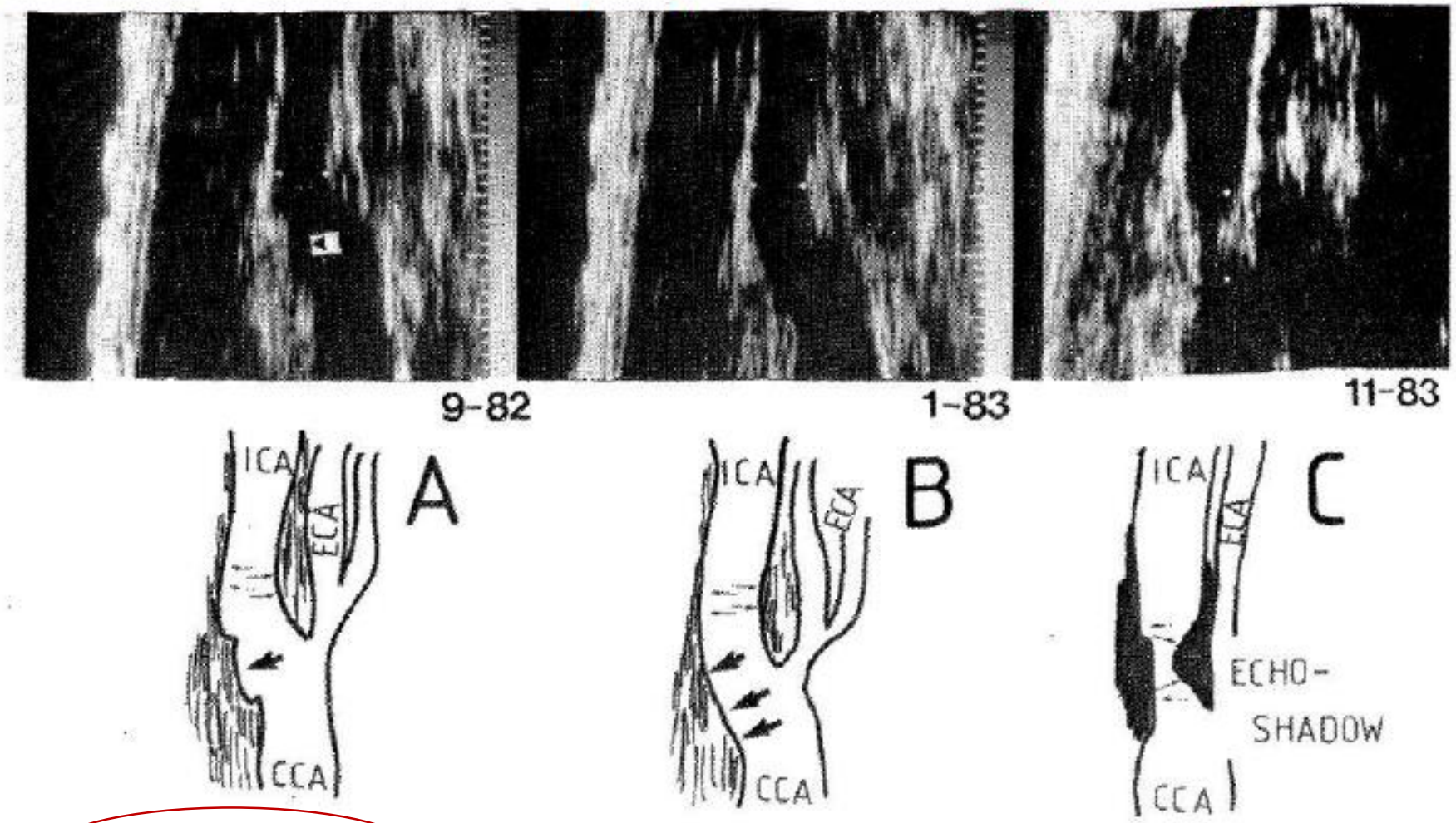
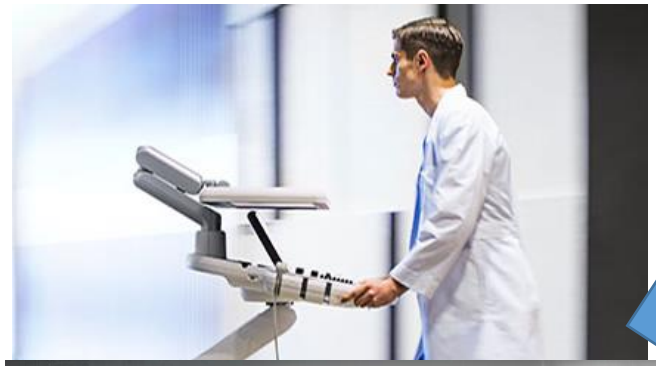


Fig 2—High resolution B-mode images of extracranial carotid system in a 60-year-old man during follow-up.

Initially (September, 1982) there was a soft plaque on the inner wall of the proximal internal carotid artery (ICA) (small arrows) and a small ulcerative crater on the anterior wall of the bifurcation (large arrow). During follow-up (January, 1983) the latter disappeared. Note the similar shadows of the external carotid artery (ECA) indicating identical sections imaged. 14 months later (C) a severe stenosis had been produced by encroachment of the posterior wall plaque and atheromatous degeneration of the anterior wall near the proximal ICA and the distal common carotid artery (CCA).

Hennerici et al. (1985) Lancet 325: 1415-9



I remember asking for smaller machines….and transducers

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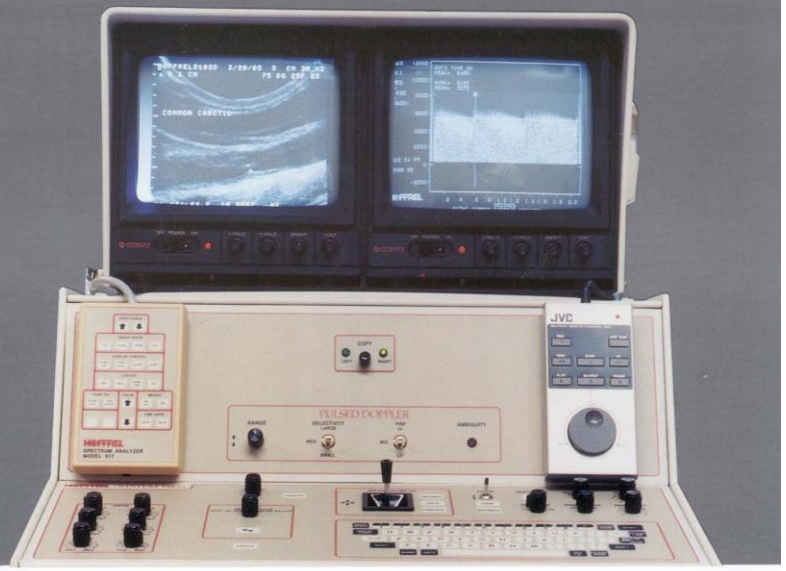
Image To some, high resolution for delineation of plaque boundaries—coupled with receiver sensitivity and wide dynamic range for detection and characterization of plaque content—are the most important image functions of a duplex machine. At Hoffrel, we agree.

Doppler Still others believe that a sophisticated, high signal-to-noise doppler with FFT sound spectrum analysis provides the most reliable, quantitative hemodynamic data possible from a vascular duplex instrument. To this, we also agree.



The Best of Both Worlds

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asking for smaller transducers again…

Carotid Surgery Based On Duplex Alone

The role of duplex scanning and arteriography before carotid endarterectomy: A prospective study

David L. Dawson, MD, R. Eugene Zierler, MD, D. Eugene Strandness, Jr., MD, Alexander W. Clowes, MD, and Ted R. Kohler, MD, *Seattle, Wash.*

Purpose: This study examines the current role of diagnostic tests done before carotid endarterectomy and the need for routine arteriography.
Methods: We prospectively studied vascular surgeons' decision-making over a 29-month period during which 111 carotid arteries in 103 patients were considered for endarterectomy. For each case the surgeon's management plan was recorded after clinical evaluation and review of the duplex scan findings, but before arteriography. This plan was later compared with the patient's ultimate clinical management.
Results: Of 111 total cases in this period, 17 were excluded from analysis because arteriography was not done or it was performed before the surgeon's evaluation. Carotid duplex scans were diagnostic in 87 (93%) of the remaining 94 cases. The carotid lesion was incompletely assessed by duplex scanning in seven patients because the disease was not

Presented at the WVS Annual Meeting January 1993

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SVT 17th Annual Conference
August 3-7, 1994
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Berdejo George
LAST NAME FIRST NAME M.I.

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COLOR FLOW DUPLEX DIRECTED MANUAL OCCLUSION OF IATROGENIC ARTERIO-VENOUS FISTULAS

George Berdejo, BA, RVT, Kurt R. Wengerter, MD, RVT, Michael Marin, MD, and Frank J. Veith, MD., Montefiore Medical Center, Bronx, N.Y.

ABSTRACT

Techniques for the application of color flow duplex directed manual occlusion (CFDMO) of femoral artery false aneurysms (FA) have been well described. Little has been reported on duplex scan evaluation and CFDMO of iatrogenic arterio-venous fistula (IAVF). Over the past 12 months we have performed duplex scans on 70 arterial sites for suspected iatrogenic FA. A patent FA was detected in 13 (18.5%) studies, and an IAVF associated with a FA was found in 2 (2.7%).

CASE 1. A 78 year old male presented with a bruit and thrill over the right CCA after several attempts at cannulation of the IJV. Color duplex evaluation revealed a FA immediately anterior to the CCA. An afferent tract from the CCA to the FA, and an efferent tract to the IJV were demonstrated. The diagnosis of IAVF with an associated FA was made. CFDMO was applied to the afferent tract of the FA, and both the FA and IAVF were successfully thrombosed.

CASE 2. A 75 year old male presented with a pulsatile mass in the left groin and a loud bruit over the external iliac vein 24 hours after cardiac catheterization. Duplex evaluation revealed low resistance flow in the CFA with a pulsatile CFV Doppler spectral waveform; a diagnosis of CFA-CFV fistula was made. The patient underwent repeat cardiac catheterization, and an arteriogram of the affected area confirmed the diagnosis. Repeat scan demonstrated an associated FA, with an afferent tract from the CFA and an efferent tract to the CFV. CFDMO was applied to the afferent tract resulting in successful occlusion of the FA and IAVF.

These two cases demonstrate the effectiveness of color flow duplex scanning for diagnosis of IAVF. Successful thrombosis of the false aneurysm by CFDMO of the afferent tract led to obliteration of the IAVF in both cases, and appears to be a useful option for the treatement of IAVF associated with false aneuysms.

The author affirms that the material herein has not been previously published as a manuscript, presented at any national meeting, or is currently under consideration for presentation or publication. The submitting author also certifies that all authors named in this abstract have agreed to its submission for presentation at the SVT Annual Conference.

Author's Signature _____

Abstract Notification Card

SVT 17th Annual Conference

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☑ **The above abstract has been accepted** for presentation at the SVT 17th Annual Conference, August 3-7, 1994, Orlando, Florida. Manuscripts for the oral and poster abstracts are due by June 27, 1994. More information will be forwarded shortly.

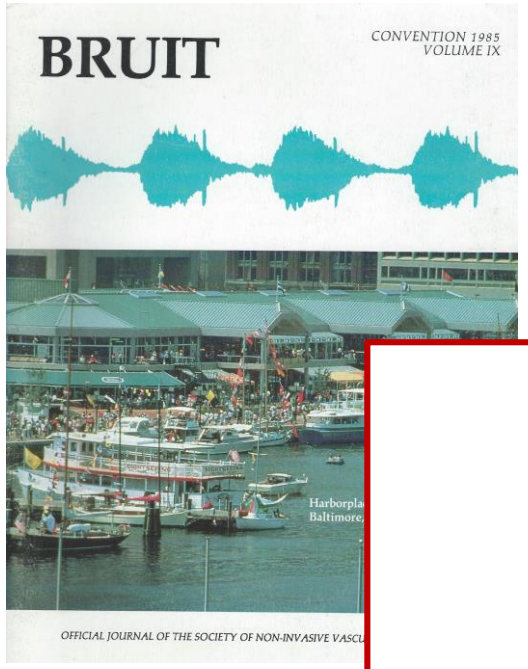
☐ Oral Scientific ☐ Oral Clinical ☑ Poster ☐ Works-in-Progress

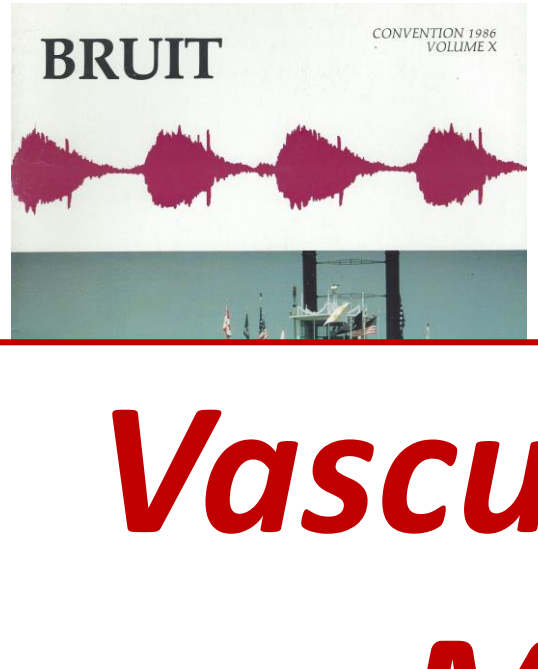
Scientific

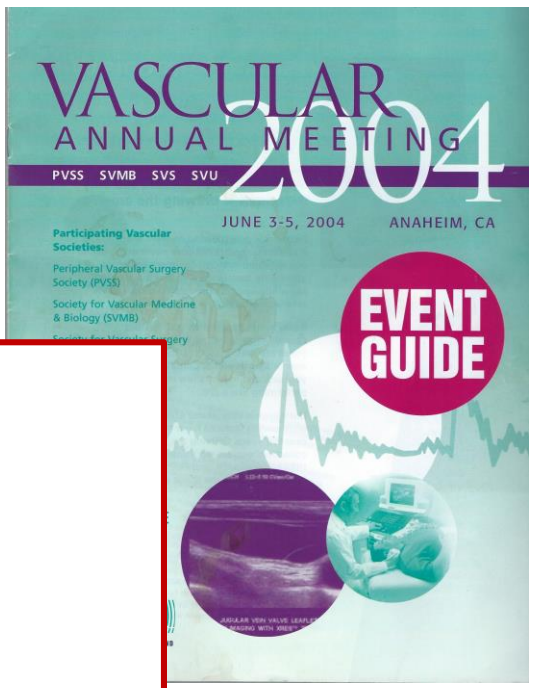
☐ **The above abstract has not been accepted.** Please consider submitting your manuscript to the *Journal of Vascular Technology* for publication.

Thank you for your interest.

Ann Marie Kupinski, MS RVT
Abstracts Chair, SVT Annual Conference







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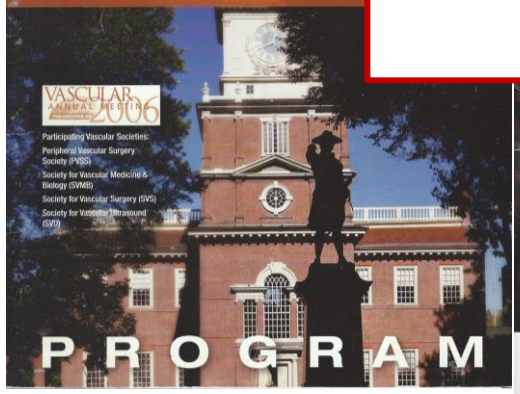
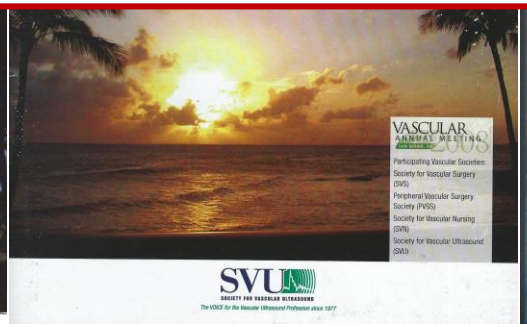
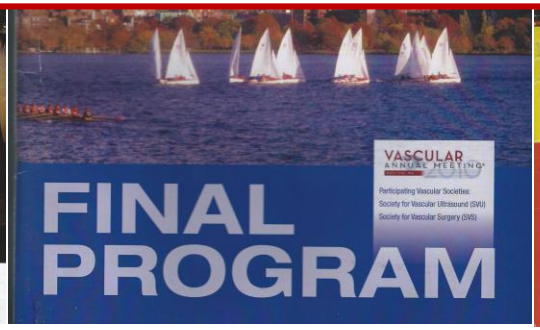
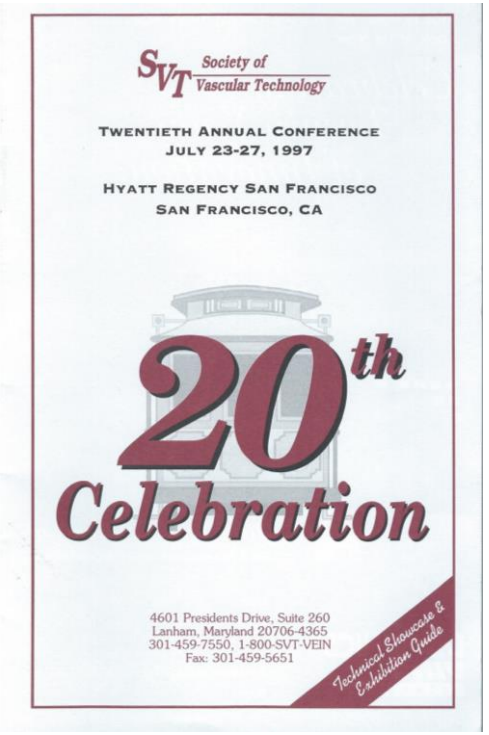
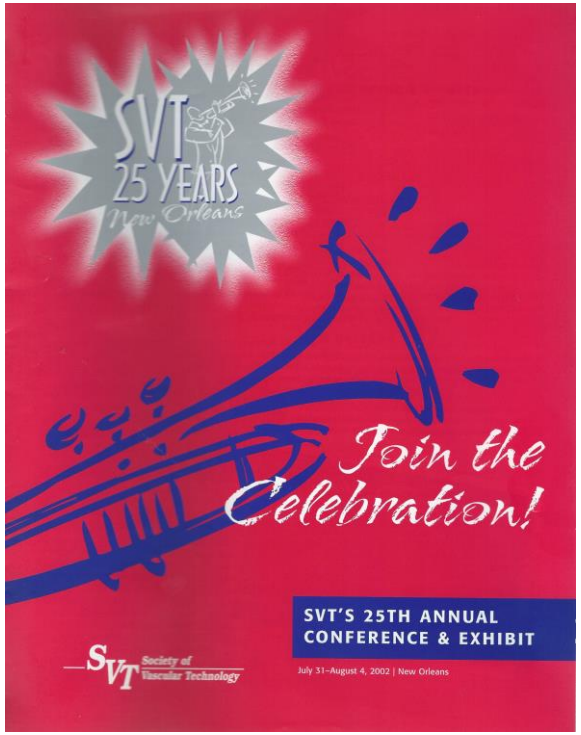
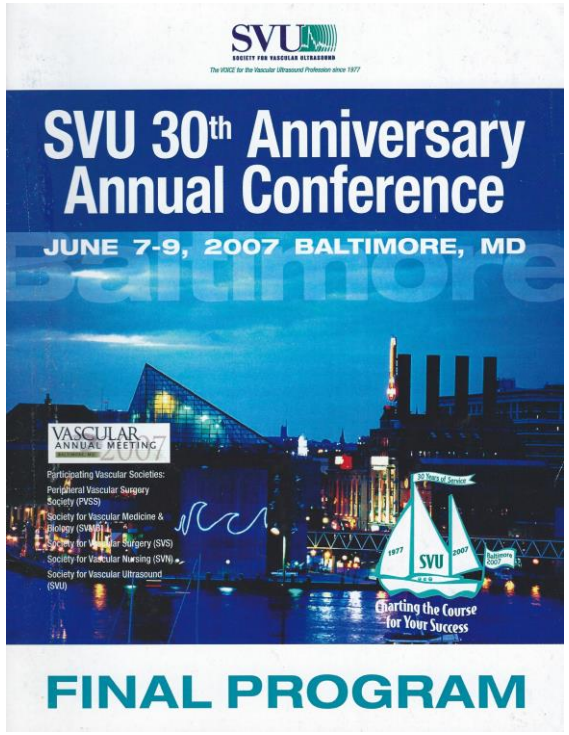


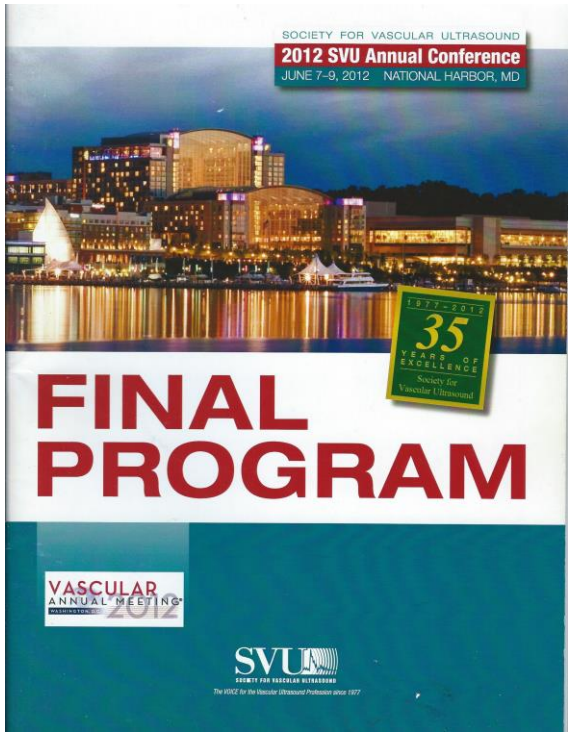


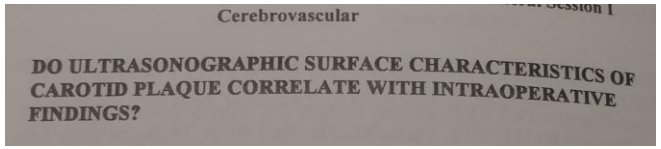




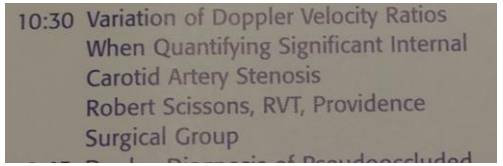




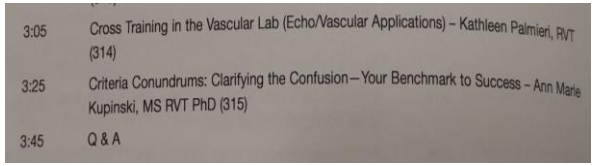




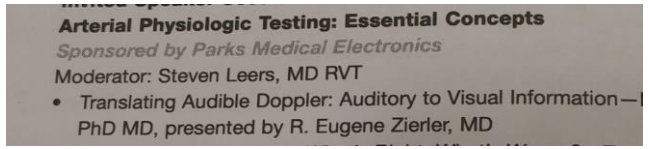
The Role of Duplex Ultrasound in Characterizing Carotid Plaque Risk -- *Timothy Wu, MD*



Intrinsic Spectral Broadening: A Possible Source of Inter-Laboratory Variability on Carotid Doppler Examinations -- *Jean Alessi-Chinetti*



Session 16: Carotid Criteria



Doppler Sounds *Philip Bendick* and *George Berdejo*

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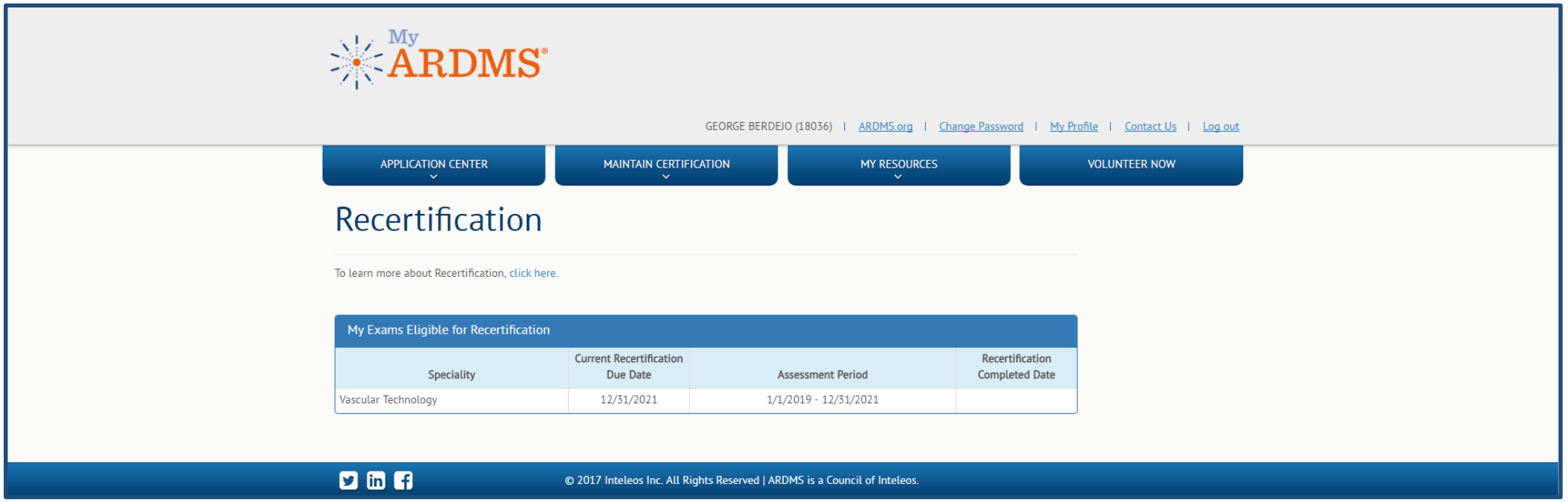

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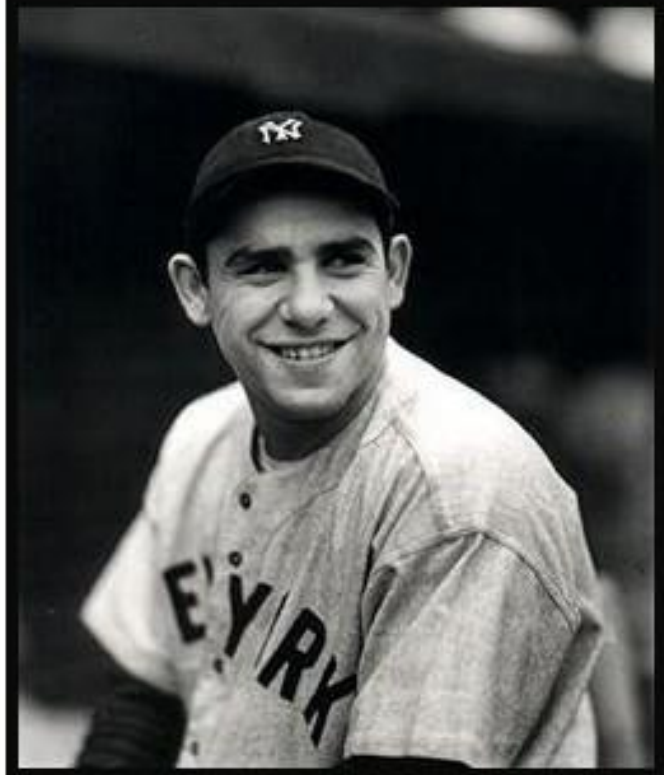

The future ain't what it used to be.

(Yogi Berra)

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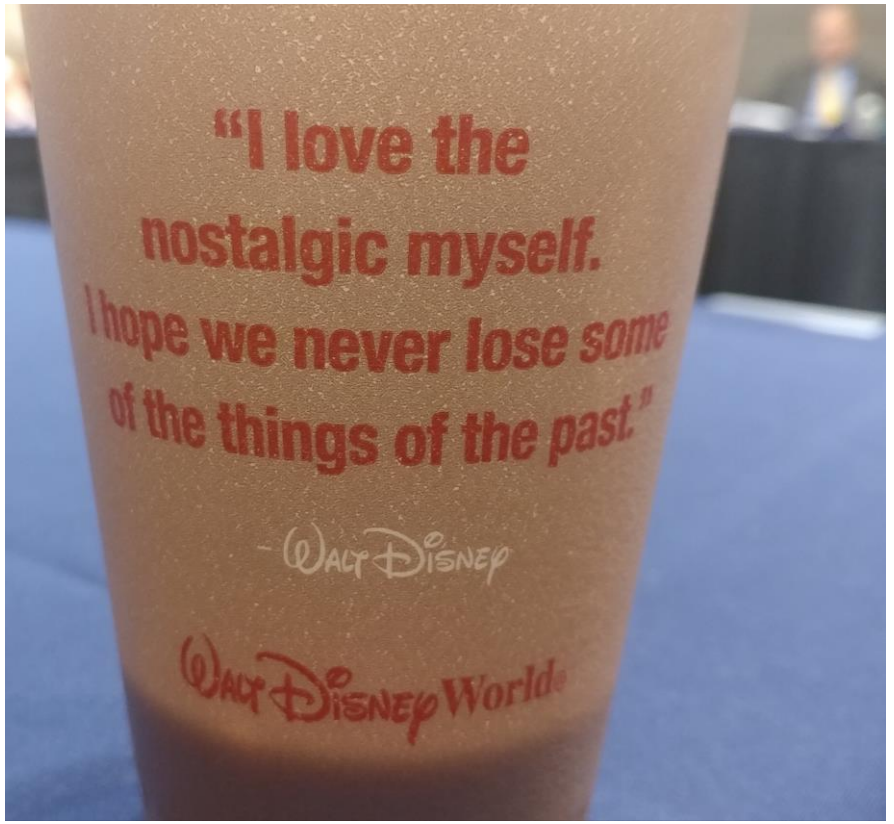

Hope we never evolve away from these attributes but only evolve in how we can do them BETTER!