VASCULAR ART

Advanced **R**evascularization **T**echnologies

Vol. 2 Spring 2026 Inside Vascular Art Conference 2025

VASCULAR ART NEWSLETTER - Vascular Health Community **www.vascularart.com**

Vascular Art

Conference 2025

INNOVATION • COLLABORATION • IMPACT

This year's Vascular Art marked a defining moment in regional vascular education. Featuring a distinguished international faculty and a high-level scientific program, the meeting delivered impactful sessions on complex aortic care, below-the-knee strategies, drug-eluting technologies, and limb salvage.

Jeddah, KSA | November 29–December 1, 2025

Inside this issue

Message from the VASCULAR ART BOARD

Dear Collegues and Friends,

On behalf of the leadership of Vascular Art, it is our distinct pleasure to reflect on the success of Vascular Art 2025. This year's meeting brought together distinguished faculty, dedicated clinicians, and emerging professionals from across the region and internationally, united by a shared commitment to advancing the field of vascular care through collaboration, innovation, and education.

Throughout the scientific program, we witnessed rigorous academic exchange, meaningful discussion, and the sharing of practical expertise that continues to influence contemporary vascular practice. From plenary sessions addressing complex clinical challenges to round table discussion focused on procedural refinement, the level of engagement demonstrated both the depth of knowledge within our community and the collective drive to improve patient outcomes.

Equally significant was the spirit of collaboration that defined this edition of Vascular Art. The diversity of perspectives—spanning institutions, specialties, and healthcare systems—enriched dialogue and strengthened our shared understanding of evolving treatment strategies. Such interaction remains fundamental to advancing standards of care and fostering sustainable professional growth.

We extend our sincere gratitude to our esteemed faculty for their invaluable contributions, to our attendees for their active participation and commitment to learning, and to our sponsors and partners for their continued support. Their collaboration was instrumental in delivering a high-quality and impactful scientific experience. As we look ahead, we remain dedicated to further strengthening Vascular Art as a platform for excellence, innovation, and global exchange within the vascular community.

EVENT AT A GLANCE

3 Days
NOV 29 to DEC 1, 2025

Jeddah, Saudi Arabia
Intercontinentel Hotel

300+
Participants

80+
Speakers and Moderators

10+
Country Presented

30+
Scientific Sessions

Together we advanced innovation and collabration in vascular care

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Scientific Highlights

Key advancements and innovations discussed at Vascular Art Conference 2025, highlighting evolving strategies and real-world clinical practice.

The following themes reflect key discussions across the scientific program, including sessions beyond those featured in this issue.

Aortic Sessions

Precision Over Complexity

- The aortic program moved beyond "can we treat?" to "how precisely can we treat complex anatomy?"
- Expansion of fenestrated and branched EVAR in hostile anatomies
- Increasing reliance on preoperative 3D planning and simulation
- Focus on deployment accuracy and sealing zones rather than device selection alone
- Real-world discussion on complications, bailouts, and durability

Complexity is no longer the barrier — precision is the differentiator.

Venous Sessions

The Hidden Disease Becomes Visible

- Venous disease finally took the space it deserves.
- Recognition of iliac vein obstruction and non-thrombotic lesions
- IVUS as mandatory, not optional, for diagnosis and sizing
- Growing confidence in dedicated venous stents
- Focus on underdiagnosed patients across multiple specialties

Venous pathology is not rare — it is under-recognized.

Carotid Sessions

Patient Selection is Everything

- Rather than debating CAS vs CEA blindly, discussions evolved into:
- Importance of plaque morphology and imaging-based risk stratification
- Identifying which patient benefits from which approach
- Emerging role of TCAR and flow reversal systems
- Emphasis on stroke prevetion strategy, not just intervention technique

The right treatment is not the same for every carotid lesion.

Access & Techniques

The Art Behind the Procedure

- A true "Vascular Art" signature theme.
- Advanced antegrade vs retrograde decision-making
- Creative bailout access strategies in no-option CLTI cases
- Ultrasound and imaging-guided precision access
- Real-life cases showing that access often defines success

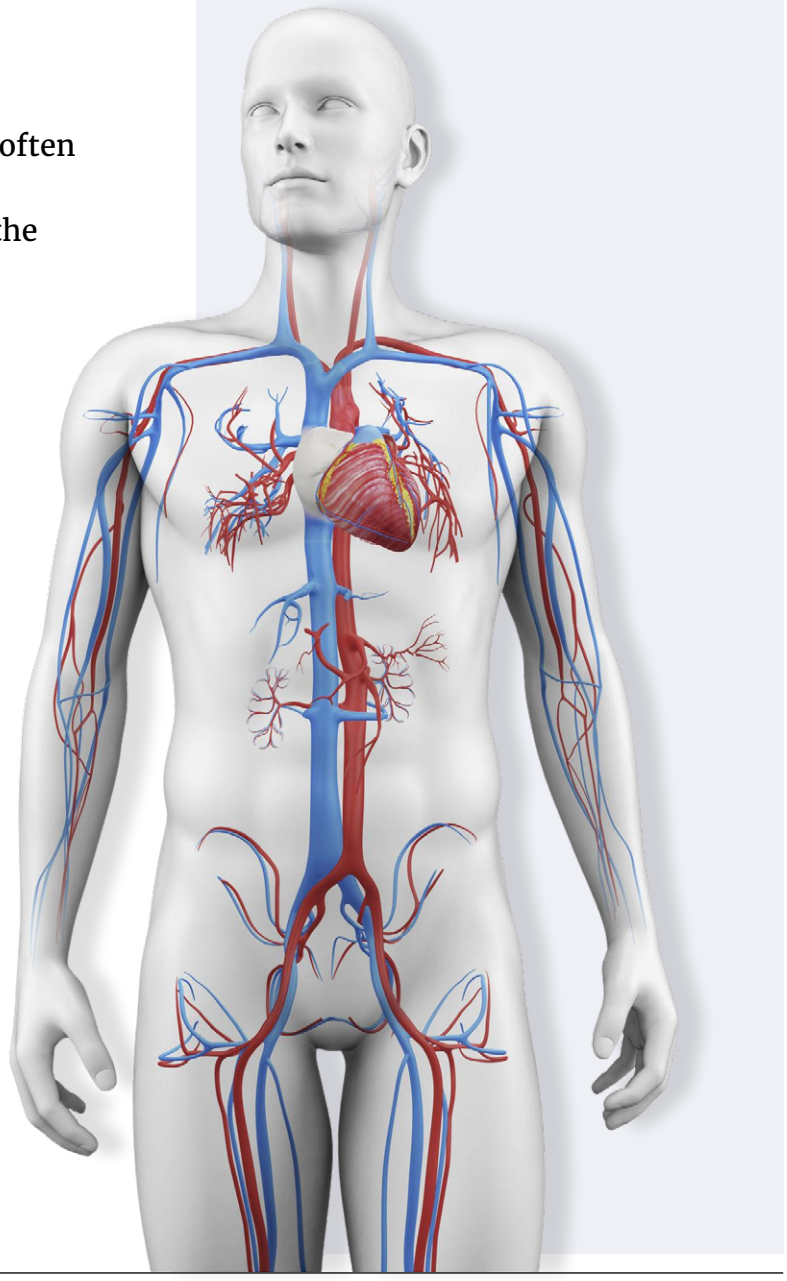
In complex intervention, access is not the beginning — it is the strategy.

Peripheral Sessions

The Reality of BTK & Limb Salvage

- Honest discussions on BTK limitations: recoil, TLR, durability
- Role of vessel preparation (scoring, atherectomy, IVL) before definitive therapy
- Increasing adoption of IVUS-guided BTK interventions
- Strong emphasis on retrograde access and bailout strategies
- Concept shift: maintaining perfusion until wound healing, not just opening vessels success in CLTI is not a procedure — it is a continuous strategy.

The focus is no longer on the device, but on the decision behind it.



Scientific Sessions Overview

From the main stage at Vascular Art 2025

The main scientific sessions formed the core of the Vascular Art program, bringing together leading experts to address the most pressing challenges in contemporary vascular practice. Covering complex aortic repair, limb salvage in advanced diabetic disease, and the evolution of endovascular technologies, these sessions delivered a comprehensive view of where the field stands today, and where it is heading. Through a combination of evidence-based insights, technical expertise, and real-world experience, they highlighted both the progress achieved and the questions that continue to shape future practice.

Aortic Session: Zone 2 Thoracoabdominal Aortic Aneurysm (TAAA)- The Most Unforgiving Landing. How to Get It Right

Presenting remotely, Dr. Vincent delivered a comprehensive presentation on thoracic endovascular aortic repair (TEVAR) with a landing zone in Zone 2 of the aortic arch, focusing particularly on the implications of left subclavian artery (LSA) coverage and the importance of revascularization strategies.

Understanding Zone 2
Zone 2 refers to the segment of the aortic arch just distal to the left common carotid artery and proximal to the left subclavian artery. In 20–50% of TEVAR cases, adequate sealing requires intentional coverage of the LSA.

20-50% of TEVAR needs LSA coverage*

The most common pathologies requiring this approach include:

- Type B aortic dissection
- Traumatic thoracic aortic injury
- Thoracic aneurysms

Why Revascularization Matters:
The presentation emphasized that LSA coverage without revascularization carries significant clinical risks, including:

- Stroke
- Spinal cord ischemia
- Left arm ischemia
- Cardiac ischemia in patients with prior LIMA coronary bypass grafting

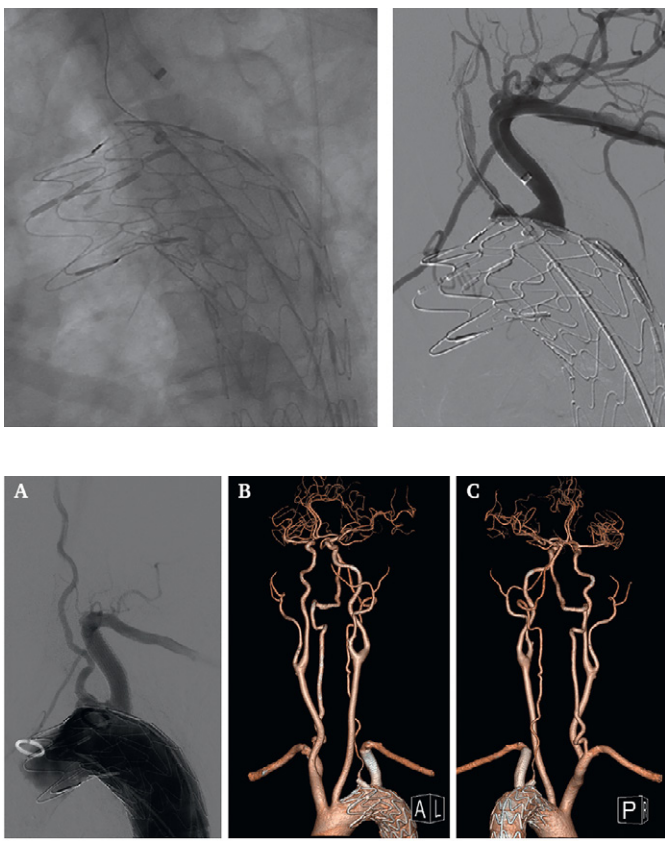
Citing meta-analyses and international guidelines (European and American), Dr. Riambau highlighted that elective revascularization is strongly recommended when LSA coverage is planned, as it significantly reduces neurologic and ischemic complications.

Surgical & Endovascular Options
Dr. Riambau also reviewed multiple revascularization strategies:
1. Carotid–Subclavian Bypass –
The classical and most widely used technique, with high primary patency rates (above 90% at 3–5 years);
complications may include phrenic nerve injury, recurrent nerve injury, lymphatic leakage, and hematoma.
2. Axillary-Based Approaches – Potentially reduced nerve and lymphatic complications, with comparable long-term patency.
3. Vertebral Artery Revascularization – Considered in specific anatomical variants (e.g., vertebral artery originating directly from the arch).
4. In-Situ Fenestration & Needle Techniques – Reported high technical success (approaching 100% in selected series), low stroke and spinal cord ischemia rates, and optimal outcomes when the angle between the subclavian artery and the aorta exceeds 40°.
5. Physician-Modified Stent Grafts (PMEGs) – Increasingly used in urgent and emergent settings, demonstrating high technical success and acceptable mortality considering case complexity.
Cost considerations were also addressed, with combined TEVAR and revascularization procedures averaging between €9,000–€12,000 depending on technique and setting.

GUIDELINE SPOTLIGHT
Elective left subclavian artery revascularization is recommended when Zone 2 coverage is planned, to reduce the risk of stroke, spinal cord ischemia, and upper limb ischemia.

(Guidance from ESVS & SVS)

Key Takeaway: The central message of the presentation was clear: When Zone 2 coverage is required, proactive left subclavian revascularization is not optional, it is a strategy that meaningfully reduces neurologic and ischemic complications and improves long-term outcomes.
Through evidence-based discussion and practical technical insights, the session provided valuable guidance for optimizing patient safety in complex thoracic aortic interventions.



In situ needle fenestration for LSA and LVA
Source: Vincent Riambau, Vascular Art 2025 Presentation

Aortic Session: TEVAR for Penetrating Aortic Ulcers- Which Lesions Require Repair

Hosaam Nasr, Consultant Vascular Surgeon
Ministry of National Guard Health Affairs
Riyadh, KSA.

Dr. Hosaam Nasr presented penetrating aortic ulcer (PAU) as the rarest yet one of the most high-risk entities within the spectrum of acute aortic syndromes. Unlike classic aortic dissection, PAU typically affects an older population with significant atherosclerotic burden and multiple comorbidities. Most lesions occur in the descending thoracic aorta and frequently coexist with intramural hematoma, a combination that further increases the risk of progression and rupture.

Clinically, PAU most often presents with chest pain radiating to the back, persistent hypertension despite medical therapy, or, in advanced cases, hemodynamic instability. Although some lesions are discovered incidentally, Dr. Nasr highlighted that even asymptomatic PAUs are not entirely benign, with a measurable risk of progression—reinforcing the importance of vigilant follow-up.

Intervention is indicated in symptomatic patients who fail optimal medical therapy, as well as in cases complicated by rupture, rapid expansion, pseudoaneurysm formation, or associated aortic dissection. High-risk morphological features on imaging, such as deep or wide ulcers, increasing aortic diameter, or adjacent intramural hematoma, also play a critical role in guiding treatment decisions. CTA remains the cornerstone imaging modality for diagnosis, risk stratification, and surveillance.

For type B PAU with suitable anatomy, TEVAR has emerged as the first-line treatment, demonstrating high technical success rates and favorable outcomes compared to open surgical repair. Open surgery remains reserved for selected cases, particularly when anatomy is unfavorable for endovascular intervention.

Meanwhile, asymptomatic patients without high-risk features can be managed conservatively with strict blood pressure control and a structured imaging surveillance protocol.

Dr. Nasr concluded by emphasizing that, despite growing consensus across guidelines, current management strategies are largely based on retrospective data. He highlighted the need for international registries, standardized definitions, and long-term outcome studies to better define intervention thresholds and fully understand the natural history of this complex and unpredictable disease.

Peripheral Session: Drug-Eluting Technologies Evolving- Paclitaxel Still Taking the Upper Hand

Giovanni Torsello, Director Institute for
Vascular Research - Münster, Germany.

In a thoughtful and balanced review, Professor Giovanni Torsello revisited one of the most debated questions in peripheral arterial disease (PAD): does paclitaxel still hold the upper hand in drug-eluting technology?

For years, paclitaxel was the only drug capable of significantly reducing restenosis after plain balloon angioplasty (PTA) and stent implantation. Early data were compelling. A meta-analysis of paclitaxel-based drug-coated balloon (DCB) studies demonstrated a pooled 24-month target lesion revascularization (TLR) rate of just 17.6% in prospective randomized trials, strong evidence of durable efficacy.

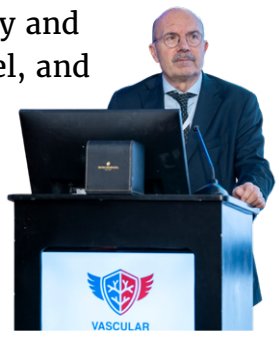
However, the controversy sparked by concerns over potential late mortality signals forced the vascular community to look beyond paclitaxel. This opened the door to sirolimus-based technologies.
Yet sirolimus brought its own challenges: slower drug diffusion and shorter tissue retention compared with paclitaxel.

To overcome these limitations, newer platforms introduced micro-reservoir systems and phospholipid coatings designed to enhance controlled release and improve drug transfer efficiency.

One notable study presented was the SOLUTION SFA Japan trial, an externaly monitored, core-lab adjudicated study involving 134 patients across 13 Japanese centers. The cohort was complex: 60% had diabetes, median vessel diameter was only 5 mm, and nearly half had popliteal involvement. Despite these challenges, outcomes were impressive.

Primary patency reached 87% at 12 months and remained strong at 81.5% at three years. Freedom from reintervention exceeded 90%, accompanied by sustained clinical improvement and ABI gains.

The main limitation? No control group. That gap is now partially addressed by the SERONA trial, a prospective randomized study conducted in Germany and Austria comparing paclitaxel, and sirolimus-based DCBs in 482 patients. At 12 months, primary patency was approximately 74% in both groups, confirming non-inferiority of sirolimus technology, with no safety differences observed. Notably, patency rates were comparable to commonly used paclitaxel platforms such as Lutonix and Luminor—effective, though not class-leading devices.



An important consideration highlighted during the discussion is the variability in device performance across studies and real-world practice. While both paclitaxel- and sirolimus-based technologies demonstrate promising results, outcomes remain influenced by factors such as lesion complexity, vessel size, and device design. Not all platforms perform equally, and differences between commercially available devices must be interpreted carefully when comparing results. This underscores the need for continued head-to-head data, standardized endpoints, and longer-term follow-up to better define the role of each technology in everyday clinical practice.

> **With limus-based technology, we now have a new tool to address restenosis.**
>
> *Giovanni Torsello*

The Takeaway:
Paclitaxel remains a proven and reliable technology. Sirolimus, however, has emerged as a credible alternative, backed by encouraging mid-term data and randomized evidence of non-inferiority.

Whether it will ultimately overtake paclitaxel depends on further studies, long-term outcomes, and real-world adoption. For now, the field is no longer defined by a single drug, but by evolving technology and expanding options for the treatment of PAD.

Peripheral Session: Surgical Management of No-Option Critical Ischemia in Diabetics Real-World Outcome

Luca Dalla Paola, MD, Chairman Diabetic Foot Unit Maria Cecilia Hospital GVM Care & Research Full Professor, Department of Experimental Medicine and Surgery Ferrara University School of Medicine.

In this clinically focused session, Dr. Luca Paola addressed one of the most demanding scenarios in diabetic limb salvage: patients with "no-option" chronic limb-threatening ischemia (CLTI)—where revascularization is not feasible.
Despite major advances in vascular and endovascular therapy, this subgroup remains at exceptionally high risk for major amputation and mortality, often compounded by significant comorbidities.

Diabetic foot disease continues to impose a substantial global burden, with CLTI and infection representing the leading drivers of limb loss. While limb salvage rates in the broader diabetic population exceed 95%, outcomes deteriorate sharply in patients with no-option ischemia. In a cohort of over 1,000 patients, approximately 8% were classified as no-option CLTI, with a one-year amputation-free survival of only 34%, underscoring the severity of this condition.

A key message from Dr. Dalla Paola's presentation was the importance of clinical stratification. Not all no-option cases should be managed the same way. In the presence of progressive infection and severe ischemia, major amputation may be unavoidable. However, in patients with stable ischemia, controlled infection, and limited tissue involvement, a conservative limb-preserving approach can be both justified and effective.

Over the past two decades, the surgical management of diabetic foot disease has undergone a significant transformation.
Modern strategies favor less ablative, more targeted interventions, supported by multidisciplinary care within specialized diabetic foot units. These structured environments, integrating surgical expertise, advanced wound care, imaging, and critical care, play a central role in improving outcomes.

Conventional surgical principles remain essential, including meticulous debridement, localized bone resection (sequestrectomy), and the use of dermal substitutes for wound coverage.
However, in no-option CLTI, these approaches alone are often insufficient. As a result, attention has shifted toward regenerative strategies aimed at enhancing microvascular perfusion and promoting tissue healing.

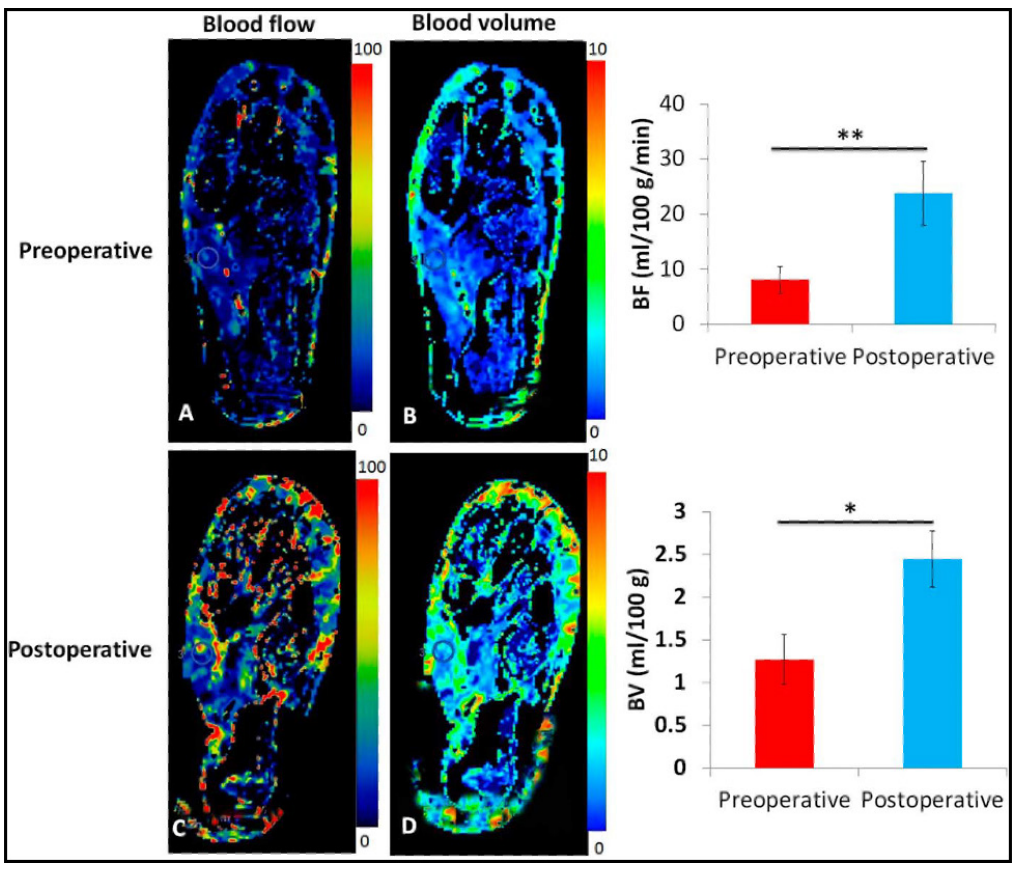
Dr. Dalla Paola highlighted three emerging techniques currently used in selected patients:

- Peripheral Blood Mononuclear Cells (PB-MNCs):

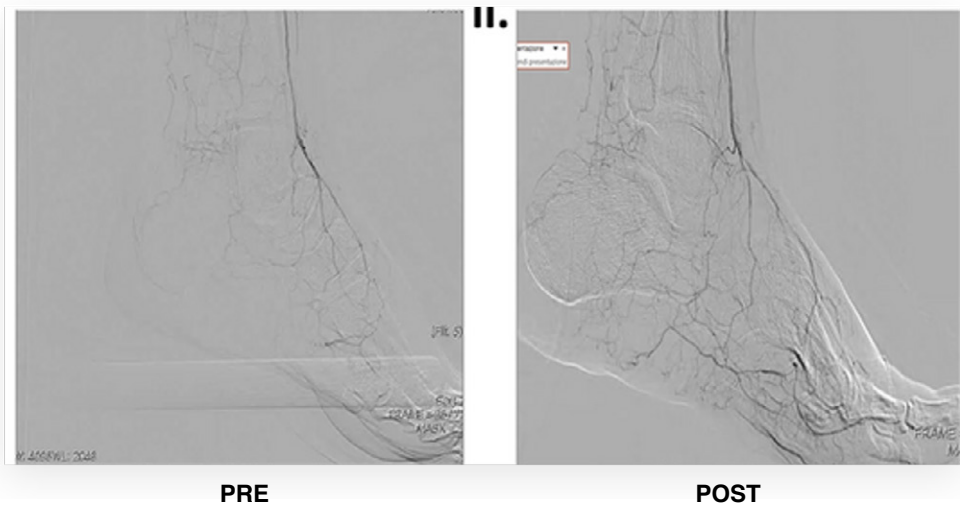
Delivered via local injection, these cells promote angiogenesis through paracrine signaling, modulation of macrophage activity, and the release of extracellular vesicles. Early data suggest improvements in tissue perfusion and amputation-free survival.

- Transverse Tibial Transport (TTT):

Based on the principle of distraction histogenesis, this technique stimulates angiogenic factor release from the bone marrow, leading to improved distal blood flow and enhanced wound healing. Clinical studies and meta-analyses have demonstrated increased perfusion and limb salvage rates.



Perfusion maps demonstrating increased blood flow and tissue perfusion following TTT intervention.
Source: Chen et al., Clin Orthop Relat Res (2020)
presented by Dr. Luca Dalla Paola, Vascular Art 2025



Pre- and post-treatment angiography demonstrating improved distal perfusion following PB-MNC therapy.
Source: Luca Dalla, Vascular Art 2025 presentation

- Micro-Fragmented Adipose Tissue Therapy (MFAT / Lipogems):

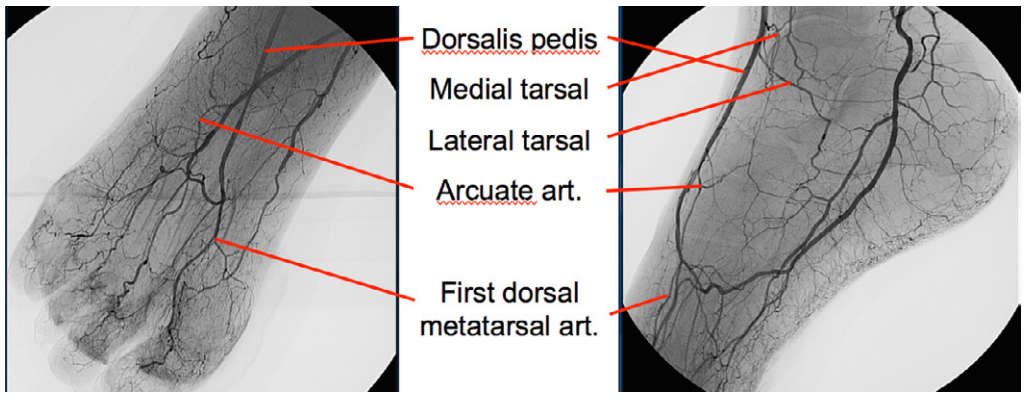
Derived from autologous fat, this approach delivers regenerative cells and growth factors that support neovascularization and tissue repair. It has shown encouraging results, particularly in complex wounds with exposed bone or osteomyelitis.

Clinical experience with these techniques suggests that, when combined with careful patient selection and structured care, they can expand the therapeutic window in patients previously considered beyond salvage. Nevertheless, Dr. Dalla Paola emphasized the need for robust randomized controlled trials to validate these approaches and define their role in standard practice.
In conclusion, while no-option CLTI remains one of the most challenging conditions in vascular and diabetic foot care, it should not be viewed as a definitive endpoint. With evolving surgical strategies, multidisciplinary organization, and the integration of regenerative therapies, there is growing potential to reduce amputation rates and preserve limb function, even in the most complex cases.

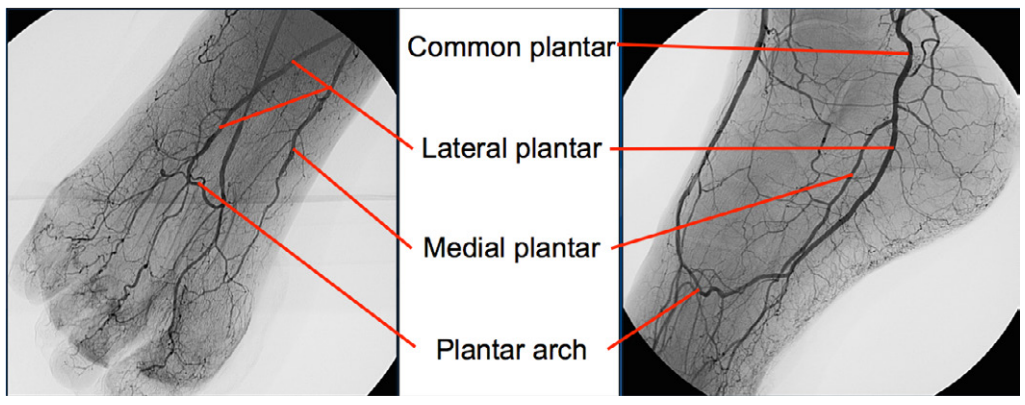
Peripheral Session: How I Navigate Below-the-Ankle Imaging That Actually Helps

August Ysa, Vascular Surgery Consultant, BTK/BTA Unit, Vascular Surgery Dpt. Hospital de Cruces.
Incollaboration with **Marta Lobato,** Vascular and Endovascular Surgeon Hospital Cruces. Barakaldo Bilbao, Basque Country, Spain.

In this highly practical and experience-driven session, August Ysa focused on one of the most challenging aspects of endovascular intervention: navigating below-the-ankle (BTA) vessels in complex disease. His central message was clear from the outset—success begins with a deep and precise understanding of anatomy.



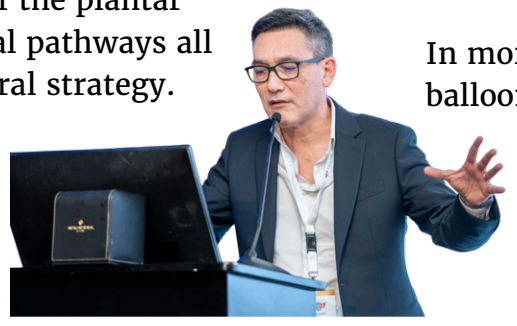
DORSAL circulation



PLANTAR circulation

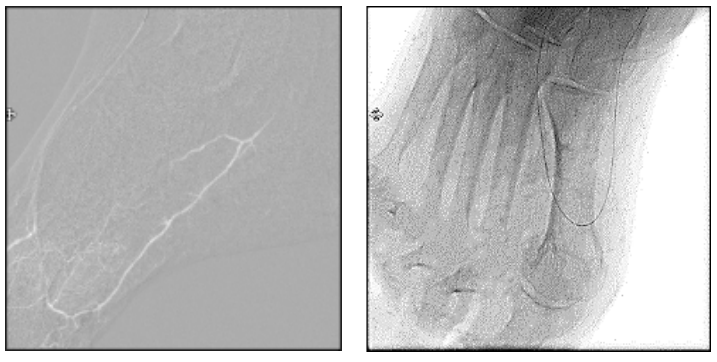
Anatomy of foot arteries.
Courtesy: Dr. Marco Manzi
Source: Adapted from presentation slide by Dr. August Ysa, Vascular Art 2025

Below-the-knee and below-the-ankle interventions are inherently complex due to the wide variability in vascular anatomy. The relationship between the dorsal and plantar circulations, the presence—or absence—of the plantar arch, and the dominance of specific arterial pathways all play a critical role in determining procedural strategy. Without this anatomical awareness, what may initially appear as a straightforward "connect-the-dots" procedure can quickly become unpredictable and unsuccessful.



Ysa emphasized that anatomical variations are not the exception, but the rule. Operators must be familiar not only with standard arterial patterns, but also with less common configurations, including absent dorsalis pedis arteries, dominant medial or lateral plantar systems, and incomplete arches. These variations directly influence both access and revascularization strategies, particularly in patients with chronic limb-threatening ischemia.

A key technical principle highlighted throughout the session was the importance of systematic imaging using at least two angiographic projections. Reliance on a single view can be misleading; structures that resemble a classic plantar loop in one projection may represent entirely different collateral pathways when assessed from another angle.



AP and LAT projections can alter interpretation, revealing different arterial pathways.

Source: by Dr. August Ysa, Vascular Art 2025 Presentation

This reinforces the need for careful interpretation before committing to a specific approach.
Moving beyond fundamentals, Dr. Ysa introduced the concept of "secret passages", alternative pathways that can be used when conventional antegrade crossing fails. Through a series of real-world cases, he demonstrated how these routes can be identified and utilized to successfully navigate complex occlusions.

Among the most valuable of these pathways are deep plantar connections, which link the dorsalis pedis artery to the medial plantar system through the tarsal vessels. In situations where direct access is not possible, these connections can provide an effective retrograde route, allowing operators to re-enter the target vessel and continue the procedure.

Another important strategy involves the junction point at the first metatarsal, where dorsal and plantar circulations converge. This region serves as a critical crossroad, enabling transition between systems and facilitating access to otherwise unreachable segments of the forefoot circulation.

Dr. Ysa also highlighted the role of collateral networks, particularly between the medial and lateral plantar arteries and the dorsalis pedis. These collaterals often become the key to success in complex cases, especially when primary vessels are occluded.
Rather than abandoning the procedure after failed attempts, operators are encouraged to explore these alternative routes systematically and patiently.

In more challenging scenarios, advanced techniques such as balloon-assisted re-entry can be used to "open the gate" and enable wire passage into the desired vessel. These techniques require both technical skill and a thorough understanding of the underlying vascular map, reinforcing the importance of preparation and planning.

Throughout the session, the ultimate goal remained consistent: achieving wound-directed revascularization. By restoring straight-line flow to the affected angiosome, whether through direct or indirect pathways, operators can significantly improve perfusion to the forefoot and enhance clinical outcomes. Final angiographic results often demonstrated what Ysa described as "bridge flow" across the foot, reflecting successful restoration of circulation despite initial complexity.

The session concluded with a set of practical take-home messages that summarize this approach. Operators should begin with a strong anatomical foundation, use imaging strategically, and remain open to alternative pathways when standard techniques fail. Equally important is the use of dedicated devices and refined techniques tailored to the unique challenges of BTA interventions.

Ultimately, Ysa's approach reframes below-the-ankle intervention not as a purely technical challenge, but as a problem of navigation and understanding. When the main road is blocked, success depends on the ability to recognize, and confidently use, the hidden pathways.

Peripheral Session: New Devices for BTA Interventions- From Microcatheters to Tiny Balloons

Michael Lichtenberg, MD Arnsberg/ Germany.

Below-the-ankle (BTA) disease remains one of the most challenging territories in endovascular intervention. Lesions are often long, diffuse, and heavily calcified, with chronic total occlusions frequently encountered. In this complex anatomical setting, restoring inflow alone is rarely sufficient, without adequate pedal outflow, wound healing is significantly compromised.

Dr. Michael Lichtenberg highlighted that BTA intervention is no longer a niche or optional procedure, but a critical component of contemporary limb salvage strategies. As experience grows, the focus is shifting from whether to intervene to how to optimize outcomes. While randomized controlled trials are still lacking, accumulating registry data and meta-analyses support the safety and clinical value of pedal revascularization, reinforcing its expanding role in daily practice.

A central technical challenge in BTA procedures is visualization. Even with modern angiography, the pedal arch can be difficult to interpret, limiting procedural precision. Suboptimal imaging may lead to incomplete revascularization or missed target vessels. To address this, new imaging technologies such as Digital Variance Angiography (DVA) have been introduced. By applying advanced algorithms to standard angiographic sequences, DVA enhances vessel visibility and allows clearer delineation of distal arterial pathways, even with reduced contrast use. This improvement in visualization has the potential to directly impact procedural success and operator confidence.

Alongside imaging advancements, device innovation is reshaping the treatment landscape. Traditional plain old balloon angioplasty (POBA) has well-recognized limitations in the pedal circulation, including vessel trauma, dissection, elastic recoil, and high restenosis rates. These shortcomings have driven the development of specialty balloons and plaque-modifying technologies designed to deliver more controlled and predictable lumen expansion, particularly in calcified vessels.

Dedicated scoring balloons, for example, allow focused force application to modify plaque while minimizing vessel injury. In parallel, adjunctive techniques such as intraluminal calcification cracking using a simple needle remain valuable, underscoring that effective BTA intervention relies on both advanced technology and refined procedural strategy. The growing range of available tools requires careful selection based on lesion characteristics, vessel size, and overall treatment goals.

Early clinical experience with these evolving approaches is encouraging. Reports demonstrate high rates of limb preservation, low complication rates, and meaningful improvements in patient clinical status following intervention. These findings support the concept that successful pedal revascularization plays a pivotal role in improving outcomes for patients with advanced limb ischemia.

Despite these advances, an important gap remains. The lack of direct comparative trials between devices and techniques limits the ability to define optimal treatment strategies. Future research will be essential to establish evidence-based guidance and determine which technologies provide the greatest long-term benefit.

Early clinical outcomes of specialty balloon use in below-the-ankle interventions.
Source: Adapted from presentation by Dr. Michael Lichtenberg, Vascular Art 2025.

Peripheral Session: Managing Popliteal Aneurysm Can Be Made Easy- Do It All in Prone

Mohammad Algarni, Consultant Vascular/ Endovascular Surgeon, King Abdullah Medical City, Makkah/ Saudi Arabia.

In this focused and practical session, Dr. Algarni addressed the management of popliteal artery aneurysms, the most common peripheral aneurysms after abdominal aortic aneurysms. Despite their relative rarity, these lesions are clinically significant, often affecting male patients and frequently presenting without symptoms—making timely recognition and appropriate intervention essential.Drawing on the 2022 Society for Vascular Surgery guidelines, he noted that repair is generally recommended once the aneurysm reaches 20 mm, or at any size in the presence of compressive symptoms.

Selected smaller aneurysms may also require treatment, particularly when intraluminal thrombus increases the risk of distal embolization. However, aneurysm size alone is not a reliable predictor of complications, reinforcing the need for individualized decision-making.

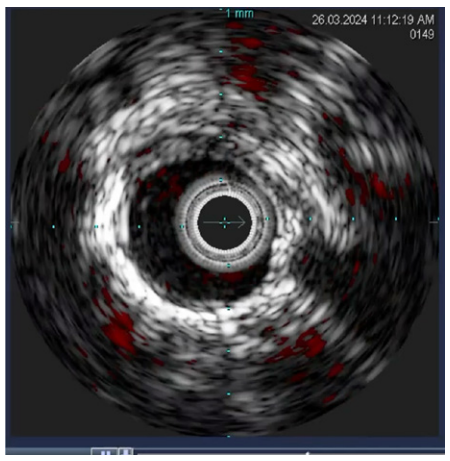
A central theme of the discussion was timing. Unlike aortic aneurysms, rupture is not the primary concern—thromboembolic events are. As such, elective intervention, guided by anatomy and patient risk profile, consistently leads to better outcomes than delayed treatment in symptomatic or high-risk cases.
Addressing technique, Dr. Algarni highlighted that both open and endovascular approaches have a role. Recent data suggest comparable early and long-term outcomes, with open repair offering slightly better primary patency, while endovascular repair is associated with higher reintervention rates. The choice of surgical approach remains largely anatomical: medial access is preferred for smaller or more extensive aneurysms, whereas the posterior approach is particularly effective for larger aneurysms confined to the popliteal fossa.
He also explored the evolving role of endoscopic vein harvest (EVH), which has demonstrated favorable outcomes, including shorter hospital stays and durable graft performance. However, its success depends heavily on operator experience and technical familiarity.
The session concluded with a real-world case of a young patient presenting with compressive symptoms, successfully managed with a posterior open repair using a native vein graft and endoscopic harvest. The outcome highlighted the benefits of precise planning and technique, with rapid recovery and early discharge.
Takeaway:
Effective management of popliteal artery aneurysms depends less on size alone and more on timing, anatomy, and thoughtful selection of technique—where tailored intervention consistently leads to optimal outcomes.

Peripheral Session: Device Limitations in Tiny Vessels- What Works and What Still Fails

Tania Guzman, MD, MPhil, FEBVS, Consultant Vascular and Endovascular Surgeon, Adjunt Clincial Associate Professor GMU, SSMC, Abu Dhabi, UAE.

Treating below-the-knee (BTK) disease remains one of the most challenging areas in endovascular intervention. As Dr. Tania Saez Guzman highlighted, operators are working in extremely small, non-elastic, and often heavily calcified vessels, where even minor trauma can compromise outcomes. Success, therefore, depends not only on technical skill, but on careful, patient-specific decision-making. Despite the growing number of available devices and techniques, comparative evidence—particularly for long-term outcomes—remains limited, leaving physicians to navigate multiple options influenced by lesion morphology, runoff, outflow, and even practical factors such as device availability and cost.

A key limitation in current practice is the continued reliance on plain balloon angioplasty (POBA). In BTK vessels, POBA alone is frequently insufficient, as it is associated with dissection, elastic recoil, and restenosis. These challenges are amplified in small, calcified arteries, where drug delivery is often suboptimal—ultimately leading to poor durability and increased risk of limb loss.



In contrast, several strategies are emerging as more effective. Intravascular ultrasound (IVUS) is increasingly recognized as essential for BTK imaging, offering more accurate vessel sizing, better characterization of plaque morphology, and improved detection of dissections that are often underestimated on angiography.

Intravascular ultrasound (IVUS) enables accurate vessel sizing and detection of dissections often missed on angiography.
Source: Presentation by Dr. Tania Saez Guzman, Vascular Art 2025

This allows for more precise device selection and safer intervention.

Calcium modification techniques also play a central role. Intravascular lithotripsy provides a user-friendly and effective method to improve vessel compliance, even in complex lesions. Atherectomy approaches, particularly orbital and laser, can be valuable in selected cases, such as fibrotic plaques or in-stent restenosis, though they require expertise and may not be widely available.

In addition, specialty balloons and temporary scaffolding strategies are gaining attention. These technologies aim to achieve controlled dilation, reduce recoil, and enhance drug delivery. Drug-reabsorbable scaffolds, in particular, offer a promising concept by combining mechanical support with drug therapy while avoiding the long-term limitations of permanent implants. Early data suggest encouraging patency and healing outcomes, especially in complex or recurrent lesions.

However, not all approaches are equally effective. Permanent metal stents below the knee remain limited by fracture risk, restenosis, and the restriction they impose on future interventions. Similarly, some atherectomy devices may carry higher risks of embolization, perforation, or dissection in very small vessels.

Ultimately, BTK intervention is shifting toward a philosophy of precision over force. Rather than relying on a single technique, optimal outcomes require a tailored approach—integrating advanced imaging, appropriate lesion preparation, and thoughtful device selection. In these millimeter-sized arteries, every decision has a direct impact on limb preservation and patient outcomes.

Aortic Session: Renal Stents in FB-EVAR- Dissection, Occlusion, or Patency

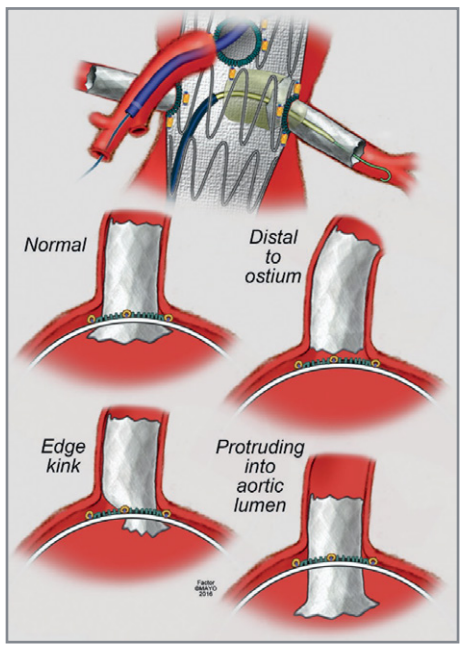
Sherif Kerdawi, Head of Vascular & Endovascular surgery department Helwan university-wadielnil hospital, general secretary of the Egyption Vascular & Endovascular Society

Renal branch complications after fenestrated and branched EVAR (F/BEVAR) are uncommon—but when they occur, they can be serious and clinically challenging. As complex repairs using off-the-shelf devices and physician-modified endografts (PMEG) become more routine, operators are increasingly required to manage multiple renal bridging stents, making precise preoperative planning and intraoperative control essential.
Dr. Sherif Kerdawi emphasized that success depends on choosing the right strategy, fenestration or branch—based on individual anatomy and flow dynamics. Renal arteries vary widely in length, angulation, and origin, requiring careful cannulation, appropriate stent positioning, and controlled flaring techniques to maintain stability and avoid dissection, kinking, or occlusion. Even small technical missteps during deployment can significantly impact long-term outcomes and increase the likelihood of reintervention.

Imaging remains a cornerstone throughout the entire process, from planning to execution and follow-up. Advanced imaging allows for better alignment and safer deployment, guiding operators in navigating complex anatomies and optimizing stent positioning. Most complications, ranging from early occlusion and kinking to later stenosis, migration, or even fracture are still largely linked to insufficient respect for native anatomy and hemodynamics.

With proper technique, thoughtful device selection, and a strong understanding of anatomical variability, renal patency after F/BEVAR remains high, while reintervention rates stay relatively low.

Continued advancements in devices and imaging technologies are further improving outcomes and expanding the applicability of these techniques. These results reinforce F/BEVAR as a reliable and evolving solution in the management of complex aortic pathology.



Bridging Stent Leaflet should be flared in 2/3 mm within Aorta
Source: Sherif Kerdawi, Vascular Art 2025 presentation.

PERIPHERAL

Vascular Art Theater

Act I Overview

Where Practice Meets Creativity
Introduced for the first time at Vascular Art 2025, the Vascular Art Theater focuses on real-world complex cases where guidelines fall short, highlighting the need for creativity, adaptability, and problem-solving in the angio suite.
Because in the most difficult moments, vascular intervention becomes not just science, but art.

Session Focus: ACT I: The Day I Had to Invent My Own Tool - When the Right Kit Wasn't There – But Creativity Was
Host: Dr. Ahmed Sakr, Vascular Art Vice President
Presenter: Dr. Bruno Migliara, MD PhD, Chief of Vascular & Endovascular -Pederzoli Hospital Italy

The Vascular Art Theater opened with a different kind of conversation, one that moves beyond guidelines, beyond IFUs, and into the reality of the angio suite.

Dr. Sakr opened the session by setting the tone:
"*Today is not about textbooks.*
This is about that moment when everything stops working... when the lesion is staring at you, and nothing in your tray can solve the problem."

It is a moment every interventionist knows well, the case that refuses to follow the rules. The moment when technique is no longer enough, and creativity becomes the only way forward.

There was no better person to explore this battlefield than Dr. Bruno Migliara.

A REAL-LIFE CHALLENGE
When Everything Has Already Failed.

Dr. Bruno presented a complex CLTI case, an emergency "foot attack" in a patient with advanced ischemia, renal impairment, and cardiac disease.
The situation was further complicated by a history of multiple failed bypasses—two above-knee and one below-knee—all occluded.

Imaging revealed the full extent of the challenge:
-Complete occlusion of the profunda
-Occluded SFA
-Failed bypass grafts
-Occluded popliteal segment
-Severely compromised tibial outflow
In short, a limb with almost no viable inflow.

Dr. Bruno:
"*The first decision, is always how to prioritize—ischemia, infection, or surgery.*"

In his practice, the approach is clear: aggressive foot surgery first to control infection, followed by revascularization.

THE TURNING POINT:
When the Plan Fails.

The initial strategy was logical—reopen the native vessels.
Dr. Bruno successfully recanalized the profunda to improve collateral flow, then proceeded with subintimal recanalization of the SFA. But at the level of Hunter's canal, the wire stopped.

Dr. Bruno:
"*No matter what I tried, I couldn't cross.*"

At that moment,
the case changed.

Inventing a Solution: Endovenous Bypass

Dr. Sakr asked directly:
"*Was there any moment you thought about aborting the procedure?*"

Dr. Bruno responded:
"*From the beginning—no. But at that point, I paused. I needed to rethink everything.*"

Instead of abandoning the case, he moved into innovation. Using a re-entry device, he created a connection from the SFA into the femoral vein, essentially building a percutaneous endovenous bypass.
When direct crossing failed again distally, he approached retrograde through the anterior tibial artery, re-entered the venous system, and ultimately connected both paths.

The final construct was completed with a covered stent bridging artery to vein and-back to artery—restoring flow to the foot.

OUTCOME:
From No Option to Limb Salvage

The result was striking.
Flow was restored.
Perfusion improved.

The wound, managed with adjunctive therapies, progressed toward healing.
At six months, duplex confirmed continued patency—with no evidence of deep vein thrombosis.

REFLECTION:
Would You Do It Again?

Dr. Sakr followed with the next question:
"*If you face the same situation tomorrow, would you do the same?*"

Dr. Bruno replied:
"*Yes, this is not a first-choice technique—but in extreme cases, it becomes a solution.*"

He emphasized that this approach is not meant to replace standard strategies, but to serve as a last-resort option when all conventional pathways fail.

THE LESSON THAT MATTERS
Dr. Sakr then asked for one key takeaway from the case.

Dr. Bruno:
"*When we perform open surgery, we must think about the future. We must respect the artery—not only for today, but for the possibility that endovascular options may be needed later.*"

BEYOND GUIDELINES:
The Core of Our Practice

Dr. Sakr concluded the session by reflecting on the broader message.
He emphasized that all interventionists face moments in the angio suite where no clear solution exists—when no available device can achieve the intended goal. In those situations, success depends on the ability to think beyond protocols and adapt in real time.

This, he highlighted, is the essence of vascular intervention:
Not only guidelines.
Not only devices.
But the ability to think differently when everything else fails.
Because sometimes, the best tool... is the one you create.

Round Table Discussion

PERIPHERAL

At Vascular ART 2025, the Round Table Discussion Program stood out for its interactive, practice-driven format, bringing together international experts and attendees for open, face-to-face dialogue.Focused on complex and often controversial topics—such as deep venous arterialization, venous stenting limits, open versus endovascular conversion, and timing in acute aortic syndromes—these sessions went beyond guidelines to explore real-world decision-making.
Designed for active participation, the discussions encouraged critical thinking, exchange of experience, and direct engagement with faculty, creating a dynamic environment where clinical challenges were translated into practical, patient-centered insights.

Ahmed Nassef, Consultant Vascular endovascular surgery the leeds teaching hospitals NHS Trust
Overview of Round III: The No-Stent Zone: Still Sacred or Time to Break the Rule?

In this engaging and thought-provoking session, Dr. Ahmed Nassef tackled a fundamental question in modern vascular practice: why has the common femoral artery (CFA) remained resistant to the endovascular revolution, and is that resistance still justified?

As endovascular therapy continues to redefine peripheral arterial disease management, most vascular territories have shifted toward minimally invasive solutions. However, the CFA stands apart, reflecting its unique anatomical, mechanical, and pathological characteristics, which continue to favor surgical management.

At the center of this argument is the CFA's critical anatomical role. Positioned at the junction between inflow and outflow vessels, it involves both the superficial and profunda femoris arteries, structures essential for maintaining limb perfusion. Any intervention must therefore preserve not only patency but also the integrity of this complex bifurcation.

CFA disease is frequently heavily calcified, irregular, and "coral reef-like," often extending across the bifurcation.

This morphology makes durable endovascular treatment difficult, whereas open surgery allows for direct plaque removal and precise reconstruction, often combined with profundoplasty when required.

Dr. Nassef strongly advocated for open common femoral endarterectomy as the gold standard, particularly in younger and fit patients.

Evidence from major comparative studies demonstrates:

- Superior long-term primary patency
- More complete revascularization with lower residual stenosis
- Greater durability with fewer reinterventions

> **The short-term advantages of endovascular therapy do not justify the long-term failures... particularly in fit patients.**
>
> *Ahmed Nassef*

He noted that many endovascular cases are left with residual stenosis, raising concerns about long-term outcomes, while surgical endarterectomy consistently achieves more definitive lesion clearance.

The CFA's high-mobility mechanical environment, exposed to flexion, compression, and torsion, further raises concerns regarding stent durability and fracture risk, particularly when preserving profunda flow is critical.
That said, endovascular therapy offers clear advantages, including lower perioperative morbidity and faster recovery, and remains appropriate in selected high-risk or non-ambulatory patients.
Ultimately, the session reinforced the importance of individualized decision-making, positioning open and endovascular approaches as complementary rather than competing strategies.
Key takeaway:
Despite rapid advances in endovascular technology, the CFA remains a "last surgical bastion." Open endarterectomy continues to provide the most reliable and durable outcomes, while endovascular therapy remains a selective option.

Poster Competition Award Vascular Art 2025

Celebrating Innovation and Excellence in Vascular Care
We are proud to recognize the winner of the Vascular Art 2025 Poster Presentation Competition, a highlight of this year's scientific program. The winning submission stood out for its clinical relevance, originality, and practical impact, reflecting the high level of innovation among participants.

Winner: Dr. Mohamed Mosaad Soliman
Institution: Mansoura university Egypt
Winning Topic: Retrograde radiofrequency ablation as a potential bailout technique in chronic venous insuffciency.

We also recognize all participants for their high-quality contributions and commitment to advancing vascular care.

Dr. Mohamed Mosaad Soliman, Poster Competition winner, with the Scientific Committee and Vascular Art President.

Interview Spotlight: A Mission to Prevent Amputation

In this issue, we speak with a clinician whose career evolved from deformity correction to a focused commitment to diabetic foot care and limb preservation. With over two decades of experience across the Kingdom, he shares insights on preventing amputations, the value of multidisciplinary care, and practical advice for clinicians and patients.

Dr. Samer Bondokji

DPM, AACFAS, CWSO. Diplomate ABMSP
Consultant Podiatrist, Foot and Ankle Surgeon at Johns Hopkins Aramco Healthcare (JHAH)

Q: What inspired your journey, and what continues to drive your work today?
A: My journey started when I completed my deformity and limb lengthening fellowship, at the time, while I was focused on and wanted to do was exactly that. When I first arrived in the Kingdom, 24 years ago, I was excited about bringing this expertise to my patients.
Gradually, my clinic had a significant increase in diabetic foot patients, and as I became more involved in that care, I realized it is much more gratifying to treat this disease than to just do deformity correction. What has been an exciting part of my journey, is that my training in deformity correction has lent itself well into the treatment of diabetic foot conditions, such as Charcot. It has become my calling to treat diabetic foot disease and prevent amputations.
The largest source of motivation comes from being able to prevent amputations in diabetic foot patients whose conditions have been deemed untreatable and designated for amputation. I have been privileged to live in different cities across the Kingdom, including Riyadh, Jeddah and now Dhahran, and as I look back at my career and the patients I have been able to treat, I realize that working to save as many limbs from amputation in the community is what has become the most important to me and wish to continue doing for the rest of my career.

Q: How do you see the role of foot care within the broader context of vascular health?
A: I have said on various occasions that vascular surgery and diabetic foot management are connected at the hip, and if not, it ought to be. In my humble opinion, it is impossible for anybody who is treating or managing diabetic feet, whether surgical or nonsurgical to do so, without having a vascular service lifeline. And I do mean a lifeline in the full sense of the word. It is imperative to have access to revascularization for diabetic foot patients, as with the absence of adequate blood supply the chances of healing are minimal to nil. So, in a successful diabetic foot unit, the vascular surgeon is the keystone in working closely with the podiatric surgeon, a must for limb preservation work.

Q: How have you applied innovation in your practice?
A: Actually, minimally invasive foot surgery is not a new concept, in fact European foot surgeons have been using this surgical technique for quite a while. What I have done is to apply the same techniques and principles of offloading and deformity correction in the diabetic foot. This has allowed me to do procedures in patients with a soft tissue envelope and blood supply that would not support traditional open surgery; thus, I was able to help more people who otherwise would only be fit for conservative treatment which would not offer them an optimal outcome.

Q: What challenges do you face in diabetic foot management?
A: Diabetic foot management is a very frustrating field for both the patient and the clinician. A major reason is the high complication rate. One of the strategies that we have adopted is to have a very low threshold for revascularization and the other is to manage the source of the ulceration, deformity and infection aggressively.
However, it is much better to be able to treat these patients at an early stage, and for that we must collaborate closely and have an open communication channel with family medicine doctors, primary care doctors, emergency room doctors and also home health care nurses and wound care nurses who usually see these patients before we do, on a regular basis or are the first to see the patient and are able to do the right referral whether it is to vascular surgery or to the podiatrist or podiatric surgeon.

Q: How important is interdisciplinary collaboration in achieving successful outcomes?
A: I can tell you in all honesty that interdisciplinary collaboration has been a game changer for us in the treatment of diabetic foot patients, with the most critical being vascular surgery. However, the role of endocrinology in blood glucose control and the role of wound care in managing the wounds and prosthetics and orthotics for proper offloading and shoe wear has also been an important part to the success of our treatment model. I would encourage anybody who is working in the diabetic foot field to establish a network. It can be a loose network. It does not have to be all under one roof, but all involved must be in communication, they should discuss cases and have case presentations every week and everyone can contribute in line with their specialty. In our hospital, we are all on first name basis and have each other's personal phone numbers.

Q: What key advice would you offer to clinicians and to patients?
A: The key piece of advice I have for clinicians is to be humble. The treatment of Diabetic foot disease requires patience, an open mind, cooperation with other specialties and clinicians and these require the ability to listen and communicate well and to constantly be in learning mode. The second advice is to always ask "why". Why is the ulcer where the ulcer is? Why is the ulcer not improving? Why is my patient not following my advice? The third advice to the clinician is to involve the patient in their care and educate the patient about their care as much as possible. Once the patient becomes involved in their own care and are informed about it, they then help you and help themselves rather than just being a receiver of care. My last advice to clinicians is to get involved in research, try to keep track of your outcomes and whenever possible publish.

My first advice to patients and families is: do not wait. Do not delay bringing the patient to the clinic or the emergency room. Another advice is to share your thoughts and concerns with your doctor or clinician, no matter how silly you may think they are. And finally, beware that not everything on social media or on the internet is correct or useful, so please ask your doctor or clinician before applying anything to the wounds.

Faculty Perspectives and Panel discussions

Key insights and shared perspectives emerging from expert discussions across the scientific program.

Across multiple plenary sessions and expert panels, discussions at Vascular Art 2026 delivered highly practical, experience-driven insights, shaped by critical questions from moderators and dynamic exchanges with faculty. The focus consistently extended beyond devices to real-world decision-making, long-term outcomes, and patient-centered strategies.

Aortic Intervention Discussions highlighted the growing role of advanced imaging and anatomical understanding as the cornerstone of procedural planning. The integration of artificial intelligence in preoperative planning was explored as a promising tool, though experts emphasized that clinical judgment remains essential. Faculty reviewed the expanding landscape of EVAR, FEVAR, and BEVAR technologies, addressing real-world performance, follow-up outcomes, and the strength of current evidence. In thoracic aortic disease, particularly blunt thoracic aortic injury (BTAI), debates focused on guideline recommendations versus registry-based real-world data.

Carotid Intervention A key area of discussion was the timing of intervention and recent guideline updates. Strong emphasis was placed on the routine use of embolic protection devices (EPDs), with practical comparisons between available systems. The evolving role of TCAR was examined in depth, highlighting its growing adoption and positioning within contemporary carotid revascularization strategies.

Drug-Eluting Technologies Significant attention was given to drug-eluting technologies, with experts highlighting the importance of understanding device-specific characteristics. The emergence of sirolimus-based platforms was discussed as a potential shift in the field. Concerns were raised regarding stenting in high-flexion anatomical zones, with a clear call for robust long-term (5-year) data, particularly for newer designs such as woven nitinol stents.

Venous Intervention Discussions reflected the rapid evolution of the field—from early diagnosis and optimal timing of DVT intervention to the expanding role of venous stenting. Experts reviewed current outcomes and highlighted the need for precision in measurement and deployment, where AI may offer future value, particularly in conditions such as May-Thurner syndrome. Additionally, various venous ablation technologies were compared, focusing on their mechanisms, indications, and clinical differences.

CLTI / Peripheral The management of chronic limb-threatening ischemia (CLTI) sparked intense debate, particularly regarding emerging technologies such as bioresorbable scaffolds, including their cost-effectiveness and historical concerns following earlier-generation outcomes. Discussions also addressed the role of atherectomy devices, emphasizing variability in operator experience, training, and availability. The ongoing debate between endovascular versus surgical strategies remains unresolved, especially in the context of long-term durability and guideline interpretation.

KEY TAKEAWAY

Overall, discussions reinforced a central message: Modern vascular practice is no longer device-driven alone, but decision-driven—guided by anatomy, evidence, experience, and increasingly, intelligent technologies.

Watch the Full Sessions

Scan to watch full sessions and panel discussions on our YouTube channel..

@VascularArt

Faculty & Leadership

International experts who led groundbreaking discussions in Jeddah, Saudi Arabia

Honoring Our Faculty

The success of Vascular Art 2025 was driven by the dedication and leadership of its Board and Scientific Committee, whose expertise ensured a program of the highest scientific standard. Together with an esteemed international faculty, they contributed to an environment of excellence, advancing dialogue and shaping the future of vascular care. Our sincere gratitude goes to every faculty member who made this event possible.

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We extend our sincere appreciation to our valued sponsors and partners for their generoud support, which played a vital role in the success of Vascular Art 2025. We look forward to continued collaboration and building future initiatives together in advancing vascular care and scientific excellence.

Honestly impressed by the organization and high slandered Program level

Dr. Ahmed Nassef

Willing to see the Next Successful Version

Dr. Bruno Migliara

I really enjoyed being here this Year , Incredible event with high standards

Dr. Guissepe Papia

Explore more
Scan to Visit the event's page

Vascular Art at SITE 2026

Following the success of Vascular Art 2025, we continue our journey by joining SITE 2026 International Symposium, contributing to collaboration and innovation within the vascular community.

We invite you to explore the program and be part of the experience.
Visit the official website and register to attend.