英文影印版

实用血管外科学

Practical Vascular Surgery

James S. T. Yao
William H. Pearce

科学出版社

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Contributors

J. Dennis Baker, MD
Professor of Surgery
UCLA School of Medicine
Chief, Vascular Surgery Section
West Los Angeles VA Medical Center
Los Angeles, California

William H. Baker, MD
Professor of Surgery
Section of Peripheral Vascular Surgery
Department of Surgery
Loyola University Medical School,
Stritch School of Medicine
Maywood, Illinois

Dennis F. Bandyk, MD
Professor of Surgery
Director, Division of Vascular Surgery
University of South Florida College of
Medicine
Tampa, Florida

Thomas Bilfinger, MD
Associate Professor of Clinical Surgery
State University of New York at Stony
Brook
University Hospital, State University of
New York at Stony Brook
Stony Brook, New York

John D. Birkmeyer, MD
Assistant Professor of Surgery and
Community and Family Medicine
Center for the Evaluative Clinical
Sciences
Dartmouth-Hitchcock Medical Center
Lebanon, New Hampshire

Andrew W. Bradbury, BSc, MD, FRCSEd
Senior Lecturer in Surgery
Edinburgh University
Consultant Vascular Surgeon
Edinburgh Royal Infirmary
Edinburgh, Scotland

Brian G. Brazzo, MD
Assistant Attending Surgeon,
Department of Ophthalmology
Manhattan Eye, Ear and Throat
Hospital
New York, New York

David C. Brewster, MD
Clinical Professor of Surgery
Harvard Medical School
Massachusetts General Hospital
Boston, Massachusetts

Richard P. Cambria, MD
Associate Professor of Surgery
Harvard Medical School
Visiting Surgeon
Massachusetts General Hospital
Boston, Massachusetts

Sandra C. Carr, MD
Assistant Professor
University of Wisconsin Medical School
Madison, Wisconsin

Douglas A. Coe, MD
Vascular Fellow
Medical College of Wisconsin
Milwaukee, Wisconsin

Anthony J. Comerota, MD, FACS
Professor of Surgery
Temple University Medical School
Chief, Vascular Surgery/Director, Center for Vascular Diseases
Temple University Hospital
Philadelphia, Pennsylvania

Jack L. Cronenwett, MD
Professor of Surgery
Dartmouth-Hitchcock Medical Center
Lebanon, New Hampshire

Michael C. Dalsing, MD
Professor of Surgery
Indiana University School of Medicine
Indianapolis, Indiana
Director, Division of Vascular Surgery
Indiana University Hospital
Wishard, Indiana
Memorial Hospital
Indianapolis, Indiana

Julie S. Droste, BSN, RN
Vascular Surgery Nurse Coordinator
Evanston Northwestern Healthcare
Evanston, Illinois

Vincent Falanga, MD, FACP
Professor of Dermatology
Boston University
Chairman of Department of Dermatology and Skin Surgery
Roger Williams Medical Center
Providence, Rhode Island

David V. Feliciano, MD
Professor of Surgery
Emory University School of Medicine
Chief of Surgery
Grady Memorial Hospital
Atlanta, Georgia

John F. Golan, MD
Assistant Professor of Surgery
Northwestern University Medical School
Evanston Northwestern Healthcare
Evanston, Illinois

David Green, MD, PhD
Professor of Medicine
Northwestern University Medical School
Chicago, Illinois

Lazar J. Greenfield, MD
Frederick A. Coller Distinguished Professor and Chairman
Department of Surgery
University of Michigan
Ann Arbor, Michigan

John W. Hallett, Jr., MD
Professor of Surgery
Associate Dean for Faculty Affairs
Mayo Clinic and Mayo Medical School
Rochester, Minnesota

Roger Higgins, PhD
Director
Somerset Noninvasive Vascular Laboratory
Troy, Michigan

Robert W. Hobson II, MD
Professor of Surgery and Physiology
University of Medicine and Dentistry of New Jersey, New Jersey Medical School
Chief, Division of Vascular Surgery
Newark, New Jersey

Kaj Johansen, MD, PhD
Professor of Surgery
University of Washington School of Medicine
Director of Surgical Education
Providence Seattle Medical Center
Seattle, Washington

Steven S. Kang, MD
Assistant Professor of Surgery
Loyola University Chicago
Maywood, Illinois

Richard R. Keen, MD
Department of Surgery
Division of Vascular Surgery
Cook County Hospital
Chicago, Illinois

K. Craig Kent, MD
Professor of Surgery
Cornell University Medical College
Chief, Division of Vascular Surgery
New York Hospital-Cornell Medical Center
New York, New York

Nicos Labropoulos, PhD
Research Assistant Professor
Stritch School of Medicine
Loyola University Chicago
Maywood, Illinois

Michael D. Malone, MD
Instructor of Surgery
Temple University School of Medicine
Senior Vascular Surgery Fellow
Temple University Hospital
Philadelphia, Pennsylvania

M. Ashraf Mansour, MD
Assistant Professor of Surgery
Section of Peripheral Vascular Surgery
Department of Surgery
Loyola University Medical School, Stritch School of Medicine
Maywood, Illinois

Bernardo D. Martinez, MD
Endovascular Surgery Fellow
Stanford University Medical Center
Stanford, California

Mark A. Mattos, MD
Assistant Professor of Surgery
Southern Illinois University School of Medicine
Springfield, Illinois

Kenneth L. Mattox, MD
Professor and Vice Chairman of Surgery
Baylor College of Medicine
Chief of Staff, Chief of Surgery
Ben Taub General Hospital
Houston, Texas

Walter J. McCarthy III, MD
Associate Professor, Department of Cardiovascular–Thoracic Surgery
Chief, Section of Vascular Surgery
Rush-Presbyterian-St. Luke's Medical Center
Chairman, Division of Vascular Surgery, Cook County Hospital
Chicago, Illinois

William D. McMillan, MD
Vascular Surgeon
Minnesota Thoracic Associates
Minneapolis, Minnesota

Mark H. Meissner, MD
Assistant Professor of Surgery
University of Washington School of Medicine
Seattle, Washington

Mark W. Mewissen, MD
Professor of Radiology
Chief of Vascular and Interventional Radiology
Medical College of Wisconsin
Milwaukee, Wisconsin

Gregory L. Moneta, MD
Professor of Surgery
Division of Vascular Surgery
Department of Surgery
Oregon Health Sciences University
Portland, Oregon

Frank A. Nesi, MD
Associate Clinical Professor of Ophthalmology and Otolaryngology
Kresge Eye Institute, Wayne State University
Detroit, Michigan

Takao Ohki, MD
Assistant Professor of Surgery
Division of Vascular Surgery
Department of Surgery
The University Hospital for the Albert Einstein College of Medicine
Montefiore Medical Center
New York, New York

Frank T. Padberg, Jr., MD
Professor of Surgery
University of Medicine and Dentistry of New Jersey, New Jersey Medical School
Chief, Section of Vascular Surgery
New Jersey Veterans Health Care System
Newark, New Jersey

Peter J. Pappas, MD
Assistant Professor of Surgery
University of Medicine and Dentistry of New Jersey, New Jersey Medical School
Newark, New Jersey

Sheela T. Patel, MD
Vascular Surgery Fellow
New York Hospital-Cornell Medical Center
New York, New York

William H. Pearce, MD
Professor of Surgery
Northwestern University Medical School
Chief, Division of Vascular Surgery
Northwestern Memorial Hospital
Chicago, Illinois

Michael Petersen, MD
Assistant Professor
State University of New York at Stony Brook
Chief, Vascular Surgery
VA Medical Center
Stony Brook, New York

John R. Pfeifer, MD
Associate Clinical Professor of Surgery
Wayne State University School of Medicine
Detroit, Michigan

John M. Porter, MD
Professor of Surgery
Head, Division of Vascular Surgery
Department of Surgery
Oregon Health Sciences University
Portland, Oregon

Mary C. Proctor, MS
Senior Research Associate
Department of Surgery
University of Michigan
Ann Arbor, Michigan

John J. Ricotta, MD, FACS
Professor of Surgery
State University of New York at Stony Brook
Chairman, Department of Surgery
University Hospital, State University of New York at Stony Brook
Stony Brook, New York

C. Vaughan Ruckley, ChM, FRCSEd
Professor of Vascular Surgery
Edinburgh University
Consultant Vascular Surgeon
Edinburgh Royal Infirmary
Edinburgh, Scotland

Alvin H. Schmaier, MD
Professor of Internal Medicine and Pathology
University of Michigan
Departments of Internal Medicine and Pathology
Ann Arbor, Michigan

Joseph R. Schneider, MD, PhD
Associate Professor of Surgery
Northwestern University Medical School
Evanston Northwestern Healthcare
Evanston, Illinois

John H. Scurr, BSc, MBBS, FRCS
Senior Lecturer
Consultant Surgeon
Middlesex and University College Hospitals
London, England

Michael B. Silva, Jr., MD
Assistant Professor of Surgery
Chief, Division of Endovascular Surgery
University of Medicine and Dentistry of New Jersey, New Jersey Medical School
Newark, New Jersey

Donald Silver, MD
Department of Surgery
University of Missouri-Columbia
Columbia, Missouri

James C. Stanley, MD
Professor of Surgery
Head, Section of Vascular Surgery
Department of Surgery
University of Michigan
Ann Arbor, Michigan

D. E. Strandness, Jr., MD
Professor of Surgery
University of Washington School of Medicine
Seattle, Washington

David S. Sumner, MD
Distinguished Professor Emeritus of Surgery
Southern Illinois University School of Medicine
Springfield, Illinois

Lloyd M. Taylor, Jr., MD
Professor of Surgery
Division of Vascular Surgery
Department of Surgery
Oregon Health Sciences University
Portland, Oregon

Jonathan B. Towne, MD
Chair, Vascular Surgery
Froedtert Memorial Lutheran Hospital
Professor of Surgery
Medical College of Wisconsin
Milwaukee, Wisconsin

Hugh H. Trout III, MD, FACS
Clinical Professor of Surgery
George Washington University School of Medicine
Bethesda, Maryland

William D. Turnipseed, MD
Professor, Department of Surgery
Section of Vascular Surgery
University of Wisconsin Hospital and Clinics
Madison, Wisconsin

Frank J. Veith, MD
Montefiore Medical Center
Albert Einstein College of Medicine
Bronx, New York

Robert L. Vogelzang, MD
Professor of Radiology
Northwestern University Medical School
Chief of Vascular and Interventional Radiology
Northwestern Memorial Hospital
Chicago, Illinois

Thomas W. Wakefield, MD
Professor of Surgery
University of Michigan
Section of Vascular Surgery
Department of Surgery
Ann Arbor, Michigan

Anthony D. Whittemore, MD
Professor of Surgery
Harvard Medical School
Chief, Vascular Surgery
Brigham and Women's Hospital
Boston, Massachusetts

James S. T. Yao, MD, PhD
Magerstadt Professor of Surgery
Northwestern University Medical School
Acting Chair, Department of Surgery
Northwestern Memorial Hospital
Chicago, Illinois

Christopher K. Zarins, MD
Division of Vascular Surgery
Stanford University Medical Center
Stanford, California

Preface

In recent years vascular surgeons have been caught up in the enthusiasm over new technology. This new technology has provided minimally invasive approaches for treating a wide variety of vascular diseases. Unfortunately, this new technology is untried, and long-term results are scant. Although it is important to stay abreast of new developments, it is also important to review traditional techniques for treating vascular disease. These techniques have provided us with sound, durable treatments. The purpose of this book is to focus on the practical aspects of vascular surgery encompassing office practice, critical care, critical pathways, simplified operative approaches, and standard surgical procedures. In the current economic environment, it is important that our treatments be efficient, cost-effective, and durable. By critically reducing excesses in diagnostic modalities and limiting long-term follow-up protocols, standard vascular surgical procedures will compete satisfactorily with the newer endovascular techniques that may be more appealing on the surface, but may be less durable.

James S.T. Yao, MD, PhD
William H. Pearce, MD

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Hugh H. Trout III, MD, FACS

INTRODUCTION

Shortly after assuming office, President Clinton risked, and indeed spent, considerable and precious political capital on trying to change (euphemistically called "reform") the health care system in the United States. Political scientists and historians will no doubt debate why a young and untested president should take such a risk so early in his first term. Interestingly, perhaps an even more profound question is why he ventured into this health care morass at all. The answer is no doubt complex and filled with Byzantine intrigue but, at its core, it probably reflects that the president foresaw an impending national crisis and made a courageous, if flawed, attempt to address the fundamental problems so as to reduce the long-term adverse impact of enhanced technology and an aging population on our health care system. Although the "reform" effort failed, the future crisis that the president presciently perceived remains.

Medicare payment policies have, to a significant extent, become the *de facto* payment policy standard for most insurance companies—that is, the insurance companies base their payment schedules on some percentage of the Medicare payment. Accordingly, Medicare policies are of critical concern for most physicians. Moreover, the Medicare system has come under intense pressure to constrain costs and the changes now taking place are almost all related to these financial limitations. Trying to predict what changes in Medicare will take place in the early part of the 21st century is futile, but it is possible to describe the forces that mandate change. Although understanding these forces may not make physicians any happier, it may be helpful in reducing the belief that an ill-defined "they" are capriciously or duplicitously trying to wreck a perfectly good and efficient health care system. Accordingly, this chapter discusses the pressures requiring change and describes some of the changes that will occur in the beginning of the 21st century.

Some of the fundamental problems are a limited amount of money available for health care; an aging population; expanded technology, an oversupply of physicians (primary care physicians as well as specialists); a medico/legal system that is inefficient

in addressing inappropriate medical practice; an appalling willingness of politicians and the public to accept conventional wisdom ("politically correct") rather than policy based on experimental evidence; lack of a system that provides appropriate incentives for the delivery of health care; and an ethos that does not include an understanding of how efficiently and at what cost the medical profession can prolong the process of dying. These problems are not unique to this country; indeed, they afflict all industrialized nations. Moreover, they cannot be "solved" (the only "solution" for most health care problems is death), but can only be managed.

Some of what follows is based on the author's opinion gleaned from living in Washington, DC, the home of policy mavens, as well as serving as the Chair of the Society for Vascular Surgery/International Society for Cardiovascular Surgery (SVS/ISCVS) Government Relations Committee. Each topic could serve as the basis for a book or a doctorate degree and much has been written about each. Accordingly, I have not attempted to use references for my statements as access to federal documents is not readily available to the medical profession, and much of what I have included comes from secondary sources, equally difficult to access. If any reader wishes to have additional information about a particular topic and has difficulty gathering it, they should contact me and I will try to help.

FORCES FOR CHANGE

Limited Money for Health Care

The percentage of the gross domestic product (GDP) that is devoted to health care has increased steadily (although, of late, at a slower rate of increase). In 1996, it was 14%, and is anticipated to grow to 16% by the year 2000 and 18% by 2005. The per capita health care expenditure is anticipated to increase from $3759 in 1996 to $5198 in 2000, and to $7352 in 2005. Predicting health care costs, however, is notoriously unreliable. For instance, in 1965, when Medicare and Medicaid were implemented, it was anticipated that in 1990 total expenditures for Medicare would be $9 billion, and for Medicaid would be $1 billion. Actual 1990 expenditures were $106 billion and $76 billion, respectively.

This trend of constantly increasing health care expenditures, whether on a per capita basis or as a percentage of GDP, clearly cannot continue. As a consequence of the stabilization of total health care expenditures (as a percentage of GDP), as they almost certainly must by the year 2010, per capita expenditures will obligatorily decrease as the population of persons older than 65 begins to increase rapidly (per capita expenditure equals total health care costs divided by number of patients). Thus, despite more patients and more sophisticated technology, it is almost certain that fewer dollars will be available after the year 2010 for per capita health care.

Aging Population

World War II resulted in a low birth rate throughout the industrialized world during the conflict. In the succeeding prosperous years, starting in 1945, the birth rate in the United States accelerated dramatically with what is now known as the Baby Boom. The members of this cohort will begin to reach 65 in the year 2010 with unsettling consequences. It is instructive to reflect on the circumstances surrounding the beginning of Social Security in the United States in 1935. Life expectancy was 62 years and it was expected that 7% of adult life would be spent in retirement. In 1995 those figures