

INTERVIEW

# Revascularization Strategies for CLTI: A Nationwide Analysis of Medicare Beneficiaries

*An Interview With Eric Secemsky, MD*

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At this year's SIR Annual Scientific Meeting, *Vascular Disease Management* spoke with interventional cardiologist Eric Secemsky, MD, from Beth Israel Deaconess Medical Center in Boston, Massachusetts, to discuss his presentation entitled "Revascularization Strategies for Critical Limb-Threatening Ischemia (CLTI): A Nationwide Analysis of Medicare Beneficiaries." The presentation provided an overview of [a study that Dr Secemsky and colleagues conducted](#) to describe variations and outcomes associated with either surgery or endovascular treatment among US hospitals providing both approaches. They analyzed Medicare beneficiaries 66 years of age and older with CLTI who were treated at institutions offering both strategies between October 1, 2015 to December 31, 2021. Dr Secemsky talked about the study and how its findings might impact patient outcomes.

***The study highlights significant variability in hospital-level strategies for treating CLTI despite both endovascular and surgical options being widely available. What do you think drives this variation in practice and how might it impact patient outcomes?***

I think how the vascular community is set up in this country is that each region and even each local city or rural community has a different point person for vascular care. We know that up to two-thirds of counties in the US don't have a practicing vascular surgeon right now, and there are still a lot of gaps in overall vascular providers, irrespective of the specialty. So, I think there are some areas where you have one provider, whether it happens to be the vascular surgeon or an interventional or endovascular provider, and that drives how practices are done, maybe a little bit more on the endovascular side with the endovascular operator, more on the surgical side with the surgical operator. But one thing that we really wanted to focus on in this study was what happens at hospitals where you have both? We looked only at hospitals that were able to offer surgical intervention and also provided endovascular therapies. And we saw there are a lot of differences. There are a lot of surgeries done at centers that have high surgical volumes. There are a lot of endovascular centers that have high endo volumes, as expected. So, how do those drive outcomes for CLTI patients was the real question.

***At hospitals that leaned more heavily on endovascular treatment, patients seemed to do better in terms of avoiding major amputation. But they also had more repeat procedures. How should clinicians balance these tradeoffs when making decisions about the initial revascularization strategy for patients with CLTI?***

How you look at repeat revascularization depends on the individual. On the one hand, what we learned from BEST-CLI is that you experience much more durable results among patients who received surgical bypass with a venous conduit. But that doesn't necessarily mean the endo failed in the true sense of what an endo program is. Sometimes we do endo and we treat as much as we can, and we know that we are going to see how the patient does. They might have to come back for a touch-up, they might have to come back for another intervention, and that is part of this strategy here. When you can do these procedures safely, and in our practice almost all our patients go home the same day, patients might say, "You know what, I would be more interested in an endovascular procedure, no surgery, no hospitalization, even if I had to come back for another procedure as part of it," they might be

more interested in that than an open surgical procedure with anesthesia and a surgical wound and maybe a rehabilitation stay. Interestingly, in BEST-CLI, despite patients having fewer repeat interventions in the surgical arm, the quality-of-life measures were similar between surgical and endovascular strategy at 1 year.

Overall, I think of this as committing to getting the optimal end result. If repeat revascularization is necessary for an endo program, then these centers are going to dedicate the time, whether it is one procedure or multiple procedures, to get you that result of keeping your limb intact. I think of it as part of the comprehensive program.

***Given the improved outcomes at high-volume and endovascular centers, do you think we should be moving toward more centralized care for CLTI, or at least in standardization?***

I think we should be individualizing treatment plans not only based on the anatomy of the arterial disease or degree of tissue loss, as well as the patient comorbidities, but also the real expertise that is available at the center. If we have a very well-regarded surgical program with really well-trained surgeons and the patient is a good surgical candidate with a healthy conduit, the patient should get bypass surgery. On the other hand, we might have centers that have a really strong multidisciplinary high-volume endovascular program, and these centers performed well at improving limb outcomes.

The goal from our study is there is no one-size-fits-all. As much as we want to standardize care, we also have to standardize based on what is available in the local community. If the local community is endovascular-focused and they are performing high-quality endovascular care, that should be the strategy. If it is a good surgical center, optimizing surgical outcomes needs to be the focus.

***What are the next steps for research in this area? Are there specific areas where you think we can make the most impact?***

I think next steps is really about how we come together as a community. We need to focus on prioritizing the patient and not our own personal physician biases. If we can all work together, create better algorithms for the appropriate revascularization strategy, share in all the care that can be equally done by different providers, that is the goal of this work and future work. We can keep doing research, but if the research is not making a difference at the local level, then the research is lost. I think we are at the point now where we need to tailor our therapies, put the patient first, work together, and understand that not one hospital looks the same as another one, and we need to leverage the strengths of those hospitals individually. ■