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EDITOR'S CORNER

DVA Shows Great Promise in Saving Limbs, Saving Lives, and Reducing Healthcare Costs

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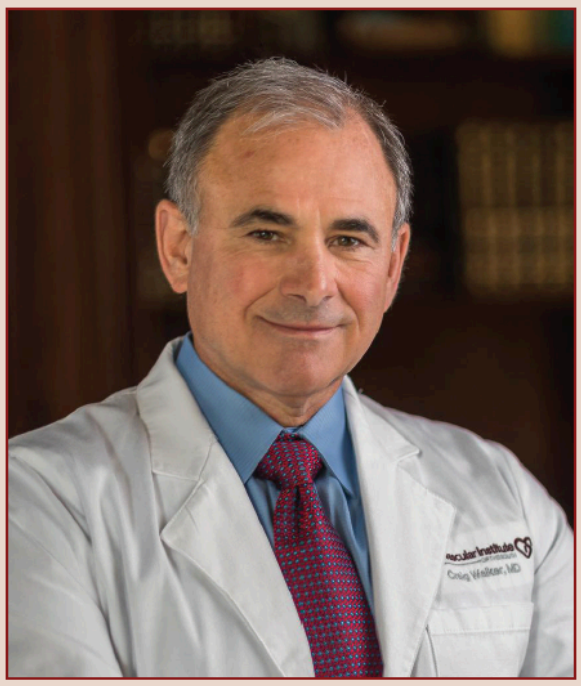

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Hello and welcome to the September 2025 edition of *Vascular Disease Management.* There are several articles in this issue that are worthy of editorial commentary. I have chosen to comment on the article entitled "Deep Vein Arterialization for No-Option Chronic Limb-Threatening Ischemia: An Overview of the LimFlow System and CLariTI Study" submitted by Darshan Randhawa, MD, Samuel Thomas, and Michael Siah, MD. (Click here to watch a video of Dr Walker's commentary.)

I have chosen this article as it reports the outcome of the first dedicated percutaneous device system designed to facilitate deep venous arterialization (DVA) to achieve limb salvage in patients with chronic limb-threatening ischemia (CLTI) who were typically considered "no option for revascularization". Historically, most of these patients were initially treated with bypass or interventional procedures doomed for failure or with primary amputation. Patency of percutaneous or open surgical procedures was exceptionally poor as all outflow foot vessels were diffusely diseased. The terms desert foot and small arterial disease have been applied to this presentation of CLTI, which occurs disproportionally in minorities and those with severe diabetes. This presentation of CLTI has been associated not only with amputation, but also high mortality and cost.

The PROMISE 1 study resulted in 70% amputation-free survival at 12 months, and the PROMISE 2 study resulted in 76% amputation-free survival at 6 months. These studies with the LimFlow system have clearly demonstrated that DVA offers great hope in treating these patients previously thought to have no options.

Many operators have utilized "off-the-shelf" products and have reported improved limb salvage with devices approved for other indications; however, these have simply not undergone as rigorous study as the LimFlow system. LimFlow deserves credit for scientifically evaluating the utility of DVA and for creating a specifically designed system.

Many questions remain about how and when to utilize DVA: Are we waiting too late to implement DVA? Is distal DVA as helpful as proximal DVA? Can we refine DVA technique to lessen arterial steal? What is the optimal timing post DVA for performing amputations such as transmetatarsal amputation for gangrenous toes? What is the ideal medical follow-up post DVA to control pain and insure patency?

The PROMISE 1 and PROMISE 2 studies by LimFlow have clearly shown great promise utilizing DVA in patients who previously did not fare well with other revascularization techniques. I suspect this is just the beginning of what may ultimately be accomplished. We will continue to innovate resulting in earlier utilization of this technique. Device improvement has the potential to improve patency. Ultimately, we will develop algorithms resulting in resulting in more appropriate follow-up.

I sincerely believe that DVA has great promise in saving limbs, saving lives, and reducing overall healthcare costs. Amputation is not only debilitating; it is associated with poor quality of life and often more cost than limb salvage. DVA is a welcomed tool in our quest of achieving improved limb-salvage in CLTI. ■