Advancing non-invasive vascular diagnostic services by promoting training and research in Vascular Science.

CSVS

THE COLLEGE AND SOCIETY
FOR CLINICAL VASCULAR SCIENCE
Great Britain and Ireland

WINTER
2025

IN THIS ISSUE

Happy New Year and welcome to the CSVS Winter Newsletter!

I am pleased to announce an update to the prize awarded for the best article featured in each quarterly CSVS newsletter. This initiative aims to recognise and reward outstanding contributions from our members.

To be considered, simply submit an article for publication (for example, case studies, CSVS study day or conference learning point summaries) in one of the quarterly CSVS newsletters. If your article is accepted and published, it will automatically be eligible for the prize.

The winning author can now receive one of the following prizes, depending on the edition in which their article appears:

- Spring and Summer editions:
  A free place at a CSVS study day
- Autumn and Winter editions:
  A £50 Amazon voucher

For full terms and conditions and newsletter article submission dates, please visit the CSVS website.

Thank you!

Jeny Anton
CSVS Newsletter Editor
newsletter@csvs.org.uk

President's Message

Happy New year and welcome to the Winter Newsletter 2026. The CSVS has had a busy and productive period across all committees. Following a successful ASM in Hull, we congratulate our prize winners and thank the conference team for delivering an excellent meeting.

Max Bitterlin – Best Trainee/Newly Qualified Abstract Presentation

Mary-Ellen Williams – Best Scientific or Case Study Abstract Presentation

Steve Wallace – Awarded the Richard Wood Memorial Prize by the Vascular Society

For those who missed the Vascular Societies' ASM, I highly recommend BMUS. Tanyah Ewen and her team delivered two vascular sessions that generated lively debate in a packed room that had standing room only.

Several key Professional Standards documents are nearing release, including updated guidance on the NHS uniform for healthcare science, a refreshed Code of Conduct and Complaints Procedure, and a joint CSVS–BMUS position statement on minimum equipment standards for DVT scanning. The PSC is also reviewing implications of the Kingdon Review for our profession.

The Education Committee has updated the Accreditation and CPD documents and introduced new policies on workshop cancellations and a newsletter article prize. Upcoming events include the Virtual Fundamentals Study Day (04/03/2026) and the Revision TwoDay Event (20–21/05/2026). These are ideal for those new to the profession or preparing for AVS theory exams. Please encourage your teams to register.

Work continues on the new Research Module, and the Research Committee continues to collaborate with the Education Committee on virtual delivery options being explored.

At national level, we are contributing to discussions at NHS England will all Professional Bodies on the future shape of the healthcare science workforce. We have also attended working groups reviewing the STP and HSST curriculum of the future which is part of the recommissioning process for Higher Education Institutions. Whilst early in development there is a strong view to move towards modularisation to allow individual modules to be taken – good for equivalence – and the inclusion on preventative health and artificial intelligence. Alongside this we have contributed to the AHCS Fellowship review, and the definition of clinical academics in healthcare science for a national strategy. The AVS–STP equivalence mapping project is entering its pilot phase ahead of a 2026 launch which should make the process quicker and easier for all.

I look forward too representing the CSVS at the AHCS Honorary Fellowships 2025 Ceremony and Chair Celebration on 3rd March in London.

We continue to support the HSST programme and celebrate the achievements of DClinSci students across all years – it was fantastic to see excellent population health presentations from our newest cohort. A new two year Memorandum of Understanding with BMUS is being signed that will strengthen longterm collaboration, while CASE is transitioning toward becoming a standalone legal entity, reducing financial risk to member organisations like the CSVS.

You will also have received details of free registration for CSVS members to the Find Your Algorithm vascular conference in London. I encourage you to take advantage of this innovative event.

Committee changes include Rob James becoming Treasurer, Natasha Strevens stepping into the Website Secretary role, and Denzil Pereira joining as a non-portfolio member. Thank you to Ben Freedman who ends his term as Treasurer and has agreed to support Rob in the background. Further opportunities to join CSVS committees will be advertised soon as we implement the new two year delivery plan. Getting involved is an excellent way to build evidence for STP equivalence and contribute to our profession.

Finally, we will introduce a monthly Executive Committee vlog in 2026 to improve transparency and streamline updates.

A huge thank you to Jeny Anton for editing this newsletter. I hope you enjoy the articles that follow.

Dr Steven K. Rogers BSc(hons), PGCert, AVS, Ph.D, FCVS
President - The College and Society for Clinical Vascular Science

Contributing to the International Vascular Cork Course

I was honoured to be invited as faculty for this year's International Vascular Cork Course, hosted by University College Cork/Cork University Hospital (CUH) in Ireland. It was held at the ASSERT Centre on 6th and 7th of November and led by Professor Brian Manning, Consultant Vascular Surgeon at CUH. The course was aimed at Trainee Surgeons to gain hands-on experience of open surgical dissection and reconstruction procedures on cadavers in their state-of-the-art surgical skills laboratory. The simulated operating rooms featured integrated audio-visual facilities to allow for real time and post-procedure feedback from expert faculty.

Alongside the open surgical programme, trainees rotated through two additional modules: bench-based large and small vessel anastomosis skills, and the vascular ultrasound module. The course welcomed 12 surgical trainees and a multi-professional faculty of Consultant Vascular Surgeons from across Ireland, SPRs, and three Accredited Vascular Scientists/Physiologists. I was invited by Veni Ramachandran, Chief Vascular Scientist/Physiologist at CUH, and worked alongside Veni and Joanne Boyce to deliver the vascular ultrasound component.

Our role at the course was to support both the faculty and delegates during the practical ultrasound sessions, providing one-to-one supervised scanning of the carotid arteries, abdominal aorta and peripheral veins on actor patients. It was a rewarding experience to help create an environment where delegates could practice scanning techniques with real-time guidance ensuring a smooth learning experience.

Crucially, this course demonstrated true multi-professional vascular education, and recognising the value of Vascular Scientist/Physiologist-led ultrasound teaching within international vascular surgical training. This collaborative teaching approach enriches learning, supports shared standards and highlights ultrasound as an essential part of vascular clinical decision making and procedural planning.

A delegate described the ultrasound component as 'clear, structured and very practical' noting that the supervised hands-on format strengthened understanding and confidence in applying scanning skills in clinical scenarios — Lynda Condell, Vascular Surgery Specialist Registrar (RCSI ST4).

It was a privilege to collaborate with colleagues in Ireland and to contribute to ongoing cross-specialty harmonisation of vascular skills development..

Written by
Ming Yeung
Clinical Vascular Scientist, Manchester University NHS Foundation Trust

Bitesize Research:
ABDOMINAL AORTIC ANEURYSM

Written by Husnayya Al-haddad, Galen Blood Flow Unit, London North West University Healthcare Hospital.

Introduction

An abdominal aortic aneurysm (AAA) is a permanent dilation of the abdominal aorta, defined as an enlargement to ≥3.0 cm or 1.5 times its normal diameter. It develops gradually due to weakening of the aortic wall. This weakening is known to result from loss of structural proteins such as elastin and collagen, combined with the constant high pressure of blood flow that causes the vessel to bulge and risk of it rupturing. AAAs are often asymptomatic until rupture. Other factors leading to the formation of AAAs include chronic inflammation, atherosclerosis which thickens and damages the arterial wall, hemodynamic stress from ongoing mechanical forces and genetic conditions (Coady MA, Rizzo JA, Goldstein LJ, Elefteriades JA, 1999).

PAPER 1

R A P Scott, Scott (2002). The Multicentre Aneurysm Screening Study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial. DOI: 10.1016/S0140-6736(02)11522-4

Summary:

In 2002 we saw the first publication of the landmark Multicentre Aneurysm Screening Study (MASS) which showed that screening significantly reduced aneurysm-related mortality. In this randomised control study there were 27, 147 participants aged between 65-74 who were offered one-time ultrasound scan using the inner-to-inner (ITI) method. Out of the 27, 147, there were 1, 333 AAAs detected. The MASS trial found an overall reduction in AAA-related mortality and found the 30-day mortality after surgery to be 6% after elective surgery and 36% mortality after emergency surgery.

Pros

This study saw a high attendance showing feasibility. It used large sample size and having the randomised group element minimised bias and gave it a strong statistical power. Furthermore, the randomised control element reduced selection bias and confounding. After being followed up after four, seven, 10 and 13 years it still demonstrated durable benefits and remained cost-effective for the NHS.

Cons

This study included only men, leaving uncertainties about benefits for women and younger men. Participation was incomplete, and because the greatest benefit occurs among attenders, maintaining high uptake is crucial. Ruptures also occurred in men who initially screened normal; several had baseline diameters of 2.5–2.9 cm. A further limitation is the use of the ITI measurement method, which may underestimate aortic size. Had the OTO method been used, some cases might have been classified as aneurysmal and monitored more closely, potentially preventing rupture.

Impact on Practise

MASS provided a definite evidence base for AAA screening, which led to the official roll-out of The National Abdominal Aortic Aneurysm Screening Programme (NAAASP) in the UK, reaching its full scale by 2013. It highlights the role of vascular ultrasound as a powerful preventive tool against AAA-related mortality. This study is applicable not just to the screening programme but also to vascular labs as it reiterates the importance of robust surveillance aiding timely elective repair and monitoring rapid growth AAAs requiring signposting. Although ITI is considered more reproducible, both ITI and OTO measurement methods are currently used across UK vascular labs. This variation highlights why standardisation may be useful.

PAPER 2

Borgbjerg.J et al (2018). Superior Reproducibility of the Leading to Leading Edge and Inner to Inner Edge Methods in the Ultrasound Assessment of Maximum Abdominal Aortic Diameter. doi. org/10.1016/j.ejvs.2017.11.019

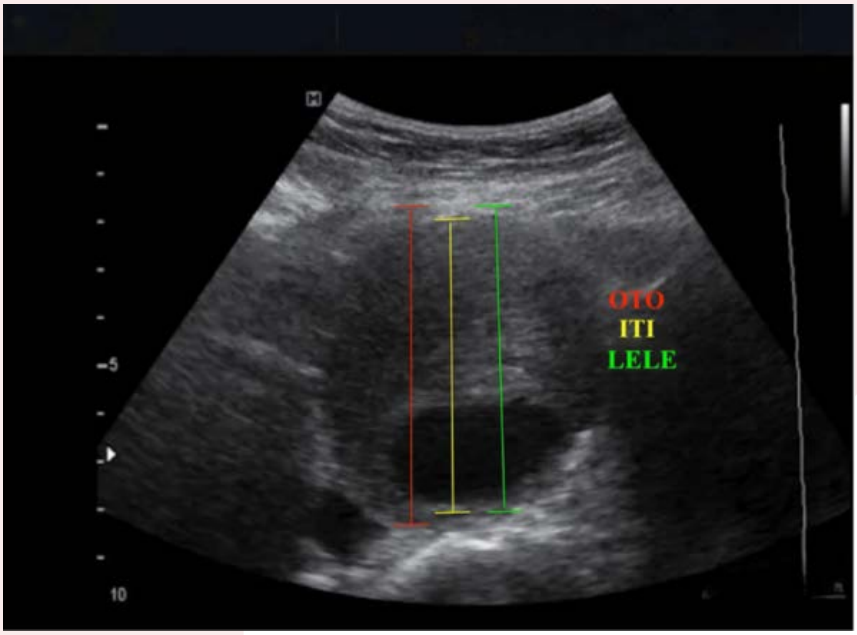


Figure 1: Caliper placement for measurement of aortic diameter OTO: outer to outer, ITI: inner to inner, LELE: leading edge to leading edge (Sidik AI, Al-Ariki MK et al, 2025).

Summary

This retrospective study examined the debate over optimal caliper placement for measuring maximum aortic diameter on ultrasound. Eighteen radiologists measured 50 static images using LTL, ITI, and OTO methods, repeating measurements to assess inter- and intra-observer reproducibility. OTO diameters were on average 5.0 mm larger than ITI and 2.6 mm larger than LTL, with LTL exceeding ITI by 2.4 mm. These discrepancies significantly affected estimated AAA prevalence, which nearly doubled when OTO was used instead of ITI. The authors conclude that LTL and ITI are more reproducible than OTO and that measurement choice strongly influences reported AAA prevalence in screening programmes.

Pros

This paper helps clarify the substantial discrepancies among the three measurement methods and their clinical implications. It compares the three caliper-placement methods, giving clear data on reproducibility and measurement differences. With 18 different radiologists involved, the inter-observer variability data are meaningful and represent a realistic range of clinical practice. By reporting limits of agreement for both inter- and intra-observer measurements, the study provides concrete estimates of how much measurement error might be expected in real-world settings. The authors went beyond measurement theory and estimated how different methods would affect AAA prevalence in screening, highlighting how methodological choice impacts screening outcomes and patient management thresholds.

Cons

Most of the static images used were non-AAA and the results may not be directly extrapolated to the whole range of aortic size, such as those measuring close to the surgical threshold of 5.5cm. Secondly, the generalisability was limited by the observer group as they solely consisted of radiologists, therefore the results may not extend to other groups such as AAA technicians and vascular scientists/sonographers. Thirdly, this study did not provide any reference to CT; the modality commonly employed when aortic repair is considered. Thus, it provides no possibility of comparing validity of the methods. Fourthly, only static images were views in axial plane, historic data has shown that this variance accounts for about half of the total variability of maximum diameter of the AA.

Impact on practise

The findings of this study have significant implications for AAA screening and surveillance. It showed that ITI and LTL measurements are more reproducible than OTO, with ITI demonstrating particularly strong consistency. The 5-mm mean difference between OTO and ITI suggests that using OTO could result in approximately 50% more AAAs being classified as positive. Although OTO may appear preferable due to its similarity to CT measurements, evidence increasingly shows it is the least reproducible of the three methods. This raises questions of why both methods are used in UK vascular labs. According to the CSVS PPGs for EVAR surveillance, local

services may choose their preferred measurement method, provided they remain aware of the significant discrepancies between techniques. Perhaps it would be useful to include both measurements in our reporting with the final decision left with the clinician. In any case, this reiterates the repeated call for standardisation.

PAPER 3

Duncan A, Maslen C, Gibson C, Hartshorne T, Farooqi A, Saratzis A, Bown MJ (2021). Ultrasound screening for abdominal aortic aneurysm in high-risk women. Br J Surg. doi: 10.1093/bjs/znab220.

Summary

This cross-sectional population-based study evaluated whether AAA screening in high-risk women offers benefits comparable to male programmes. Women with AAA have a higher rupture risk and worse surgical outcomes, accounting for a third of ruptured AAA deaths. The FAST study invited 6,037 women aged 65–74 with high-risk factors to a single ultrasound screen; 5,200 attended (86.7%). AAA prevalence was low at 0.29% (15 women), with only three large AAAs detected and one repaired. Current smokers had the highest prevalence (0.83%) but the lowest attendance. Screening was also associated with reduced quality-of-life scores. The authors conclude that although attendance was good, the very low AAA prevalence makes targeted screening of high-risk women unlikely to be clinically or economically worthwhile.

Pros

The study was conducted over three years and involved a substantial sample size of 5,200 participants who attended screening. It highlights gender differences in AAA risk, noting that high-risk women may be more prone to aneurysm rupture. This study brings attention to the need for sex-specific screening strategies and increased awareness of AAA risk in women and by selecting women with known risk factors (smoking, coronary disease), the study targets the subgroup with the highest pre-test probability more relevant than general-population screening. The invitation and screening process mimicked that used in established male screening programmes, increasing generalisability. Lastly, the study went beyond detection, also exploring potential negative psychological impacts of screening.

Cons

The study used an ITI diameter measurement and a ≥ 3.0 cm threshold to define AAA, which may underestimate disease burden in women who naturally have smaller aortas than men (mean diameter: 1.57 cm in women vs. 1.79 cm in men). Only three large AAAs detected, and only one repair carried out, therefore limiting evidence that screening leads to meaningful interventions. Furthermore, only three large AAAs detected, and only one repair carried out, limiting evidence that screening leads to meaningful interventions. Lastly, the study reports detection and prevalence, but does not provide long-term data on rupture, mortality, or benefit of surveillance/repair.

Impact on practise

Although women are not currently offered routine AAA screening, these findings suggest that vascular laboratories could consider enhanced surveillance for high-risk women who are current smokers or have coronary artery disease. Those with sub-aneurysmal aortas could also benefit from this as women are known to have smaller aortas than men and using the same absolute threshold as men might under-detect relative dilation. This supports arguments for sex-specific thresholds or size-index adjustments in women.

PAPER 4

Sidik AI, Al-Ariki MK et al (2025) Advances in Imaging and Diagnosis of Abdominal Aortic Aneurysm: A Shift in Clinical Practice. Cureus. doi: 10.7759/cureus.81321.

Summary

This PRISMA-style literature review summarises recent advances in imaging for abdominal aortic aneurysm (AAA) and how they are reshaping clinical practice. It covers established modalities (ultrasound, CT, MRI) as well as emerging techniques such as IVUS, PET-CT and AI-driven image analysis. The review highlights how these developments enhance detection, risk stratification, preoperative planning and decisions about surveillance versus intervention. With AAA prevalence declining, due to reduced smoking and better cardiovascular risk control, the authors note a shift toward targeted rather than population-wide screening. They also emphasise the need to standardise imaging protocols, particularly aortic diameter meas-

urement methods. Finally, the review suggests that integrating AI with genetic or biomarker data could enable more personalised management through improved risk prediction and tailored surveillance or treatment strategies.

Pros

Firstly, extensive number of studies were used in this paper. Secondly the paper draws attention on the latest advancements that are available and how they can transform AAA for personalised care. The review points to future possibilities signalling where research and clinical practice might head next. Lastly, by discussing caliper placement techniques and the impact on measured aortic diameter, the paper draws attention to an often overlooked but critical source of variability in AAA management.

Cons

As a review covering many modalities and studies, there is wide variation in methods, populations, and quality which could mean some recommendations are based on limited or early-level evidence. Techniques like IVUS, PET-CT for wall inflammation/stress, or AI-driven segmentation are promising but not yet universally available or validated in large prospective cohorts. Therefore, the translation into routine clinical practice remains uncertain. High-resolution CTA, MRA, PET-CT, or AI-assisted analysis may be expensive, require infrastructure and expertise, limiting its broader implementation, especially in resource-constrained settings.

Impact on practise

This study tells us that the future of screening should place focus on refining risk-based stratification models to optimise screening and treatment strategies. Caliper placement is crucial as are standardisation of protocols and vascular labs should adopt and adhere to a consistent caliper placement method (e.g. inner-to-inner, or other standard), to ensure accurate, reproducible aortic diameter measurements, especially important for surveillance over time. Overall, despite advances, this paper confirms that US remains the preferred first-line screening too as it is non-invasive, cost-effective, widely available, and sensitive for initial detection.

PAPER 5

Tuveson V, Löfdahl HE, Hultgren R (2016). Patients with abdominal aortic aneurysm have a high prevalence of popliteal artery aneurysms. Vasc Med. doi: 10.1177/1358863X16648404.

Summary

This cross-sectional study assessed how common popliteal artery aneurysms (PAA) are in patients with AAA and whether those with both conditions share distinct risk factors. Among 465 AAA patients, 225 underwent popliteal imaging, with PAA detected in 19% using a ≥12 mm definition and 11% using ≥15 mm. Patients with both AAA and PAA reported claudication more often. Clinical examination identified only 26% of radiologically confirmed PAAs, though specificity was high. The authors conclude that PAA is relatively common in AAA patients and, given the low cost and low risk of imaging and the poor sensitivity of physical exam, recommend popliteal artery screening for all men and women diagnosed with AAA.

Pros

Demonstrates high prevalence of PAA in AAA patients as it Identifies that 11–19% of AAA patients have a popliteal aneurysm. Helps justify routine screening protocols as it shows physical exam is unreliable as Clinical examination only detected ~26% of PAAs, therefore, it strengthens the case that ultrasound is essential, not optional. It further supports a low-cost, high-value screening addition as PA US is quick, non-invasive, and inexpensive and can easily be added to existing AAA surveillance. This study applies to both men and women as it recommends screening for all AAA patients, simplifying guidelines.

Cons

Not all AAA patients received popliteal imaging as only 48% of the cohort had popliteal imaging and this could potentially introduce selection bias. Imaging definition varies (12 mm vs 15 mm) as the different diameter thresholds changed prevalence notably (19% vs 11%). This could lead to inconsistency if other labs use different criterias. This study does not show outcomes as this study identifies prevalence but does not follow patients to see which PAAs later thrombosed, which required surgery and if there were any impact on limb ischemia.

Impact on practise

Based on the prevalence of PAAs observed in this study, it seems reasonable to consider incorporating PAA screening into AAA assessments. However, the literature contains inconsistent definitions regarding PAA thresholds for intervention. Currently, practice varies across to local trusts with no definitive measurement in place to flag PAA requiring surgical intervention. Clear, standardised protocols for PAA diameter within the CSVS for example would therefore be beneficial for vascular laboratories to follow as these do not currently exist.

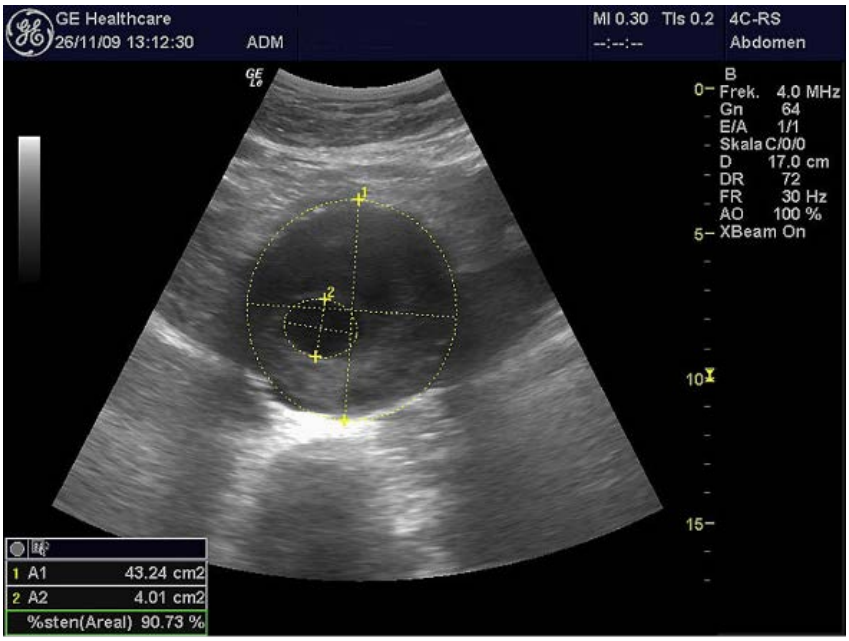


Figure 2: Cross-sectional view, with area measurements using the built-in semiautomated program to calculate the relative intraluminal thrombus size (Behr-Rasmussen et al., 2014).

PAPER 6

Behr-Rasmussen C et al (2014). Mural thrombus and the progression of abdominal aortic aneurysms: a large population-based prospective cohort study. Eur J Vasc Endovasc Surg. doi: 10.1016/j.ejvs.2014.05.014.

Summary

This population-based prospective study investigated whether the relative size of intraluminal thrombus (ILT) in abdominal aortic aneurysms (AAAs) influences aneurysm growth. Using ultrasound in men aged 65–74, ILT area was measured relative to the aneurysm cross-section. ILT was common, increasing in prevalence and size with larger AAAs, and greater relative ILT was significantly associated with faster aneurysm growth, independent of factors like smoking and blood pressure. The findings suggest that ILT may contribute to AAA progression, with higher thrombus burden linked to more rapid expansion.

Pros

The use of a semi-automated sonographic method provides a non-invasive, reproducible measurement tool for evaluating thrombus relative to aneurysm size, which is directly relevant to vascular labs. Adjustment for key confounders supports a direct link between thrombus burden and growth, not just diameter alone.

Cons

The mean observation time was relatively short (1.8 years), so long-term thrombus impact beyond early growth trends is uncertain. Although this is useful, ultrasound is less precise than CT/MRI for quantifying thrombus volume which can introduce measurement variability. This study only assessed men aged 65–74 and the findings may not generalise to women or younger patients. Although it identifies an association between ILT size and growth it cannot confirm whether the thrombus drives expansion or simply reflects underlying disease processes.

Impact on practise:

This study helps understand that routine documentation of thrombus area/relative ILT would be useful to document alongside diameter measurements when reporting. Furthermore, by incorporating ILT assessment it may help identify AAAs that are likely to expand faster, possibly prompting closer surveillance intervals. Lastly, it would also be useful to mention diameter reduction to compliment overall diameter measurements within our report when scanning AAAs.

Congratulations to Beverly, the winner of this edition's prize. She will be awarded a £50 Amazon gift card for her article on the 'Contrast EVAR Workshop'.

The Contrast EVAR Workshop

The just concluded CSVS Contrast EVAR Workshop on September 26, 2025 was held in a very conducive and accessible location at the Core Technology Facility, Grafton Street, Manchester. It was a timely event and of great help for those who wants to explore and deepen their knowledge in the current advances of technology in vascular sonography.

Contrast EVAR (Endovascular Aortic Repair), a minimally invasive procedure, which uses Sonovue which is a non-nephrotoxic contrast agent to visualise small endoleaks which often are not seen in conventional colour duplex examinations. It has been helpful overtime, guiding the vascular surgeons' need for intervention.

Following the arrival, registration, and refreshments, the workshop started in time with Mr. Chris Lowe, Consultant Vascular Surgeon, Manchester University Hospital Foundation Trust and Northern Care Alliance, sharing his expertise in the surgical perspective, tackling a bit of EVAR's history, EVAR implantation and application of CEUS pointing out some of the information surgeons look for and need from a duplex scan and other imaging modalities prior to performing the surgical procedure.

There were short tea and coffee breaks in between to get refreshments where everyone as well gets a chance to catch up and meet with colleagues from the different institutions. Lunch offered was buffet-style, options with the favourite sandwiches, salads, and hot dishes.

After the lunch break, the session was continued by Ellie Magson, Field Sales Associate, GORE, who discussed about Material Science and Innovation of EVAR stents, tackling how the GORE PTFE and ePTFE were discovered and evolved overtime up to its usage now. The presence of a physical stent samples being passed around for everyone to have a closer look was appreciable as all the attendees were able to hold and see a real example of an EVAR stent.

After all the substantive lectures, an overview of AAA and EVAR was shared by Julia Warne, Gloucestershire Hospitals NHS Foundation Trust, giving a talk of how NAAASP commenced and has been operational and beneficial in the prevention of AAA rupture. Then she proceeded on how AAA's are measured, summing up the different aneurysm types, and treatments available. Following, the technical portion and live demonstrations were then presented by Tanyah Ewen, North West Anglia NHS Foundation Trust, expounding and focusing on the role of duplex ultrasound in EVAR, exploring scanning techniques and emphasising proper reporting/interpretation.

Moreover, Joao Carreira, Manchester University NHS Foundation Trust, shared his expertise and experience about CEUS EVAR, relating how they are performed and set up in their department. The topic was backed by Lee Smith, Manchester University NHS Foundation Trust, explaining about how contrast works in physics point of view, software, image optimisation, safety, and obtaining of consent due to possible side effects.

The event was wrapped-up with a practical hands-on workshop using the different mid-range and hi-end Philips and GE machines. Their Clinical Application Specialists showcased the different ultrasound machines' capability, showing all the knobology readily available to use for image optimisation. All the participants were given a chance to try the machines and have a real-time scanning on the different patients who joyfully volunteered which facilitated the culminating activity better. Among the cases scanned were AAA aneurysms and endoleaks in comparison with a normal abdominal aorta.

Top of the list where most participants got interested and amazed were these 2 advanced machines, the GE Vscan, a wireless probe that enables one to scan portably even with a tablet or phone as it connects via Bluetooth. I was given a chance to try it on a carotid artery and it gave amazing B-mode, colour and Doppler images. Also, the Philips MATRIX array transducer was fabulous, I tried it on the abdominal aorta and was able to acquire volume and saved time as in one plane it can show both transverse and longitudinal view with excellent image quality.

Overall, the workshop was very helpful, a must see and join! It boosts not only ones knowledge and confidence but also network as we come to meet different people in the same area of practice. We ended the workshop having a group photo for documentation and freebies from Mindray. Looking forward to more of such activities in the future, where you are empowered mentally and at the same time given the chance to put it into practice with the guidance of the experts. I can say, I will surely apply

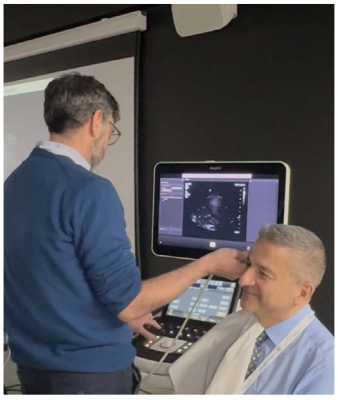
what I have learned and if given the chance, I would desire to dive into partaking a contrast enhanced ultrasound scan. Thank you to the CSVS organising committee, sponsors, volunteers and everyone who made this workshop possible and successful!

Written by
Beverly Daping
Clinical Vascular Scientist, University Hospitals of Leicester NHS Trust

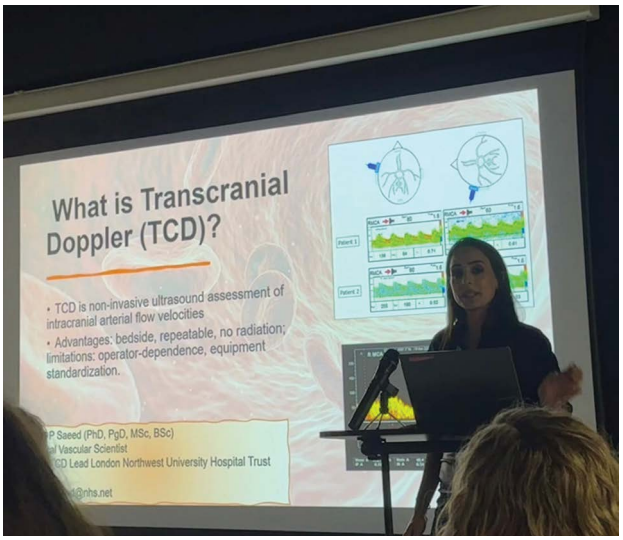
CSVS Annual Vascular Meeting 2025 in Hull

Day One

Once upon a time in a cold, sunny corner of Yorkshire, the ASM kicked off with the usual energy and excitement catching up with colleagues from around the country over one too many coffees. The first morning primarily had streams for the Vascular Society and I really enjoyed having time to explore the various topics being presented. I particularly gravitated to the Venous Forum Abstract session (as did many others it felt like with queuing out the door to get a slice of the action). I was particularly interested by the work out of the team in Newcastle regarding common femoral vein recanalization in individuals with a history of intravenous drug use; a topic of particular interest to me given my own research project (sorry, shameless plug). Presentations on making venous intervention more environmentally friendly were particularly thought provoking as well given this was being addressed through working with industry partners to reduce packaging waste. This is something we can all consider in our day-to-day practice as well whether that be using gloves only when necessary to recycling gel bottles. Small wins but the overriding message from the talk was that change can start with the individual by advocating for positive change.



Following on from discussions in previous ASMs, it was interesting to hear the experiences from sonographer-led varicose vein treatment in the private sector. This theme carried through with many surgical colleagues highlighting across the morning that developing new and improved treatment option(s) is not the most important issue from their perspective and instead the focus should be on how to reduce RTTs to deliver improved patient care and reduce waiting lists. One part of that is con-



sidering who delivers vein treatments and in what setting. These discussions culminated in the Venous Forum debate: "Varicose veins are the most important vascular surgery problem". Given this was delivered in the Venous Forum, it is perhaps not surprising that the For argument by Chris Twine (Consultant Vascular Surgeon, North Bristol NHS Trust), got the votes from the room but the Against argument by Dan Carradice (Consultant Vascular Surgeon, Vascular Surgery Speciality Leeds) was compelling over the need for Cardiovascular disease needing a united front as a whole for awareness, research and securing government funding/policy change. This led nicely into the Joint Symposium and it was interesting the hear the wide variety of current Vascular RCTs and how nurse-led claudication clinics can more effectively use members of the MDT.

The afternoon saw the start of the CSVS programme in The Edge with a particular focus on TCD with two insightful presentations by Dr Nazia Saeed (London Northwest University Hospital Trust) and Natasha Strevens (Imperial College Healthcare NHS Trust) followed up by an excellent live demonstration by Ben Freedman on our now past president Dr Kamran Modaresi who had a lovely transtemporal window! As with previous years, it is great to experience a different scan type, which is away from most labs 'bread and butter' workload. I loved seeing a return of the ultrasound room with all the major ultrasound machines on offer and time to get hands-on with TCD scanning. It is so valuable to hone skills on one's own machine and explore the other options on the market in a friendly non-time pressured environment.

I had the pleasure of delivering the Training Breakout again this year with my Education Committee colleagues Hannah Williamson (Lead Clinical Vascular Scientist, University Hospitals Sussex NHS Foundation Trust) and Julia Warne (Clinical Vascular Scientist, Cheltenham General & Gloucestershire Royal Hospitals) to conclude the day's proceedings. This annual session is aimed at all members aspiring towards achieving AVS status and we were very lucky this year to be joined by Ms Emily Kirkham, Consultant Vascular Surgeon Cheltenham General & Gloucestershire Royal Hospitals. Ms Kirkham delivered an excellent interactive session on report writing for peripheral arterial, peripheral venous and carotid duplex. It really focussed on the clinical question of scan requests and the clinical implications of scan findings with a number of great examples of reports and scan schematics kindly accumulated by Julia Warne. Lots of great questions and answers throughout and I certainly have plenty of take away learnings for honing my own scanning and reporting.

By Max Bitterlin
Clinical Vascular Scientist
University Hospitals Bristol and Weston NHS Foundation Trust

Day 2

After having a much-needed decaf coffee (some may dispute whether this even equates to a coffee!) I made my way to The Edge to attend day two of the ASM led by CSVS. This year our dedicated venue was located opposite the main exhibition hall, personally I was not keen on the set up of this but despite this the conference and extended teams managed to pull it off.

Dr Kamran Modaresi (Past President of CSVS) opened the day by outlining the programme, starting with the abstract session. One of the standout presentations was delivered by Max Bitterlin (Clinical Vascular Scientist, University Hospitals Bristol and Weston), who discussed barriers to healthcare access for people experiencing homelessness with venous disease. He highlighted issues including stigma, embarrassment from venous ulcer odour, limited health understanding, and lack of time to seek care due to substance dependency, where activities like begging, prostitution and shoplifting dominated their time, perpetuating a cycle that leaves little room for medical care. His eye-opening talk earned him the award for the Best Newly Qualified Trainee presentation.

This year's keynote address was delivered by Lorenzo Patrone, Vascular Interventional Radiologist, who joined from Florence, Italy via Teams (coordinated on the day by Jo Walker). He spoke about the important role of below-the-knee and ankle vessel recanalisation in patients with chronic limb-threatening ischaemia (CLTI), highlighting the significance of below-the-ankle flow and pedal acceleration time. Lorenzo took the opportunity to promote his upcoming FYA Congress taking place in February 2026 in London on therapeutic algorithms and more, with free entry for vascular scientists to attend. Lorenzo's talk complimented an earlier abstract presentation by Steven Wallace (Clinical Vascular Scientist, University Hospitals of Liverpool Group), who emphasised the importance of routinely obtaining pedal vessel measurements in vascular laboratories when assessing patients with CLTI.

After the morning segment finished, I headed up to the exhibition hall at Connexin Live for lunch and networking where I met with many of my friends, including Samiya Ali (Clinical Vascular Scientist, Lewisham and Greenwich NHS Trust), who was attending her first ASM this year. It was great to also catch up with my exceptionally humble former colleague, Consultant Vascular Surgeon Mr Taha Khan and to find that his sense of humour still remains as gold as ever... almost as good as mine!

Earlier this year, I took part in the Circulation Foundation's (CF) September Vascular Awareness Month initiative, which featured "a day in the life of a vascular scientist" in my lab at Northwick Park Hospital. After meeting CF Chair and Vascular Surgeon Neeraj Bhasin in Hull and receiving his positive feedback on the social media presence, I look forward in continuing future CF collaborations. As always, it was a pleasure to catch up with Gail at the CF stand at the Connexin Live exhibition hall and hearing her stories about the engaging free public event that took place at St Stephen's Shopping Centre. I think community-based engagements are an excellent way to educate people and to raise awareness around vascular disease.

Later in the afternoon, Dr Matthew Bartlett (Head Clinical Vascular Scientist, Research and Training lead, Royal Free Hospital) delivered a talk on Doppler waveform interpretation. Personally, this is an area I am keen to further develop. He despaired seeing words such as "strongish" and "bouncy" on reports and emphasised the crucial role of vascular scientists in ensuring clear language used in reports so that referrers are not misled. He encouraged using the CSVS guidelines on waveforms, which I will now look at more closely myself. Later in the day, it was wonderful to see Dr Bartlett receive the Ann Donald Award for his invaluable contributions in the prize session. Within the prize session we also saw Mary-Ellen Williams from Alder Hey Children's NHS foundation Trust win the award for the best Scientific Case study on her abstract based on her perspective of 'Rare paediatric presentation of diffused advanced Takayasu Arteritis'.

The last segment of the day featured the inauguration of the next CSVS President. Dr Modaresi opened his address by thanking the Executive Committee, sub-committee members, and past Presidents, acknowledging their longstanding efforts that he continued during his term. After a light-hearted remark about his questionable fashion choices in his

younger years he reflected on the current NHS crisis, noting that such challenges are not new by recalling similar issues dating back to 1968!

Despite persistent pressures, he spoke of the significant progress made within vascular care, highlighting that vascular surgeons once worked under general surgery rather than as a distinct specialty and that once a upon a time vascular scientists did not exist! Dr Modaresi concluded his final speech as President by introducing his successor, Dr Steven Rogers, Consultant Vascular Scientist.

Dr Rogers delivered a heartfelt and moving inaugural speech in which he highlighted many of Dr Modaresi's achievements. These included his contribution to the workforce development framework with NHS England for Healthcare Science, his involvement in developing venous intervention documentation on behalf of specialist vascular nurses and vascular scientists within the Vascular Society, and his support for GIRFT. In addition, Dr Modaresi played a key role in the undergraduate degree programme, helped to standardise paperwork with the CSVS Professional Standards Committee, supported the Circulation Foundation, improving document control, overseeing the launch of the new CSVS website as well as securing gift aid with Ben Freedman. To echo Dr Rogers, and on a more personal note, it has been inspiring seeing my colleague Kamran working tirelessly behind the scenes as a president, while still being a very present and selfless manager in the lab.

To end the two-day ASM, Dr Rogers outlined his extensive two-year plan as President, some of which includes; launching a President's vlog to improve engagement through regular updates from the CSVS Executive Council, supporting humanitarian projects in areas affected by natural disasters, disease outbreaks, and conflict, and providing greater support for students pursuing STP equivalence. He also highlighted plans to appoint a patron to help fundraising for education and humanitarian work and to support the NHS 10-year plan. On behalf of CSVS membership, we wish Dr Rogers every success in his presidency; the role may have its challenges, but I am sure it is one he is more than capable of.

Overall, I enjoyed my attendance in Hull. A special thanks to the conference team for their efforts in organising the event, and to the Executive Committee members. The next ASM is set to take place in Liverpool.

By Husnayya Al-haddad
Clinical Vascular Scientist
London North West University Hospital Trust

AVS Accreditation

Huge congratulations to these members for successfully passing their AVS Exams

- Jayne Sheldreck
- Jennifer Francis
- Alex D'amico
- Ioanna Xanthi

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