

A publication of the Society of NeuroInterventional Surgery

Introducing the SNIS Foundation *Lee Jensen, MD, SNIS Foundation Chair*

foun-da-tion [foun-dey-shuh n], noun

1. the basis or groundwork of anything.
2. the natural or prepared ground or base on which some structure rests.
3. an institution financed by a donation or legacy to aid research, education, etc.
4. an endowment for such an institution.

In 2004, the ASITN Executive Committee took the momentous step of changing its name to the Society of NeuroInterventional Surgery. This change occurred because our membership base had transformed from primarily interventional neuroradiologists, to a conglomeration of neurospecialists dedicated to the diagnosis and treatment of neurovascular diseases. This diverse group of individuals is the foundation upon which our premier, all-inclusive neurointerventional society has been built.

With our Society as its substantial base, we reached yet another milestone. In March, we launched the SNIS Foundation – an institution dedicated to the promotion of research and education in our field that will ultimately benefit patient care. Specifically, it is our hope to be able to provide financial support for the education of trainees through fellowship grants, to fund the research endeavors of our colleagues, and to award cash prizes for outstanding scientific papers.

We could not fulfill this mission without the generosity of our corporate sponsors, some of whom have already donated funds to the Foundation. However, we cannot meet our mission on industry funding alone. It is going to take the contribution of each and every one of us. We have all greatly benefited from the innovations in our budding field, and, as such, we all have an obligation to support the research that has led to these advances.

Toward that end, the SNIS Executive Committee respectfully requests that as you renew your membership this year, to please include a tax-deductible contribution to the SNIS Foundation. This contribution should be considered a strategic investment in the future of our specialty. If we do not support our investigators and educators, who will? Nature abhors a vacuum, and if we do not fill this void, there are others who would be happy to take up the reins of research and education in our stead.

With a little help from our membership and our friends, we can in all confidence equip the SNIS Foundation to carry out our mission and achieve its goals. Please make your contribution today, for the benefit of our specialty, our Society and our patients.



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PRESIDENT'S COLUMN

Cameron McDougall, MD

John Kenneth Galbraith was a prominent economist, diplomat and writer in the second half of the last century. His Scottish heritage, Canadian birth and immigration to the United States resonated with me but it was the clarity of his writing that attracted me to him as an author. He was a long time a professor at Harvard University, the American ambassador to India and an adviser to John F. Kennedy during his presidency. Galbraith's uncanny ability to coin a phrase and to present an argument clearly made his writing compelling reading for me, regardless of whether or not I ultimately embraced his position. You are no doubt familiar with one of his phrases that we all use without thinking: "conventional wisdom". I would recommend as an introduction to his writing the small monograph, "On the Nature of Mass Poverty". As a student somewhat acquainted with poverty, I borrowed this book from the library and to my embarrassment, held on to it long past its due date.

In one of his books Galbraith talked about patriotism. Humans are inherently tribal, with natural inclinations to cohesion within one's own group and distrust of others groups. Galbraith commented that he never quite understood the societal pressure towards monogamy in terms of love of country, or why loving a country other than one's country of residence is often viewed as somewhat suspect. I imagine that this loyalty-bred anxiety is more common among immigrants who, with their dual experience are confronted more directly with comparisons between their home and their adopted lands.

What do the sentiments of a book from a bygone era have to do with

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me, you, us – now in this time and in this place in history? Just this – this is nothing new under the sun. Conflicting messages, evolving processes, allegiance to what was and what is now. Indeed, in our clinical corner of the universe, we are facing challenges on many fronts. Some we greet enthusiastically. Others we face with resignation. From my time as a medical student, I have been struck that there is always among our ranks an element of pessimism and sense that the sky is continually falling.

I expect many of us are asking these days "When will these challenges ever resolve?" Of course they never will. Our small specialty faces all the challenges that other larger, better resourced specialties face and then some. We will have to deal with the coming changes in federal health care policy, contin-

ued financial pressures to do more with less, increasing and possibly burdensome accountability. Additionally, who and what we are as a specialty remains a work in progress.

Some may become opportunities, but conflict and competition for resources has been the theme of the human story from the beginning. While we may shake our heads and mutter under our breaths that we wouldn't want our children to follow in our footsteps, a more sober reflection will generally lead us to the realization of how wonderfully privileged we are to be able to practice our profession.

But here is the good news. The SNIS is well positioned to address these issues. When I picture our field, I think of a series of Venn diagrams with neurology, neurosurgery and neuroradiology overlapping at the center, where SNIS represents the common space, and in that space, plays the diplomat's role. As members, there is no reason to feel a requirement to be monogamous, or a sense of primacy toward ones specialty of origin or the SNIS. We must understand that our parent societies cannot act other than in their own self interest but we must be smart enough to recognize areas of complementary interest. Leveraging our relationships and demonstrating integrity in our role as the honest broker in this field has served us well and allowed us to demonstrate influence well beyond what our numbers would otherwise predict. We must continue to act unwaveringly as advocates for better care for our patients through the enhancement of our members' abilities to care for them. This is our mission. This is our strength.

9th SNIS Practicum

Debuts International Endovascular Stroke Conference

Kristine Blackham, MD
Practicum Co-Chair



The 9th SNIS Practicum broke new ground this year with a novel platform focusing on the neurointerventional treatment of stroke. This year's event, June 4-5 in Seattle, was rechristened as the inaugural International Endovascular Stroke Conference and was, by all accounts, a tremendous success. The program was targeted to the practicing neurointerventionalist and attracted nearly 200 practitioners and industry representatives for a comprehensive and international presentation on the current trends in stroke treatment and research.

The sessions reviewed current concepts in stroke therapy, with excellent case demonstrations and a detailed discussion of challenges, expertly led by Practicum Co-Chair Donald Frei and Peter Rasmussen. Each session was highlighted by point-counterpoint lectures on controversial topics, such as stenting in acute stroke or the ethicality of randomized trials for endovascular stroke therapy, with opinions by leading neurologists and neurointerventionalists such as David Fiorella, Satoshi Tateshima, Kyra Becker and Christopher Fanale. The highlight of the point-counterpoint lectures was a hotly contested item: "Who should be performing stroke interventions?" which was expertly and professionally debated by Donald Heck and David Sacks.

Other sessions this year that met with great reviews were dedicated to the "Comprehensive Stroke Program" and the "Global Approach to Stroke Treatment." By facilitating forums with neurologists, neurointerventionists, nurses and CEOs who function as administrators within large stroke programs, the Practicum offered participants the chance to consider the practical issues associated with building and leading a stroke practice. Additionally, the superb international session led by Italo Linfante – with participants from Canada, Australia, Japan and Europe – provided thought-provoking, innovative and sometimes humorous insights to neurointerventional practice based on the influences imposed by different health-care systems and cultures from around the world.

The discussions were liberal and the participants enjoyed many sessions with audience response questions, which allowed glimpses into the practice patterns of the attendees. One of the most compelling lectures was that of Gilberto Gonzalez, who spoke on his decade-long experience with imaging in acute stroke at Massachusetts General Hospital, which challenged some of our current thinking and practice with hard-earned evidence.

As stroke continues to be a hot topic across the medical landscape, this year's Practicum was yet one more reflection

of the commitment of SNIS to resource the neurointerventional community with information and thought leadership on everything from the clinical to the administrative. Many thanks to the program committee for bringing this vision to life and to the forum attendees for their steadfastness and deliberation in honing their knowledge and expertise for the good of patients everywhere.

SNIS Would Like to Thank the Generous Supporters of the 9th SNIS Practicum

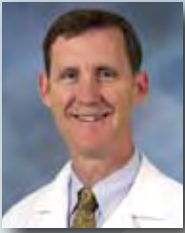
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See pages 8-9 for photo highlights from the 9th SNIS Practicum!



Colin Derdeyn, MD
SNIS Immediate Past President

A Better System for Device Development, Approval and Coverage

While bettering the system for device development and approval probably falls into the category of complaining about things that I have no power to change, it is still a worthwhile topic to consider – albeit within a perfect world. Indeed, what one would think could be said with certainty is that effecting a better system would require major legislative and regulatory changes. But who knows? We are contemplating and possibly witnessing even greater changes in health care right now.

The current system for developing medical devices and bringing them to market has some major limitations. Ultimately, these limitations hurt the American public, both medically (denying access to newer, better treatment) and economically (creating barriers for device development). To illustrate this point, consider mechanical stroke intervention. A more systematic approach that coordinates the Food and Drug Administration (FDA), the Centers for Medicare and Medicaid Services (CMS), and the National Institutes of Health (NIH) would benefit the American public, the device industry, and physicians.

The federal mandate for FDA approval requires establishing safety and technical efficacy of the device. Generally, this is accomplished through a clinical trial of some sort to prove, for instance, that the device does what it is supposed to do: e.g., the retriever can remove a thrombus. As devices are different than drugs, where efficacy is

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generally measured by clinical outcome, device trials usually carry the additional burden of adding clinical outcome endpoints. Consequently, device trials can be quite expensive.

Where it concerns reimbursement, the decision by CMS is based on clinical data and involves active input by physician specialty groups and industry. The level of evidence is often variable and the mandate for CMS is “medical necessity,” not technical efficacy. In the case of mechanical stroke intervention, the data was limited to a single large prospective case series compared to historical controls. While the device was effective in removing thrombus, there was very little evidence that patient outcome was improved. While we were fortunate in the case of these mechanical thrombectomy devices, we have not had the same success with other devices, such as intracranial stents. In addition,

the lack of randomized trial evidence has likely slowed the adoption of intra-arterial ischemic stroke intervention into practice. Issues related to patient selection also remain unresolved.

In considering what we should do, perhaps a better system would be to allow a pre-determined period of provisional CMS reimbursement after FDA-approval, with a mandatory registry for reporting outcome. FDA approval could be at a lower bar of safety and technical efficacy, as the registry phase would provide for a better estimate of these two parameters. During this interval, physicians could gain more experience, companies could make design iterations, and everyone could learn more regarding optimal patient selection. There is financial incentive as well as companies could recoup some of their development costs. And if the registry data were compelling, no randomized trial would be needed and CMS coverage would be granted. If not, an NIH-funded trial could be designed for some subset of patients. CMS reimbursement would be limited to device use in the trial until it is completed. All in all, this would ensure that these trials would recruit and would be completed in a timely manner.

As new ideas are the fuel that optimizes the engine of growth and change, it is important to stay open and consider opportunities to forge a new way. Without innovation, we'll be no better off in five, ten or twenty years than we are right now.

Our Specialty's Heritage

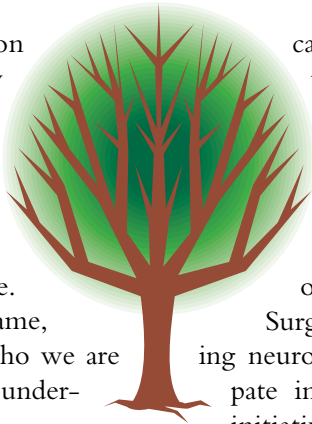
"The subject of history is the life of peoples and mankind."

– Leo Tolstoy

Cervantes notes of Don Quixote that "...history is in a manner a sacred thing". There are many reasons that these prosaic words ring true; perhaps most clearly it is because a people's history is its heritage. History defines whence we came, lends an understanding to who we are and in some ways helps us to understand where we can go.

Interventional neuroradiology, endovascular surgical neuroradiology or, its present preferred name, neurointerventional surgery, has a rich, albeit a somewhat brief history. The field's colorful past and its relative youth are made obvious by these diverse names attributed to our field itself – each trying to focus on specific aspects of the field yet each still slightly missing its mark.

History is people. In fact, recorded history is very much influenced by the individuals who write it as well as live it. Understanding how this field has evolved since its inception certainly includes the need to understand the individuals involved in the development and growth of the specialty. And there have been many: those who serve as teachers and mentors, and those who are the students and apprentices. As an example, most recently, Alex Berenstein, in his recollections of neurointerventional's history, has recorded the table of individual trainees over the course of his career.¹ Understanding training relationships and chronology enriches and adds important character to the history of our field. Information regarding individuals' professional genealogy, or pedigree as it were, provides a unique human dimension to the field. A most intriguing and fortunate aspect of neurointerventional surgery is that its youth lends itself to a



careful 'capture' and description of its *global* development and history.

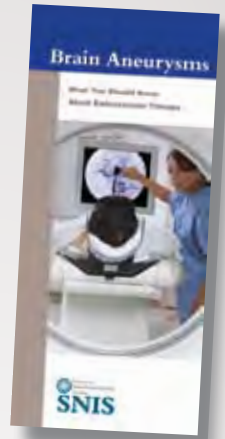
It is therefore with this in mind that the members of the History Committee of the Society of NeuroInterventional Surgery (SNIS) invite practicing neurointerventionists to participate in a global, specialty wide initiative. Such an initiative, although ambitious, will serve to enrich and solidify the history of the field, which, in turn, will serve as one of the necessary foundations upon which the history of endovascular treatment can be built. It will enable its members to trace the various 'schools of thought' in the diagnosis and endovascular treatment of various disease processes. Although these 'schools of thought' are still very much in their formative years, like fields older than ours, they are certain to develop a rich tradition and a wonderful history.

The Neurointerventional Family Tree Data Form will be located on the SNIS website in time for the 2011 SNIS Annual Meeting. We invite all practicing neurointerventionists to fill the form out as completely as possible. Once completed, the form can be submitted electronically to Eddie Woods (woods@snisonline.org) or faxed to the SNIS office at 703-537-0650.

To liberally paraphrase Tolstoy in the epilogue from War and Peace, "...the subject of history is the life of a specialty". We thank you in advance for helping to document the history of our field and welcome your suggestions to further our cause.

¹Berenstein A, Song JK, Niimi Y. Personal accounts of the evolution of endovascular neurosurgery. *Neurosurgery* 2006;59(Suppl 3):S15-21.

SNIS Debuts New Aneurysm Patient Information Brochure



We are pleased to announce the debut of an updated educational brochure on aneurysms, available immediately. This piece represents the first of a new series of brochures focused on cerebrovascular conditions. The medical content was provided by Donald Frei, MD and, per our standard process, the brochure was reviewed and approved by our Practice Building Committee.

As these educational pieces have always registered significant interest from our membership, we trust you will find this updated piece useful for your patients and their caregivers. There are three ways to place your order, go to www.snisonline.org and click through to our online store to purchase; return the form you received in the mail to the office or, you may call 703-691-2272 to place your order over the phone.

As SNIS is committed to resourcing our membership and all neurointerventional practitioners with material that provides accurate and clear information on very complex conditions, we encourage you to share this resource with other clinicians who could benefit as well.



JNIS Update

Rob Tarr, MD, Editor-in-Chief

JOURNAL OF NEUROINTERVENTIONAL SURGERY

Greetings from the *Journal of NeuroInterventional Surgery*! As we approach the two-year anniversary of the birth of JNIS, I couldn't be more proud of the remarkable progress we have made during such a short time.

Consider our wins. The quantity and quality of submissions to the journal continues to improve exponentially. Thomson Reuters, the agency which offered us indexing, awarded JNIS an initial Impact Factor. An initial Impact Factor of 1.069 in June 2011, a ranking considered to be high for a start-up journal and one that positions JNIS above multiple already-established neuroscience journals. And finally, given the continuing rising bar of quality and quantity of manuscript submissions, we have made the decision to increase the number of journal publications from four print issues per year to six print issues per year in 2012.

Additionally, we are working behind the scenes to make JNIS more accessible. The journal website offers many excit-

ing features that we are working diligently to make fully operational. These include video uplinks, podcasts and twitter. With regards to video uplinks, I would encourage authors to consider submitting pertinent video clips with their manuscripts which will be considered for posting during the review process. Another journal perk which we hope to implement in the near future is the opportunity to issue CME credits to reviewers and ultimately to the readership at large.

There are many who are responsible for the progress of the journal, including the authors who have submitted their scientific work, the reviewers for their efficient and insightful comment, the JNIS International Advisory Board and the staff at BMJ. But, and perhaps most of all, we should credit the JNIS Associate Editors (Felipe Albuquerque, Dave Fiorella, Josh Hirsch, Charlie Prestigiacomo, and Sam Zaidat) for their significant investment of time and tireless efforts on behalf of JNIS.

From the beginning, we stated that the mission of JNIS was to be the home for neurointerventional scientific work and literature. We have not wavered in our support of that mission. We invite you to join us as we continue to utilize this publication to build on our already robust portfolio of scientific work. You may either submit your articles to the journal for review and consideration, or suggest ideas for review article topics for publication in JNIS. Instructions for the submission process can be found at www.jnis.org. For topic suggestions, or overall ideas on how to improve the journal, please feel free to email me directly at editor@jnis.org. While I can't guarantee we will implement every suggestion that comes our way, I will guarantee that we will consider all of them.

Thank you for your continued support of JNIS.

AHA/ASA Publish Updated Stroke Prevention Guidelines

The American Heart Association/American Stroke Association announced the publication of revised stroke prevention guidelines in *Stroke*. The guidelines were last updated in 2006. In the United States, 795,000 strokes occur annually. Of these, approximately 87% are ischemic strokes, and approximately 25% occur in patients who have had a previous stroke.

The guidelines writing committee chair, Karen Furie, MD, commented, "Since the last update, we've had results from several studies testing different interventions. We need to re-evaluate

the science every few years to optimize prevention."

According to the guidelines, treating metabolic syndrome and undergoing carotid angioplasty may prevent recurrent stroke or transient ischemic attack (TIA). Key updates include:

- The value of screening for metabolic syndrome after stroke is still not clear; however, if it is diagnosed, patients should receive counseling for lifestyle changes and treatments for metabolic syndrome components that are also stroke risk factors, especially high

blood pressure and high cholesterol.

- If a stroke survivor has severe blockage of the carotid artery, angioplasty and stenting may be an alternative to surgery if the patient is at low risk for complications.
- Excluding patients whose stroke or TIA was caused by a clot from the heart, among those taking an antiplatelet drug to prevent another stroke, either aspirin alone, aspirin combined with dipyridamole, or clopidogrel are reasonable options.

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SNIS Joins the World of Social Media

By all measures, social media is considered one of the most significant communications trends in modern times. Facebook registers millions of users around the world; most individuals and companies now have Twitter accounts in addition to email; and YouTube has transcended its entertainment functionality and become a credible venue for companies to push out their information. The popularity of these new ways of communicating even gave rise to a 2010 blockbuster hit: Social Network.

Keeping pace with the times, SNIS, too, has joined the online world of social media in an effort to broaden its communications with members and the

general public. Specifically, the society has established a presence on Facebook, where we currently have almost 100 members. Designed as a closed page (to block patients, etc.), our Facebook page serves the purpose of facilitating conversations among members related to any variety of topics, allowing each member to not only post thoughts and insights, but pictures and video too. If you are a current Facebook user and would like to join us, just search Society of NeuroInterventional Surgery and put in a request! And while you're at it, let us know how you would like to use this tool. Case discussion? Message board? It's up to all of you!



Additionally, you can find SNIS on Twitter, at @SNISinfo So far, we have used this venue mainly to push out conference information and highlights in real-time, but we also look forward to leveraging this forum to share SNIS news throughout the year. If you are a “tweeter,” please look us up on Twitter and follow us.

We'll keep you attuned to new updates as we have them. Meanwhile, looking forward to joining you online!

SNIS Member Honored with Military Award

A Hero of Military Medicine award was the most recent for Army Col. Rocco Armonda to add to his collection.

Armonda previously received the Bronze Star for his service in Iraq, is a professor at the military's Uniformed Services University of Health Sciences, in Bethesda, and works as a neurosurgeon and director of cerebrovascular surgery and interventional neuroradiology for the National Capital Neurosurgery Consortium.

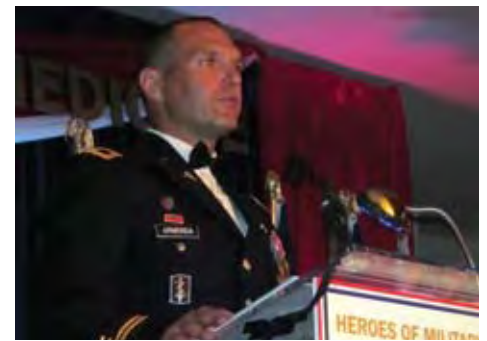
But for Armonda, the accolades are not the job's greatest reward. “It was an idea of a greater way of life, where you're part of something bigger than yourself,” Armonda said. “You get a greater way to serve than serving yourself.”

Armonda's services have been in high demand, as combat gear advancements have resulted in a greater number of service members injured at war surviving their injuries and requiring previously unnecessary neurological surgeries once they make it to an operating room. “In the past, most of these patients didn't make it off the battlefield,” he said.

The nature of war in Iraq led Walter Reed Army Medical Center in Washington, D.C. and National Naval Medical Center in Bethesda to transform into trauma hubs and forced the surgeons tasked with fixing these new war injuries to reapply their skills to fit trauma needs.

“It changes the culture, in terms of creating a more team approach that has a rapid sense of urgency that the disease requires,” Armonda said. Previously, the two hospitals operated on a steadier pace where doctors analyzed cases at length and discussed treatment alternatives with ease. The hospitals had to bring in new, state-of-the-art equipment, update operating rooms and make sure staff was prepared to handle new responsibilities, Armonda said.

Between 2004 and 2006, there was a spike in the number of injured service members returning from Iraq, with as many as 80 percent of the patients in the hospitals' intensive care units suffering a trauma injury, Armonda said. Now, those numbers are down to between 10 percent and 15 percent of the ICU population at Walter Reed and



Bethesda Naval. Before the war in Iraq, trauma was all but absent from the ICU, Armonda said.

The shift to a wartime hospital also has challenged the facility's surgeons to repurpose their skills.

Armonda, for example, learned how to use a microcatheter to release the bubble that forms in blood veins to treat aneurysms. But since the wars, Armonda has been using that technique to treat trauma-induced brain injuries in which blood vessels are damaged by shards of skull, smashed in a combat blast.

The shift from treating tumors to blast injuries was jarring and a change that required time to adjust, Armonda said. But being adaptable to war also is part of a military doctor's training, he said. “It's a variation on a theme,” Armonda said, “how your specific skills translate to wartime.”

Highlights from the 9th SNIS Practicum and Inaugural International Endovascular Stroke Conference (IESC)

June 4-5, 2011 • Sheraton Seattle Hotel



• Seattle, Washington



CMS Releases Final “Meaningful Use” Rules

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Sometimes people use the terms “Electronic Medical Record” or “EMR” when talking about Electronic Health Record (EHR) technology. Very often an Electronic Medical Record or EMR is just another way to describe an Electronic Health Record or EHR, and both providers and vendors sometimes use the terms interchangeably. For the purposes of the Medicare and Medicaid Incentive Programs, eligible professionals, eligible hospitals and critical access hospitals (CAHs) must use certified EHR technology. Certified EHR technology gives assurance to purchasers and other users that an EHR system or module offers the necessary technological

capability, functionality, and security to help them meet the meaningful use criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information. For more information about which EHR systems and modules are certified for the Medicare and Medicaid EHR Incentive Programs, please visit <http://healthit.hhs.gov>.

The Medicare EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals, and CAHs that demonstrate meaningful use of certified EHR technology.

- Participation can begin as early as 2011.
- Eligible professionals can receive up to **\$44,000** over five years under the Medicare EHR Incentive Program.

There’s an additional incentive for eligible professionals who provide services in a Health Professional Shortage Area (HSPA).

- **To get the maximum incentive payment, Medicare eligible professionals must begin participation by 2012.**
- Incentive payments for eligible hospitals and CAHs may begin as early as 2011 and are based on a number of factors, beginning with a **\$2 million** base payment.
- **Important! For 2015 and later, Medicare eligible professionals, eligible hospitals, and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement.**

Registration for this Incentive Program is now open. Visit <http://www.cms.gov/EHRIncentivePrograms/> for more information.

The Lighter Side of Medicine

These are actual writings from various hospital charts.

- The patient refused an autopsy.
- The patient has no previous history of suicides.
- Patient has left white blood cells at another hospital.
- She has no rigors or shaking chills, but her husband states she was very hot in bed last night.
- Patient has chest pain if she lies on her left side for over a year.
- On the second day, the knee was better, and on the third day it disappeared.
- The patient has been depressed since she began seeing me in 1993.
- The patient is tearful and crying constantly. She also appears to be depressed.
- Discharge status: Alive but without permission.
- Healthy appearing decrepit 69-year old male, mentally alert but forgetful.
- Patient had waffles for breakfast and anorexia for lunch.
- She is numb from her toes down.
- Occasional, constant, infrequent headaches.
- Patient was alert and unresponsive.
- Rectal examination revealed a normal size thyroid.
- I saw your patient today, who is still under our car for physical therapy.
- She stated that she had been constipated for most of her life, until she got a divorce.



- While in ER, she was examined, x-rated, and sent home.
- The skin was moist and dry.
- Both breasts are equal and reactive to light and accommodation.
- Examination of genitalia reveals that he is circus sized.
- The lab test indicated abnormal lover function.
- Skin: somewhat pale but present.
- The pelvis exam will be done later on the floor.
- Patient has two teenage children, but no other abnormalities.

FDA Outlines Plans to Improve 510(k) Process

The US Food and Drug Administration (FDA) announced a plan containing 25 actions it intends to implement during 2011 to improve the most common path to market for medical devices. The complete report and related documents are available on the FDA's website.

In the report, the FDA outlined its key actions, which include:

- Streamlining the de novo review process for certain innovative, lower-risk medical devices;
- Clarifying when clinical data should be submitted in a premarket submission, guidance that will increase the efficiency and transparency of the review process; and
- Establishing a new Center Science Council of senior FDA experts to ensure timely and consistent science-based decision making.

To bolster the safety of medical devices, the FDA will establish a public database of important device information regarding the safety and effectiveness known to the manufacturer for select higher-risk devices on a case-by-case basis through device-specific guidance.

Jeffrey Shuren, MD, JD, director of the FDA's Center for Devices and Radiological Health (CDRH) stated that these actions will result in "a smarter medical device program that supports innovation, keeps jobs here at home, and brings important, safe and effective technologies to patients quickly."

In September 2009, CDRH set up two internal working groups to address concerns relating to the premarket notification process. According to the FDA, industry argued that the 510(k) process was unpredictable, inconsistent, and opaque, whereas consumers and health care professionals argued that the review process was not robust enough. At the same time, CDRH also asked the independent, non-profit Institute of Medicine to conduct a study of the program that is still ongoing.

The two working groups issued 55 recommendations in August 2010. After reviewing public comments, CDRH now intends to take 25 actions to improve the 510(k) program in 2011, including new guidance and enhanced staff training. CDRH is also giving the Institute of Medicine an opportunity to provide feedback on seven recommendations before making a final decision.

Michael Brothers Award Recipient Named at ASNR

SNIS is pleased to announce that the 2010 recipients of the Michael Brothers Memorial Award are Professor Juan R. Cebal from George Mason University and Christopher Putman, MD from Inova Fairfax Hospital. Their manuscript, "*Hemodynamic Characteristics Associated to Cerebral Aneurysm Rupture*" was named the Best Paper in Interventional Neuroradiology at the 48th Annual Meeting of the American Society of Neuroradiology, held May 15-20, 2010 in Boston, Massachusetts.

Congratulations to Professor Cebal and Dr. Putman!

AHA/ASA Publish Updated Stroke Prevention Guidelines

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Therefore, patients and doctors much consider risk factors, cost, tolerance, and other characteristics to tailor the appropriate therapy.

- Stroke or TIA survivors who are diabetic should follow existing guidelines for blood sugar control.
- All stroke or TIA patients who have a carotid artery blockage should aim for optimal medical therapy through a multifaceted approach, including antiplatelet drugs, statin therapy, and lifestyle risk factor changes such as blood pressure management.

- When patients with high stroke risk due to atrial fibrillation need to temporarily stop taking warfarin, they should receive low-molecular-weight heparin as bridging therapy to reduce the risk of blood clots.

Dr. Furie added that high blood pressure is the most critical risk factor for recurrent stroke. Doctors should work with patients to find the best drug regimen to suit each individual's blood pressure control needs.

Welcome New SNIS Members!

The following new members have been approved for membership since January 1. Please help us extend a warm welcome to them.

Senior Members

Barbara Albani, MD

Christiana Care Health System
Newark, DE

Christopher Boyd Baker, MD

Maine Medical Center
Portland, ME

Robert D. Ecker, MD

Maine Medical Center
Scarborough, ME

Mayank Goyal, MD

University of Calgary
Calgary, AV
Canada

Muhammad S. Hussain, MD*

Cleveland Clinic
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Rochester, MN

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Touro College of Osteopathic Medicine
New York, NY

Naz Moaddab

George Washington School of Medicine
Washington, DC

* Moved from Junior to Senior membership

SNIS Adds to Staff

SNIS is pleased to announce the addition of our third staff member! Having joined us on January 10, Anthony Portillo takes on the newly created position of Administrative Coordinator. In this capacity, Anthony will support Eddie in such areas as membership growth, committee development and conference support.

A graduate of George Mason University with a degree in Communications, Anthony has put his skills to work in numerous customer service positions post-graduation. In joining SNIS, Anthony said his goal was to combine his outgoing nature with his desire to work on behalf of something he believes in because “that combination motivates me to work hard and continue to refine my skills in order to expand my opportunities to make an impact.”

In his few short months with SNIS, his impact can already be felt. Marie commented, “Having another team member in the office is making a notable impact on



work flow and efficiency. More resources translates into more opportunities to divide and conquer and maximize our efforts on behalf of our members and our society.”

If you get a chance, please welcome Anthony to the team. You’ll be seeing – and hearing – a lot from him in the year ahead.

Members may contact Anthony at portillo@snisonline.org or 703-691-2272.

Welcome Anthony!

Attention Fellowship Directors!

SNIS is updating our website and we are in need of a more complete list of Neurointerventional Fellowship Programs. If you are a Fellowship Director, please send us an e-mail to info@snisonline.org so that we can send you the proper form to complete to place your information on the website.

The purpose of this list is to provide potential applicants with an easy reference for contact information and to promote fellowship opportunities.

Thank you for taking the time to make sure that we have the most recent information.

Are You Getting the Most Out of Your Membership?

If SNIS does not have your email address, the answer to this question may well be a resounding no! Although we make sure to communicate our news to you through multiple venues – including standard mail, the SNIS web site, and even the occasional phone call – without question, emails rank at the top of the list where it concerns members’ preferred communication vehicle.

As we are highly sensitive to the quantity of emails that you receive each day, SNIS carefully aims for no more than 1-2 a month. Why would you want to receive these emails? To get the latest news on items including information on upcoming meetings, breaking news related to society or neurointerventional developments, information on committees or task forces in which you may be interested, valuable membership surveys

that help us gauge your needs and the impact of our work – and much more!

Remember – SNIS prioritizes confidentiality where all of our membership information is concerned; thus, we will never pass on your email address to outside vendors.

Be sure to send us your email address now – so that you won’t miss out on valuable news that is pertinent to you! You may provide your email address to us by sending it to info@snisonline.org or calling us at **703-691-2272**.



See you next year...

**SNIS 9th Annual Meeting
and 3rd Annual Fellows Course**

Save the Date!

July 23-27, 2012

Hilton San Diego

Bayfront Hotel

San Diego, California



Society of
NeuroInterventional
Surgery

SNIS



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The SNIS Foundation is formed as a charitable organization under section 501(c)(3) of the Internal Revenue Code. Its tax exemption application is currently pending. Donations are tax deductible as a charitable contribution to the maximum extent allowed by law. Please consult your tax advisor.

The SNIS Foundation would like to thank the following members who have already confirmed their commitment through a tax-deductible donation to the SNIS Foundation. You too can be considered a Founding Donor if you donate prior to the 2012 SNIS Annual Meeting. Contact the SNIS Office at 703-691-2272 for more information or a donation form.

SNIS Foundation Founding Donors (as of 7/8/11)

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- Shaye I. Moskowitz, MD, PhD

CALENDAR OF EVENTS

SNIS Events

Society of NeuroInterventional Surgery 10th SNIS Practicum

April 27-28, 2012
Sheraton New York Hotel & Towers
New York, New York
Contact: SNIS, 703-691-2272

Society of NeuroInterventional Surgery 9th Annual Meeting

July 23-26, 2012
Hilton San Diego Bayfront Hotel
San Diego, California
Contact: SNIS, 703-691-2272

Society of NeuroInterventional Surgery 3rd Annual Fellows Course

July 26-27, 2012
Hilton San Diego Bayfront Hotel
San Diego, California
Contact: SNIS, 703-691-2272

Other Events

11th WFITN Congress
November 8-11, 2011
Cape Town International
Convention Centre
Cape Town, South Africa
Contact: www.wfitn2011.org

4th ESMINT Teaching Course 2011
December 4-8, 2011
Universitat Pompeu Fabra
Barcelona, Spain
Contact: www.esmint.eu

International Stroke Conference
February 1-3, 2012
New Orleans, Louisiana
Contact: www.strokeconference.org

The Embolus

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