From the Society for Vascular Surgery

# Aortic disease: The quest to improve patient outcomes

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It is it a great honor to stand here before you today to deliver this Roy K. Greenberg distinguished lecture. I would like to thank the Society for the invitation and for this great honor. I have many people to thank for helping me out in the daunting task of putting together this presentation, and I am to them forever grateful. It is with pleasure that I see here so many of those that have become close friends along my journey to standing here. Thank you. But there is also great sadness in my heart as I stand here missing my great friend and mentor Roy, to whose honor I am giving this talk.

I remember as a young surgical intern sitting in one of our vascular conferences at the department in Malmö sometime in the early spring of 1998. The usual cases were being discussed by the attendings, while we were all trying to catch a glimpse of the miniature hard copy computed tomography (CT) scans being projected on the light box at the front of the room. I remember distinctly that a case was reviewed of a patient presenting with a thoracoabdominal aortic aneurysm (TAAA). The discussion was going back and forth on the treatment options. Overall, I got the sense that this case was indeed very complex, and the attendings were doubtful if the patient was a suitable candidate for this very complex surgery. Already back in those days, the department had a steady stream of visitors from all over the world who came to visit, train, and learn about new technologies under the guidance of Krassi Ivancev who was the lead interventional radiologist in Malmö and who had pioneered the introduction of endovascular techniques. So it was quite common that our conferences were held in English despite this not being the official language. During the conversation regarding the patient with the thoracoabdominal aneurysm, I suddenly heard a voice from the back of the room stating innocently "that seems to be a very straightforward type IV TAAA repair." All heads turned around, and one of the attendings immediately exclaimed "Really! Why don't you just take us through the steps of how you would do that then." As I looked to the back I saw a young man sitting relaxed in slightly baggy clothes with a 5 o'clock shadow on his chin. He had a big smile on his face and a distinct, penetrating look in his dark eyes. He proceeded to say, "I would start with a left thoracotomy entering the 7th intercostal space," and he proceeded to describe in detail every step of a type IV TAAA repair. The room felt silent. Roy had introduced himself to the department.

Timothy A. Resch, MD, PhD

This was my first encounter with Roy and little did I know at the time that he would become not only great mentor to me but also a very close friend. He has impacted me more on a professional and personal level than I can ever describe to you. He still impacts not only my practice on a daily basis because of the fact that his techniques and ideas are still very central to what we do as aortic surgeons but also me as a person being guided by Roy's outlook on life, family, and friends.

*The Quest—WWRD (What Would Roy Do?)*

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**Fig 1.** Previous speakers for the Roy. K Greenberg Distinguished Lecture. **Left,** Prof Stephan Haulon, Hopital Cardiologique, Lille, France. **Middle,** Dr Gustavo Oderich, Mayo Clinic, Rochester, Minn. **Right,** Prof Matthew Eagleton, Cleveland Clinic Foundation, Cleveland, Ohio.

In preparation for this talk, I obviously wanted to share with you all the great achievements that Roy accomplished. I had a plan to present to you an overview of Roy's ideas, patents, publications, and major contributions in the field of endovascular aortic repair. Then I realized that this had already been done (Fig 1). How does one follow that? Nevertheless, I pushed on determined to dig deeper, find more, and deliver more clearly. But after producing slide after slide packed with content I started hearing a voice in the back of my head that with increasing volume and intensity said: "Why would you do that?" As you can imagine, the voice was quite familiar to me and left no room to doubt who was the messenger. Thus, I decided that I would attempt to show you instead where we have been, how we got where we are, and perhaps where we are going in the future now that Roy is not here to guide us. So, I reached out to friends and colleagues all around and asked them to share with me, and you, what directions we are going. It turned out that Roy had more to do with the latest developments than I had ever imagined.

*Difficult to see. Always in motion is the future*
— Yoda, The Empire Strikes Back

I think you would all agree with me that we have come a long way in improving care for our patients with aortic disease in the past 2 decades. The revolution and evolution of endovascular therapies has changed the playing field for our patients in a way no one could have imagined 20 years ago. Symbiotically with this technical revolution, the fields of medical imaging, genetics, and cellular and biological diagnosis have expanded almost exponentially. It is easy to get carried away on this high-speed chase for the next best thing and to forget what our true quest is. It all starts and ends with our patients. Everything we do and everything we work so hard to achieve in the field of medicine in general and vascular surgery, in particular, must be aimed at improving the care for them.

And the care of our aortic patients begins long before we ever consider putting them on an operating table. As a medical student and as a young trainee, I was taught that aneurysmal disease was a part of the family of atherosclerotic disorders that affected all vascular patients. Hereditary risk affected only a limited number of patients and mostly only males. If evident features of connective tissue disorders were not present, it was most likely a normal, sporadically

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