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Peripheral Vascular Surgery Society

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2012 - 2013

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‘ 12 - ‘13 Committees

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Accreditation

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the Peripheral Vascular Surgery Society. The American College Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™

The American College of Surgeons designates this live activity for a maximum of 14.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learning Objectives

This activity is designed for peripheral vascular surgeons. Upon completion of this course, attendees should be able to: (1) Define criteria for re-intervention in lower extremity arterial disease; (2) Understand the optimal method of screening for carotid artery disease; (3) Know and prevent radial artery access complications and; (4) Establish simulation based training.

Disclosure Information

In compliance with ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.

Marketing Acknowledgement

The Peripheral Vascular Surgery Society wishes to recognize and thank the following companies for their ongoing support through marketing:

Abbott Vascular
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Past Meetings & Presidents

Date	Location	President
1976	Chicago, IL	Organizational Meeting
1977	Dallas, TX	Steven M. Dosick, MD
1978	San Francisco, CA	Robert G. Scribner, MD
1979	Chicago, IL	William S. Gross, MD
1980	Chicago, IL	Charles A. Andersen, MD
1981	Dallas, TX	Larry H. Hollier, MD
1982	Boston, MA	G. Edward Bone, MD
1983	San Francisco, CA	Robert C. Batson, MD
1984	Atlanta, GA	Lee C. Bloemendal, MD
1985	Baltimore, MD	George J. Collins, Jr.
1986	New Orleans, LA	Jonathan B. Towne, MD
1987	Toronto, Canada	Thomas S. Riles, MD
1988	Chicago, IL	Paul T. McDonald, MD
1989	New York, NY	Anthony J. Comerota, MD
1990	Los Angeles, CA	John W. Hallett, Jr., MD
1991	Boston, MA	Paul M. Orecchia, MD
1992	Chicago, IL	David L. Rollins, MD
1993	Washington, DC	Frank T. Padberg, Jr., MD
1994	Seattle, WA	Peter G. Kalman, MD
1995	New Orleans, LA	William J. Quinones-Baldrich, MD
1996	Chicago, IL	Joseph L. Mills, MD
1997	Boston, MA	Gary Giangola, MD
1998	San Diego, CA	J. Gordon Wright, MD
1999	Washington, DC	Jeffrey R. Rubin, MD
2000	Toronto, Canada	Donald L. Akers, Jr., MD
2001	Baltimore, MD	Thomas F. Lindsay, MD
2002	Boston, MA	R. Clement Darling, III, MD
2003	Chicago, IL	Jeffrey L. Ballard, MD
2004	Anaheim, CA	Samuel R. Money, MD
2005	Chicago, IL	Lewis B. Schwartz, MD
2006	Philadelphia, PA	Robert A. Cambria, MD
2007	Baltimore, MD	William D. Jordan, Jr., MD
2008	San Diego, CA	W. Charles Sternbergh, III, MD
2009	Denver, CO	Tina R. Desai, MD
2010	Boston, MA	Karl A. Illig, MD
2011	Chicago, IL	Marc A. Passman, MD
2012	Baltimore, MD	Martin R. Back, MD

Schedule-At-A-Glance

Thursday, January 31, 2013

7:00 am - 9:00 am	Executive Committee Meeting
7:00 am - 5:00 pm	Registration
9:00 am - 12:30 pm	**FELLOW LUMINARIES**
10:30 am - 11:00 am	Coffee Break
12:45 pm - 1:30 pm	**FEATURED SPEAKER LUNCHEON** Norman M. Rich, MD, Col, MC, USA (Ret) F. Edward Hebert School of Medicine, USUHS, Bethesda, MD
1:30 pm - 4:30 pm	**SOCIETY FOR MILITARY VASCULAR SURGERY SCIENTIFIC PROGRAM** **SVMS SCIENTIFIC SESSION I** Opening Remarks: W. Darrin Clouse, MD
1:35 pm – 1:45 pm	**M1** **Evaluating the Degree of Carotid Artery Stenosis Utilizing CT Angiography Versus Duplex Ultrasound and Digital Subtraction Angiography** Douglas R. Stoddard*, Niten N. Singh, Charles A. Kitley*, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA
1:45 pm – 1:55 pm	**M2** **Consequences of Cross Clamping the Aorta: A Histologic and Inflammatory Perspective** Steven Satterly, Shashikumar Salgar*, Matthew Martin*, Niten Singh - Madigan Army Medical Center, Tacoma, WA
2:00 pm – 2:10 pm	**M3** **Fishing For A Safe and Effective Vascular Closure Device: A Single Institution's Experience With the Femoral Introducer Sheath and Hemostasis (FISH™) Device** Gregory Skerrett*, Gilbert Aidinian, Llewellyn Lee, Patrick Cook - William Beaumont Army Medical Center, El Paso, TX
2:10 pm – 2:20 pm	**M4** **Pharmacologic Attenuation of the Hyperdynamic Response After Aortic Occlusion** Wayne Causey*, Seth Miller*, Matthew Martin*, Niten Singh - Madigan Hospital, Tacoma, WA
2:20 pm – 2:30 pm	**M5** **A Process Improvement Project To Improve IVC Filter Retrieval** Leo J Daab*, Paul W White, Scott R Golarz, David R Whittaker, Robert M Craig, Charles J Fox - Walter Reed National Military Medical Center, Bethesda, MD

Schedule-At-A-Glance

2:30 pm – 3:00 pm	Coffee Break
	SVMS SCIENTIFIC SESSION II
3:00 pm – 3:10 pm	**M6** **Resuscitative Endovascular Balloon Occlusion of the Aorta For Hemorrhagic Shock: A Review of the Literature With Implications For Modern Practice** Sahar T Leazer*[1], Jonathan J Morrison J Morrison[1], Zackary M Arthurs[1], Jeremy W Cannon*[1], Jonathan L Eliason[2], Todd E Rasmussen[1] - [1]US Army of Surgical Research, Fort Sam Houston (San Antonio), TX; [2]University of Michigan, Michigan, TX
3:10 pm – 3:20 pm	**M7** **Feasibility of Carotid Stenting Through Brachial Access In Difficult Arch Anatomy** Patrick Neville, Brian Santin, Patrick Muck, Matthew Recht, Sophia Afridi, Pryze Smith*, Joann Lohr - Good Samaritan Hospital, Cincinnati, OH
3:20 pm – 3:30 pm	**M8** **Repair of Aberrant Right Subclavian Artery Entirely Via A Supraclavicular Approach** Aaron C Baker[1], Brodus Atkins[2], W. Darrin Clouse[2], Robert Noll[2], James Sampson[2], Timothy Williams[2] - [1]University of California Davis Medical Center, Sacramento, CA; [2]David Grant Medical Center, Travis Air Force Base, CA
3:30 pm – 3:40 pm	**M9** **A Case of Subclavian Vein Thrombosis With Poland Syndrome** Steven Satterly*, Charles Andersen, Niten Singh - Madigan Army Medical Center, Tacoma, WA
3:40 pm – 3:50 pm	**M10** **Common Femoral Endovenectomy With Inline Iliac Vein Stenting: A Hybrid Solution To Daunting Problem** Mel J Sharafuddin, Rachael M Nicholson, Sara Mijal*, Adonis J Lysandrou* - University of Iowa Carver College of Medicine, Iowa City, IA
3:50 pm – 4:00 pm	**M11** **Case Report of An Anterior Trans-Abdominal Approach To A Type II Endoleak Repair** Douglas R. Stoddard*, Niten N. Singh, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA
4:00 pm – 4:30 pm	Discussion
4:30 pm	Meeting Adjourns
5:00 pm – 7:00 pm	**WELCOME RECEPTION**

Schedule-At-A-Glance

Friday, February 1, 2013

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
7:00 am – 9:15 am	**SCIENTIFIC SESSION I** Moderators: Mark Conrad, MD & Katherine Gallagher, MD Opening Remarks: Ruth L. Bush, MD, MPH, President
7:00 am – 7:15 am	**1** **Comparison of Acute Versus Chronic Dynamic Intimal Flap Movement In Stanford Type B Aortic Dissections (ATBD) and the Effects of Thoracic Endovascular Stent Grafting** Frank R Arko, III, Aaron H Hurd*, Tzvi Nussbaum*, Christopher Boyes*, Stephen G Lalka*, Timothy S Roush - Sanger Heart and Vascular Institute, Charlotte, NC
7:15 am – 7:30 am	**2** **Results of Routine Adjunctive Spinal Drainage and/or Left Subclavian Artery Bypass In Thoracic Endovascular Aortic Repair** Dean J. Arnaoutakis*, George J. Arnaoutakis*, Robert J. Beaulieu*, Christopher J. Abularrage*, James H. Black, III - The Johns Hopkins Hospital, Baltimore, MD
7:30 am – 7:45 am	**3** **Acute Complications After Balloon Assisted Maturation of AVF's** Anil Hingorani, Enrico Ascher*, Natalie Marks*, Andrea Carollo*, Pamela Boniviscage* - Lutheran Medical Center, Brooklyn, NY
7:45 am – 8:00 am	**4** **Restenosis and Symptom Recurrence After Endovascular Therapy For Claudication: Does Duplex Ultrasound Correlate With Recurrent Claudication?** Douglas W Jones*, Ashley R Graham*, Peter H Connolly*, John K Karwowski*, Harry L Bush, Darren B Schneider, Andrew J Meltzer - New York Presbyterian Hospital - Weill-Cornell Medical Center, New York, NY
8:00 am – 8:10 am	**5 (RF)** **Paroxysmal Nocturnal Hemoglobinuria: A Red Clot Syndrome** Jeffrey D Crawford, Victor W Wong*, Thomas Deloughery*, Erica L Mitchell, Timothy K Liem*, Gregory J Landry*, Gregory L Moneta* - Oregon Health and Sciences University, Portland, OR

Schedule-At-A-Glance

8:10 am – 8:20 am

6 (RF Video)
Videoscopic Basilic Vein Harvest For the Creation of Transposed Brachial-Basilic AV Fistulas: A Novel Protocol
John P Leone*[1], Alexander Glaser*[1], Rick Hufstetler*[2], Karl Illig[3] - [1]Tampa General Medical Group, Tampa, FL; [2]Tampa General Hospital, Tampa, FL; [3]University of South Florida/ Tampa General Hospital, Tampa, FL

8:20 am – 8:30 am

7 (CR)
IVUS As A Novel Tool For the Diagnosis of Endofibrosis
Danielle Campbell*, Katherine A Gallagher, Shipra Arya*, Tina Chen*, Dawn Coleman, Peter Henke, Jon L Eliason, John Rectenwald - University of Michigan, Ann Arbor, MI

8:30 am – 8:45 am

8
Post-Discharge Care Matters: The Relationship Between Quality of Diabetic Care, Readmission and Survival For Lower Extremity Revascularization
Benjamin S Brooke*, Randall R DeMartino*, Kristina A Giles*, Richard J Powell, David H Stone, Brian W Nolan, Philip P Goodney - Dartmouth-Hitchcock Medical Center, Lebanon, NH

8:45 am – 9:00 am

9
Surgical Complications of Radial Artery Catheterization
Karan Garg, Brittny S Williams-Howell, Stephanie Saltzberg, David Dexter, Todd L. Berland, Thomas S Maldonado, Caron B Rockman - NYU Langone Medical Center, New York, NY

9:00 am – 9:15 am

10
Surgical Site Infections and Complications Following Vascular Groin Procedures
SreyRam Kuy*, Anahita Dua, Bhavin Patel*, Nader Tondravi*, Gary R Seabrook, Kellie R Brown, Brian D Lewis, Cheong J Lee, Peter J Rossi - Medical College of Wisconsin, Milwaukee, WI

3:00 pm

Registration Re-Opens

3:30 pm – 4:00 pm

Coffee/Snacks – Visit Exhibitors

4:00 pm – 6:00 pm

SCIENTIFIC SESSION II
Moderator: Jean Bismuth, MD

4:00 pm – 4:15 pm

11
Open Mesenteric Interventions Are Equally Safe As Endovascular Interventions and Offer Better Long-Term Patency
Shipra Arya, Stephanie Kingman*, Jordan Knepper, Jonathan L Eliason, Peter K Henke, John E Rectenwald - University of Michigan, Ann Arbor, MI

Schedule-At-A-Glance

4:15 pm – 4:30 pm

12
Preliminary Experiences With Early Primary Closure of Foot Wounds Following Lower Extremity Revascularization
Neal R Barshes, Carlos F. Bechara, George Pisimisis, Panos Kougias - Baylor College of Medicine, Houston, TX

4:30 pm – 4:45 pm

13
Do PSVR Ratios Correlate With ABI Value and Symptoms After SFA Intervention? Lessons From the VIBRANT Trial
Patrick Geraghty[1], Mark W. Mewissen*[2], Gary M Ansel*[3], Michael R Jaff*[4] - [1]Washington University Medical School, Saint Louis, MO; [2]St. Luke's Hospital, Milwaukee, WI; [3]Riverside Methodist Hospital, Columbus, OH; [4]Harvard Medical School, Massachusetts General Hospital, Boston, MA

4:45 pm – 5:00 pm

14
Retrograde Popliteal Access Is Safe and Effective - It Should Be Added To the Vascular Surgeon's Portfolio
Houssam K Younes*, Abindra Sigdel*, Charudatta S Bavare*, Mitul S Patel*, Hosam F El-Sayed, Jean Bismuth, Eric K Peden, Alan B Lumsden, Mark G Davies - Methodist DeBakey Heart and Vascular Center, Houston, TX

5:00 pm – 5:10 pm

15 (RF)
Supervised Exercise Programme Improves Aerobic Fitness In Patients Awaiting Abdominal Aortic Aneurysm Repair
Hashem Barakat*, Yousef Shahin, Peter McCollum, Ian Chetter - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

5:10 pm – 5:20 pm

16 (CR Video)
Use of the Artis-Zeego iGuide Program To Perform A Translumbar Glue Embolization of A Type-2 Endoleak: A Video Case Report
Mikel Sadek*, Todd L Berland, Thomas S Maldonado, Firas F Mussa, Caron B Rockman, Genn R Jacobowitz, Patrick J Lamparello, Mark A Adelman, Frank J Veith, Neal S Cayne - New York University Langone Medical Center, New York, NY

5:20 pm – 5:30 pm

17 (CR)
Pulmonary Emboli and Internal Jugular Vein Aneurysm In A Patient With Neurofibromatosis 1
Brian Santin, Sara McKeever*, Chris Paprzycki*, Matt Recht* - Good Samaritan Hospital, Cincinnati, OH

5:30 pm – 5:45 pm

18
Heparin Bonding Does Not Improve Patency of PTFE Arteriovenous Grafts
Matthew T Allemang*[1], Brian Schmotzer*[2], Virginia L. Wong*[1], Alex Chang*[1], Ryan Lakin*[1], Kenneth Woodside*[1], John Wang*[1], Vikram S. Kashyap[1] - [1]University Hospitals Case Medical Center, Cleveland, OH; [2]Case Western Reserve University, Cleveland, OH

Schedule-At-A-Glance

5:45 pm – 6:00 pm

19
Is There Benefit To Universal Carotid Artery Duplex Screening Prior To Cardiac Surgery?
Brian C Adams*[1], Ross M Clark*[1], James M Goff, Jr.[1,2] - [1]University of New Mexico School of Medicine, Albuquerque, NM; [2]Raymond G. Murphy VA Medical Center and the University of New Mexico School of Medicine, Albuquerque, NM

6:00 pm – 6:30 pm **PVSS MEMBER BUSINESS MEETING**
(Members Only)

6:30 pm - Free Evening

Saturday, February 2, 2013

6:00 am – 7:00 am Continental Breakfast

6:00 am – 9:30 am Registration

7:00 am – 9:00 am **SCIENTIFIC SESSION III**
Moderators: W. Darrin Clouse, MD & Ravi Rajani, MD

7:00 am – 7:15 am

20
The Impact of Gender On Angioplasty and Primary Stenting For Femoropopliteal Occlusive Disease: Results of the DURABILITY II Trial
Rami O Tadros[1], Peter L. Faries[1], Krishna J Rocha-Singh[2], Sung yup Kim*[1], Victoria Teodorescu[1], Sharif H Ellozy[1], Michael L Marin1, Ageliki G Vouyouka[1] - [1]The Mount Sinai Medical Center, New York, NY; [2]St. John's Hospital, Springfield, IL

7:15 am – 7:30 am

21
Patient-Centered Outcomes and Risk-Adjusted Hospital Mortality In Major Vascular Surgery
Micah E Girotti*, Jonathan L Eliason, Justin B Dimick*, Peter K Henke* - University of Michigan, Ann Arbor, MI

7:30 am – 7:45 am

22
Use of Anti-Xa Levels To Monitor Heparin Therapy - A Failed Trial In A Hospitalized Population
Joann M Lohr, Thomas Panke, Thomas Imhoff, Janice Miller, Angela N Fellner* - Good Samaritan Hospital, Cincinnati, OH

7:45 am – 8:00 am

23
Outcome Predictors of Limb Salvage In Traumatic Popliteal Artery Injury
Anahita Dua*, Jaecel O Shah, Robert E Lasky, Kristofer Charlton-Ouw, Ali Azizzadeh, Anthony Estrera, Hazim J Safi, Sheila M Coogan - University of Texas-Houston, Houston, TX

Schedule-At-A-Glance

8:00 am – 8:10 am	**24 (RF)** **The Endovascular Management of Arterial Injuries Associated With Posterior Knee Dislocation** Zachary K. Baldwin, Rishi Roy*, Andrea Barker - University of Mississippi Medical Center, Jackson, MS
8:10 am – 8:20 am	**25 (RF)** **Assessment of Initial Wound Healing Following Amputations** Amani D Politano*, Jennifer Wang*, Mehul S Patel*, Kenneth J Cherry*, Gilbert R Upchurch*, Jr.*, Margaret C Tracci* - University of Virginia, Charlottesville, VA
8:20 am – 8:30 am	**26 (RF)** **When To Call It A Day: Incremental Risk of Amputation After Multiple Revascularization** Alexander T. Hawkins*, Maria J. Schaumeier*, Ann D. Smith*, Nathanael D. Hevelone*, Louis L. Nguyen* - Brigham and Women's Hospital, Boston, MA
8:30 am – 8:45 am	**27** **A Cost-Effectiveness Analysis of Revascularization For Limb Salvage Among Patients With Marginal Baseline Functional Status** Neal R. Barshes[1], Panos Kougias[1], C. Keith Ozaki[2], George Pisimisis[1], Carlos F. Bechara[1], Helene K. Henson*[1], Michael Belkin[2] - [1]Baylor College of Medicine, Houston, TX; [2]Brigham and Women's Hospital, Boston, MA
8:45 am – 8:55 am	**28 (CR)** **Re-Entry Device Aided EVAR In Patients With AAA and Unilateral Iliac Artery Occlusion** Jason T Lee, George K. Lee, Vinit Varu*, Shu Chang* - Stanford University Medical Center, Stanford, CA
8:55 am – 9:05 am	Introduction of the President
9:05 am – 9:35 am	**PRESIDENTIAL ADDRESS** **I Have But One Candle of Life To Burn…** Ruth L. Bush, MD, MPH
12:00 pm – 1:00 pm	**SKI-IN/SKI-OUT LUNCH**
3:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks Last Chance To Visit Exhibitors

RF - Rapid Fire; CR - Case Report

Schedule-At-A-Glance

4:00 pm – 6:00 pm

SCIENTIFIC SESSION IV
Moderators: Peter Nelson, MD & Brian DeRubertis, MD

4:00 pm – 4:15 pm

29
Concomitant Intracranial Aneurysm and Carotid Artery Stenosis: An Institutional Review of Patients Undergoing Carotid Revascularization
Matthew J Borkon, Han Hoang*, Caron Rockman, Firas Mussa, Jafar J Jafar, Thomas Riles, Frank J Veith, Mark A Adelman, Thomas S Maldonado - New York University Langone Medical Center, New York, NY

4:15 pm – 4:30 pm

30
Endovascular Popliteal Artery Aneurysm Repair: A Decade of Experience
Jeffrey Jim, Enjae Jung, Brian G Rubin, John A Curci, Luis A Sanchez, Patrick J Geraghty - Washington University in St. Louis, St. Louis, MO

4:30 pm – 4:45 pm

31
Disparate Preoperative Surveillance and Rupture of Abdominal Aortic Aneurysm For the Elderly Poor
Matthew W Mell, Laurence C Baker*, Mark A Hlatky* - Stanford University, Stanford, CA

4:45 pm – 5:00 pm

32
Postoperative and Long-Term Outcomes Following Open Repair of Ruptured Abdominal Aortic Aneurysms In Octogenarians
Hashem M Barakat*, Yousef Shahin, Ian Chetter, Peter McCollum - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

5:00 pm – 5:10 pm

33 (CR)
Endovascular Management of Middle Aortic Syndrome With Associated Saccular Aneurysm In A Newborn
Siddharth Patel, Dennis Kim*, Ravi Veeraswamy - Emory University, Atlanta, GA

5:10 pm – 5:20 pm

34 (CR)
Coil Embolization of Ascending Aortic Pseudo-Aneurysm Post Open Repair of Type A Aortic Dissection
Vikalp Jain*, Luis Gruberg*, Thomas V Bilfinger*, Apostolos K Tassiopoulos, Shang A Loh - Stony Brook University Medical Center, Stony Brook, NY

5:20 pm – 5:30 pm

35 (RF)
A Novel Approach To EVAR Simulation Using Patient Specific Modeling
Gavin R Davis, Murray L Shames, Karl A Illig, George Yang*, Thu -Hoai Nguyen* - USF, Tampa, FL

RF - Rapid Fire; CR - Case Report

Schedule-At-A-Glance

5:30 pm – 5:45 pm	**36** **Validated Assessment Tool Paves the Way For Standardized Evaluation of Trainees On Anastomotic Models** Cassidy Duran[1], Murray L Shames[2], Jean Bismuth[1], Jason T Lee[3], APDVS Committee for Education and Simulation - [1]The Methodist DeBakey Heart & Vascular Center, Houston, TX; [2]University of South Florida Health, Tampa, FL; [3]Stanford University School of Medicine, Stanford, CA
5:45 pm – 6:00 pm	Q & A, Discussion
7:00 pm – 10:00 pm	**PRESIDENT'S DINNER** All attendees are welcome to purchase tickets to attend this separate subscription event.

Sunday, February 3, 2013

6:30 am – 7:00 am	Continental Breakfast
6:30 am – 9:00 am	Registration
7:00 – 9:00 am	**SCIENTIFIC SESSION V** Moderators: Ravi Veeraswamy, MD & Christopher Smolock, MD
7:00 am – 7:15 am	**37** **Risk Factors Associated With the Abdominal Aortic Aneurysm Diagnosis In Patients Screened At A Regional Veterans Affairs Health Care System** Kevin C Chun*[1], Kai Y. Teng*[1], LeAnn A. Chavez*[1,2], Elyse N. Van Spyk*[1], John G. Carson*[1,2], Eugene S. Lee*[1,2] - [1]VA Northern California Health Care System, Mather, CA; [2]University of California, Davis, Sacramento, CA
7:15 am – 7:30 am	**38** **Mini-Incision Thoracobifemoral Bypass In the Endovascular Era** Amy E Reppert*, Omid Jazaeri*, Ashok Babu*, Mark Nehler*, Brett T Reece* - University of Colorado, Aurora, CO
7:30 am – 7:45 am	**39** **CEAP Classification Relationship To VLU Closure: A Retrospective Analysis of A Prospective Randomized Controlled Trial of VLU Treatment With A Novel Spray-Applied Cell Therapy** Jamie A Schwartz*[1], Cynthia Gendics*[1], Robert S Kirsner*[2], Herbert B Slade*[3], John C Lanits, III[1] - [1]St Luke's- Roosevelt Hospital Center, New York, NY; [2]University of Miami, Miami, FL; [3]University of North Texas Health Science Center, Fort Worth, TX

Schedule-At-A-Glance

7:45 am – 8:00 am	**40** **Does Pulse Volume Recording Aid In Peripheral Arterial Disease Stratification?** Benjamin A Eslahpazir*[1], Matthew T Allemang*[2], Ryan O Lakin*[2], John C Wang[2], Teresa L Carman[2], Virginia L Wong[2], Henry R Baele[2], Vikram S Kashyap[2] - [1]Case Western Reserve University School of Medicine, Cleveland, OH; [2]University Hospitals Case Medical Center, Cleveland, OH
8:00 am – 8:10 am	**41 (CR)** **Endovascular Management of Chronic SVC Syndrome With SVC Occlusion** Robert W Fincher*, Magdiel Trinidad* - University of Arizona, Tucson, AZ
8:10 am – 8:20 am	**42 (CR)** **Percutaneous Retrieval of An Inferior Vena Cava Filter Causing Right Ureter Obstruction** Kristina Thornburg*, Amber Batool*, Melissa Obmann, Shivprasad Nikam*, David Mariner* - Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA
8:20 am – 8:30 am	**43 (RF) -** *Unable To Attend Meeting* **Isolated Axillary Artery Aneurysm In A Patient With A Patent Ipsilateral Arteriovenous Fistula** Yan T. Ortiz-Pomales*, Jennifer B Smith*, Jeffrey S Weiss, Kevin Casey - Naval Medical Center San Diego, San Diego, CA
8:30 am – 8:45 am	**44** **Short- and Mid-Term Results of Iliac Artery Flush Occlusion Stenting With the Assistance of An Occlusive Contralateral Iliac Artery Balloon** Carlos F Bechara, Neal R Barshes, George Pisimisis, Peter H Lin, Panagiotis Kougias - Baylor College of Medicine, Houston, TX
8:45 am – 9:00 am	Q & A/Discussion
9:00 am	Winter Annual Meeting Adjourns

RF - Rapid Fire; CR - Case Report

Full Program & Abstracts

Thursday, January 31, 2013

7:00 am - 9:00 am	Executive Committee Meeting
7:00 am - 5:00 pm	Registration
9:00 am - 12:30 pm	**FELLOW LUMINARIES**
10:30 am - 11:00 am	Coffee Break
12:45 pm - 1:30 pm	**FEATURED SPEAKER LUNCHEON** Norman M. Rich, MD, Col, MC, USA (Ret) F. Edward Hebert School of Medicine, USUHS, Bethesda, MD

Full Program & Abstracts

1:30 pm - 4:30 pm **SOCIETY FOR MILITARY VASCULAR SURGERY SCIENTIFIC PROGRAM**

SVMS SCIENTIFIC SESSION I
Opening Remarks: W. Darrin Clouse, MD

1:35 pm – 1:45 pm **M1**

Evaluating the Degree of Carotid Artery Stenosis Utilizing CT Angiography Versus Duplex Ultrasound and Digital Subtraction Angiography

Douglas R. Stoddard*, Niten N. Singh, Charles A. Kitley*, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: The purpose of this study is to examine the accuracy and correlation between computed tomographic angiography (CTA), duplex ultrasonography (DUS), and digital subtraction angiography (DSA) in patients with carotid artery stenosis (CAS).

Methods: A retrospective review of prospectively collected data was performed on all patients who underwent carotid DUS, CTA and DSA between January 2007 and June 2012. Standard duplex criteria were utilized and all axial CTA images were reviewed by an independent radiologist. Data was evaluated using the intra-class correlation to determine the overall degree of consistency in measurement among the three imaging modalities. Pearson's correlation coefficient was employed to identify the relationship between each individual imaging modality.

Results: Fifty-five carotid arteries in 44 patients (72.7% male, mean age 69.4 years, range 43.4 to 86.2 years) were evaluated using all three modalities. In 20 of 55 vessels (36.4%), CAS correlated in all three imaging modalities. In 32 of 55 vessels (58.2%), DUS correlated with DSA. In 28 of 55 vessels (50.9%), CTA correlated with DSA. In 11 of 55 vessels (20.0%), DUS and DSA were consistent with each other but discordant with CTA. The intra-class correlation between all three imaging modalities was 0.685. Degree of stenosis was underestimated in 70.4% of the vessels by CTA.

Imaging	Pearson Correlation (r)	p-value
DUS and CTA	r (55 studies) = 0.697	<0.01
DUS and DSA	r (55 studies) = 0.691	<0.01
CTA and DSA	r (55 studies) = 0.689	<0.01

Imaging	Intra-class Correlation	p-value
DUS, CTA, and DSA	0.685 (95% CI: 0.560 - 0.789)	<0.01

Conclusion: Our results suggest that there is a moderate degree of correlation between all three imaging modalities, CTA does not add significantly to the data provided by DUS, and CTA underestimates the percent stenosis compared to both DUS and DSA.

Full Program & Abstracts

1:45 pm – 1:55 pm **M2**

Consequences of Cross Clamping the Aorta: A Histologic and Inflammatory Perspective

Steven Satterly, Shashikumar Salgar*, Matthew Martin*, Niten Singh - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: Massive abdominal trauma and subsequent hemorrhagic shock can require heroic life-saving intervention via aortic cross clamp. The survivability from degree of injury and subsequent supraceliac cross-clamping is typically poor. Multi-organ failure and death is common following survival of the initial insult despite resuscitation and restoration of perfusion. Blood products are limited in an austere environment similar to a military deployment. We sought to model consequences of supraceliac aortic cross-clamping in the setting of hemorrhagic shock and no available blood products.

Methods: 7 porcine models were utilized for the experiment, 3 control animals and 4 animals for the experimental group. Control pigs were splenectomized. The experimental group was subjected to Class III (35%) hemorrhagic shock and subsequent cross-clamping of the supraceliac aorta for 50 minutes. Resuscitation goal was for mean arterial pressure (MAP) of ≥ 40 mmHg for 6 hours following intervention. Serum lab values were taken during the experiment. Histologic samples from the kidney and liver were obtained immediately following course of resuscitation.

Results: Epinephrine requirement to maintain mean arterial pressure ≥40 mmHg was significantly increased in cross-clamp animals compared to control (3052±850µg; n=4). Mean lactate levels in treated groups were significantly ($P<0.05$) higher than in sham group (2.1±1.5). Liver injury/function biomarkers (Alkaline phosphatase, Alanine amino transferase, Gamma glutamyl transferase, Glucose) varied significantly ($P>0.05$) between cross-clamp and control groups. Liver injury scores of 1.5±0 and 2.25 ± 0.95 in control and cross-clamped groups, respectively. Kidney injury scores were 1±0 and 1.75±0.96 in sham and cross-clamp groups. Inflammatory markers HIF-1α, eNOS, iNOS2, and iNOS3 were markedly upregulated in the kidney from treated groups compared to control.

Conclusions: Supraceliac aortic cross-clamp dramatically increases both the inflammatory cascade as well as renal and hepatic tissue injury following isotonic fluid resuscitation in Class III shock.

Full Program & Abstracts

2:00 pm – 2:10 pm **M3**

Fishing For A Safe and Effective Vascular Closure Device: A Single Institution's Experience With the Femoral Introducer Sheath and Hemostasis (FISH™) Device

Gregory Skerrett*, Gilbert Aidinian, Llewellyn Lee, Patrick Cook - William Beaumont Army Medical Center, El Paso, TX

Introduction & Objectives: A number of vascular closure devices (VCD) are available for use by endovascular providers with the intent to decrease access site complications and shorten time to ambulation. The objective of this study is to determine the safety and efficacy of the newly FDA approved Femoral Introducer Sheath and Hemostasis (FISH™) device. The FISH™ is a novel closure mechanism that deposits a plug of bioresorbable extracellular matrix known as small intestinal submucosa (SIS®) which gets remodeled into the arterial wall and serves as a scaffold around which the artery heals itself.

Methods: Between December 2009 and August 2012, 57 arteriotomies underwent closure with the FISH™ device at our institution. A retrospective review of each patient's medical record was performed and pertinent data was compiled to include, indication for procedure, anticoagulation status, vessel accessed, device failure, and time to hemostasis.

Results: A total of 36 males and 20 females underwent vessel closure with the FISH™. Twenty-seven were anticoagulated at the time of closure. Hemostasis was obtained in under 2 minutes in all but 2 patients. In the two patients with prolonged bleeding 1 was due to a device failure requiring pressure to be held for 20 minutes and the other patient had a prophylactic FemoStop™ device placed due to active disseminated intravascular coagulation. In follow up that extends up to 2 years there have been no access site complications. The overall success rate for the FISH™ is 96%.

Conclusions: The FISH™ vascular closure device has proven to be effective and safe in a variety of patients. Further research needs to be conducted on a larger number of patients to assess the true risk profile and to make an accurate comparison to the other available closure devices.

Full Program & Abstracts

2:10 pm – 2:20 pm **M4**

Pharmacologic Attenuation of the Hyperdynamic Response After Aortic Occlusion

Wayne Causey*, Seth Miller*, Matthew Martin*, Niten Singh - Madigan Hospital, Tacoma, WA

Introduction & Objectives: Aortic occlusion is accompanied by a hyperdynamic cardiovascular response secondary to increased systemic vascular resistance and increased cardiac output. This can contribute to increased myocardial stress and possibly fatal arrhythmias. This study was designed to determine if pharmacologic medications are able to attenuate the adverse hyperdynamic response occurring with hemorrhage and a supraceliac aortic cross clamp in a porcine model.

Methods: In a validated porcine model demonstrating a significant hyperdynamic response to a 50 minute suprarenal aortic cross clamp following 35% blood volume hemorrhage. In our experiment, 8 experimental swine (ES) were given hydrogen sulfide at 4mg/min during aortic cross clamp and compared to 5 controls (C).

Results: 13 swine were length and weight matched. Time intervals were divided every 15 minutes during the course of the aortic cross clamp. At cross clamp, mean arterial pressure (MAP) was 60mmHg in the C compared to 65mmHg in the ES but H2S administration attenuated this response at 15minutes (103 vs. 141mmHg, p=0.21), 30 minutes (125 vs. 150 mmHg, p=0.15), 45 minutes (120 vs. 149 mmHg, p=0.043), with equal pressure 10 minutes after CC release when H2S infusion was complete (80.8 vs. 80.6mmHg). Heart rate was not significantly decreased at CC application, 15 minutes, 30 minutes, or 45 minutes (all P>0.1), but was decreased upon cross clamp release (144 vs. 183 bpm, p=0.011). There was not a significant change in invasive hemodynamic parameters to include cardiac output, systemic vascular resistance, pulmonary vascular resistance, and stroke volume.

Conclusions: The administration of H2S during the time of supraceliac aortic cross clamp causes decreases in mean arterial blood pressure and decreased heart rate after cross clamp release without significant changes in invasive hemodynamic parameters. As demonstrated in this study, targeted pharmacologic therapy is possible to minimize adverse invasive hemodynamic parameters with aortic occlusion.

Full Program & Abstracts

2:20 pm – 2:30 pm **M5**

A Process Improvement Project To Improve IVC Filter Retrieval

Leo J Daab*, Paul W White, Scott R Golarz, David R Whittaker, Robert M Craig, Charles J Fox - Walter Reed National Military Medical Center, Bethesda, MD

Introduction: The American Association for the Surgery of Trauma has recently focused attention on temporary IVC filter (T-IVCF) removal following reports of low retrieval rates in urban trauma centers. Despite vigilant follow up in the military, a similarly low retrieval rate has prompted us to establish a registry and track T-IVCFs placed at Walter Reed National Military Medical Center (WRNMMC) to improve retrieval rates.

Methods: The Peripheral Vascular Surgery Service at WRNMMC initiated an IVC filter registry in July 2012 as a process improvement project. All patients receiving an IVC filter are entered into a database. Monthly, this database is reviewed. Indications for filter placement are reviewed. Patients no longer requiring an IVC filter are scheduled for removal. Data from this registry from July 2012 through December 2012 is being collected and will be presented. This data will be compared to previously published data.

Results: The results of the aforementioned data review will be presented to highlight the effects of focusing on IVC filter retrieval as a process improvement project at WRNMMC.

Conclusions: Previously reported rates of IVC filter retrieval of 18-21% have improved after the implementation of dedicated follow-up and filter registries. We have previously reported our 18% retrieval rate at Walter Reed Army Medical Center. A large number of filters were not retrieved because of ongoing indications for a filter. By reviewing these patients monthly, we hoped to increase our retrieval rate. We will present the results of this strategy at WRNMMC.

2:30 pm – 3:00 pm Coffee Break

Full Program & Abstracts

SVMS SCIENTIFIC SESSION II

3:00 pm – 3:10 pm

M6

Resuscitative Endovascular Balloon Occlusion of the Aorta For Hemorrhagic Shock: A Review of the Literature With Implications For Modern Practice

Sahar T Leazer*[1], Jonathan J Morrison J Morrison[1], Zackary M Arthurs[1], Jeremy W Cannon*[1], Jonathan L Eliason[2], Todd E Rasmussen[1] - [1]US Army of Surgical Research, Fort Sam Houston (San Antonio), TX; [2]University of Michigan, Michigan, TX

Introduction: Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) is an emerging technique for aortic control in the setting of torso hemorrhage. It provides inflow control in addition to after-load support. Our aim is to summarize the available evidence in order to assess the utility of REBOA in contemporary clinical practice.

Methods: "REBOA" and related keywords were used to search the Pubmed Database for all English language animal and human studies published between 1953 to 2012.

Results: The search identified 49 publications; 35 in a clinical setting and 14 in large-animal studies. The majority (60%) of clinical studies were published after 1997 (post FDA approval of the first endografts) and are represented by the following specialties: vascular surgery (52%), trauma surgery (17%), spine surgery (17%), obstetrics (11%) and general surgery (3%). Within these specialties, REBOA was used emergently in 79% of the studies and electively in 21%. Electively, REBOA was predominantly used in the infrarenal aorta to control blood loss during sacral tumor resection. Emergently, REBOA has utility in severe postpartum hemorrhage as well as in the proximal control of ruptured abdominal aortic aneurysms. Within the trauma setting, REBOA has been used to achieve thoracic and infrarenal control. REBOA has been examined in numerous animal studies, predominantly in the thoracic aorta (80%), comparing the technique to open operative approaches as well as the metabolic consequences. REBOA has been demonstrated to increase central aortic pressure, while limiting hemorrhage in several injury models, although this does incur a metabolic burden which is recoverable with appropriate critical care.

Conclusion: REBOA is a promising technique which has utility in the control of the aorta in a number of settings. Further clinical studies and improved endovascular balloon technologies are required to advance this adjunct in the setting of hemorrhagic shock.

Full Program & Abstracts

3:10 pm – 3:20 pm **M7**

Feasibility of Carotid Stenting Through Brachial Access In Difficult Arch Anatomy

Patrick Neville, Brian Santin, Patrick Muck, Matthew Recht, Sophia Afridi, Pryze Smith*, Joann Lohr - Good Samaritan Hospital, Cincinnati, OH

Introduction & Objectives: Carotid artery stenting (CAS) has been reported to be an alternative to carotid endarterectomy (CEA) for carotid artery stenosis due to the improvements of stents and embolic protection devices. However, the transfemoral route can be unavailable or high risk, in cases of in difficult arch anatomy. We assessed the feasibility, safety, and efficacy of CAS through the right brachial approach in patients with difficult arch anatomy.

Methods: The charts of all patients undergoing carotid stenting from a right brachial approach were retrospectively reviewed. In this report, the charts of 6 patients who underwent CAS using the right transbrachial approach were reviewed. Charts were reviewed for patient demographics, radiographic results as well as procedural results. Neurologic results and access site complications were examined.

Results: 2 males and 4 females were treated. 1 right ICA, 3 left ICAs and 2 left CCAs and were treated. Technical success was 100%. Patient follow-up ranged from 16 days to 804 days. The morbidity and mortality were both 0%. No strokes were encountered. Major and minor local complications at the puncture site were not encountered.

Conclusions: Difficult arch anatomy may increase carotid artery stenting (CAS) procedural difficulties and complications through the transfemoral route. We suggest that CAS via transbrachial route is an effective and safe treatment for carotid stenosis in the setting of difficult arch anatomy. Carotid stenting in difficult arch anatomy can be safely done by transbrachial route depending upon operator's experience.

Full Program & Abstracts

3:20 pm – 3:30 pm

M8

Repair of Aberrant Right Subclavian Artery Entirely Via A Supraclavicular Approach

Aaron C Baker[1], Brodus Atkins[2], W. Darrin Clouse[2], Robert Noll[2], James Sampson[2], Timothy Williams[2] - [1]University of California Davis Medical Center, Sacramento, CA; [2]David Grant Medical Center, Travis Air Force Base, CA

Introduction & Objectives: Aberrant right subclavian artery is a known arch variant, only rarely requiring surgical intervention. Traditionally, patients presenting with dysphagia lusoria undergo repair via a supraclavicular approach in conjunction with a thoracotomy, or hybrid endovascular techniques more recently. We report a case performed entirely via a right supraclavicular approach.

Methods: A 78-year-old man with chronic cough and hoarse voice presented with progressive dysphagia to solids and liquids. Barium swallow demonstrated a filling defect of the thoracic esophagus with proximal dilation (Figure1). CT scan revealed an aberrant right subclavian artery without aneurysmal degeneration. He was subsequently taken to the operating room for repair. A right supraclavicular incision was performed with division of both heads of the sternocleidomastoid muscle. The right subclavian artery was identified and dissected out posterior to the esophagus. The artery was divided and the proximal portion over sewn (Figure2). A subclavian-to-carotid transposition was then performed with preservation of the vertebral artery (Figure3). The sternocleidomastoid was re-approximated.

Results: The patient did well postoperatively with complete resolution of dysphagia. A post-operative duplex ultrasound demonstrated a widely patent anastomosis with good flow to the subclavian and carotid arteries distally. Direct laryngoscopy showed normal cord function bilaterally.

Conclusions: Dysphagia lusoria from a non-aneurysmal aberrant right subclavian artery can successfully be approached via a single neck incision safely, obviating the need for additional incisions or adjunctive endovascular techniques.

Full Program & Abstracts

Figure 1: Upper GI barium swallow shows an indentation on the thoracic esophagus caused by the aberrant retroesophageal right subclavian artery.

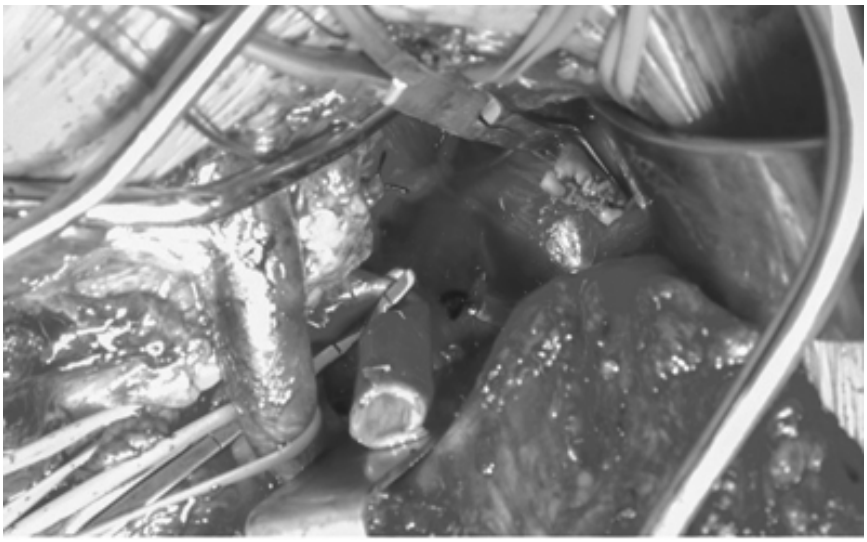


Figure 2: The aberrant right subclavian artery was dissected out posterior to the esophagus via a supraclavicular incision, divided and proximally over sewn.

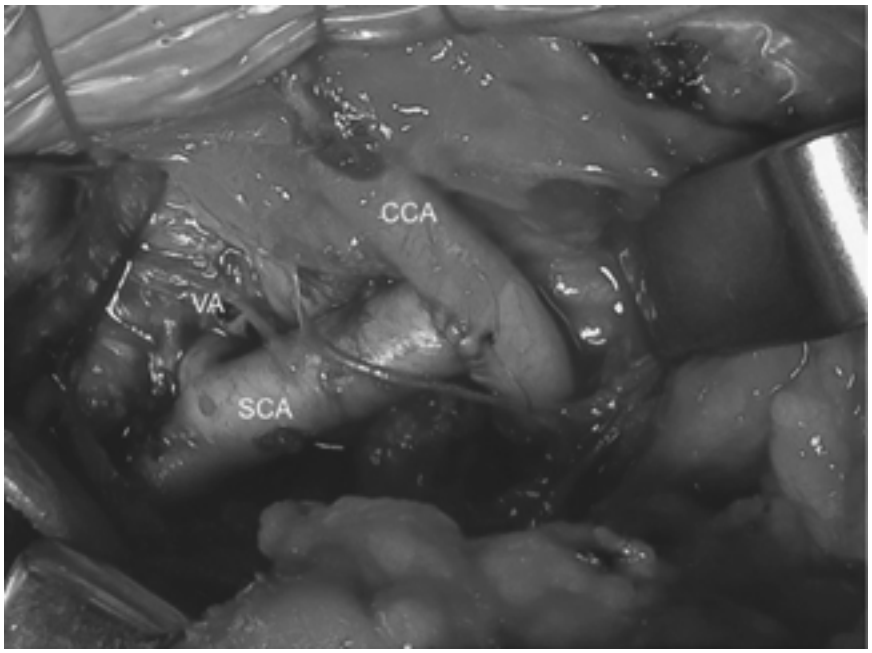


Figure 3: Subclavian carotid artery transposition with preservation of the vertebral artery.

Full Program & Abstracts

3:30 pm – 3:40 pm **M9**

A Case of Subclavian Vein Thrombosis With Poland Syndrome

Steven Satterly*, Charles Andersen, Niten Singh - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: 38-year-old female presented with several days of a painful, swollen and edematous left upper extremity. She stated several months of intermittent positional swelling prior to presentation. Patient's medical history was notable for congenital absence of the left breast requiring repeat reconstructive surgery and implants. The patient was otherwise healthy. Duplex ultrasound revealed a thrombosis of the left subclavian vein. Subsequent invasive venogram revealed a similar finding. Patient underwent catheter directed thrombolytics through the basilic and cephalic vein for 48 hours. Repeat venogram revealed resolution of thrombosis. A temporizing angioplasty of the involved segment of subclavian vein was performed. Patient was maintained on therapeutic levels of Lovenox as an outpatient with complete resolution of symptoms after one week. Anterior scalenectomy with first rib resection via supra- and infra-clavicular incisions was completed. Hypertrophied subclavius and costochondral tissue with a thickened 1st rib were decompressed. Surgery and 2 weeks of anticoagulation resulted with complete resolution.

Poland syndrome is comprised aplasia or hypoplasia of breast tissue, nipple, and the sternocostal portion of the pectoralis major muscle, and also absence of the costal cartilages. Venous thoracic outlet syndrome occurs in approximately 3% of all thoracic outlet cases. We present the first case of Paget-Schroeder's Syndrome and the second case of documented Thoracic Outlet Syndrome in a patient with a history of Poland syndrome.

Methods: A literature search of "PubMed," "Medline," "Ovid" for articles using the following key words: "Paget-Schroeder," "Paget-Schroetter," "Disease," "Syndrome," "Venous Thoracic Outlet Syndrome," "Effort Induced Thrombosis," and "Poland Syndrome."

Results: A single case of neurogenic Thoracic Outlet Syndrome and Poland Syndrome.

Conclusions: Poland syndrome is a rare risk for development of acute subclavian vein thrombosis. Inherent congenital hypoplasia or subsequent reconstructive surgery on or near the thoracic outlet may lead to a higher risk of developing 'Paget-Schroeder' syndrome.

Full Program & Abstracts

3:40 pm – 3:50 pm **M10**

Common Femoral Endovenectomy With Inline Iliac Vein Stenting: A Hybrid Solution To Daunting Problem

Mel J Sharafuddin, Rachael M Nicholson, Sara Mijal*, Adonis J Lysandrou* - University of Iowa Carver College of Medicine, Iowa City, IA

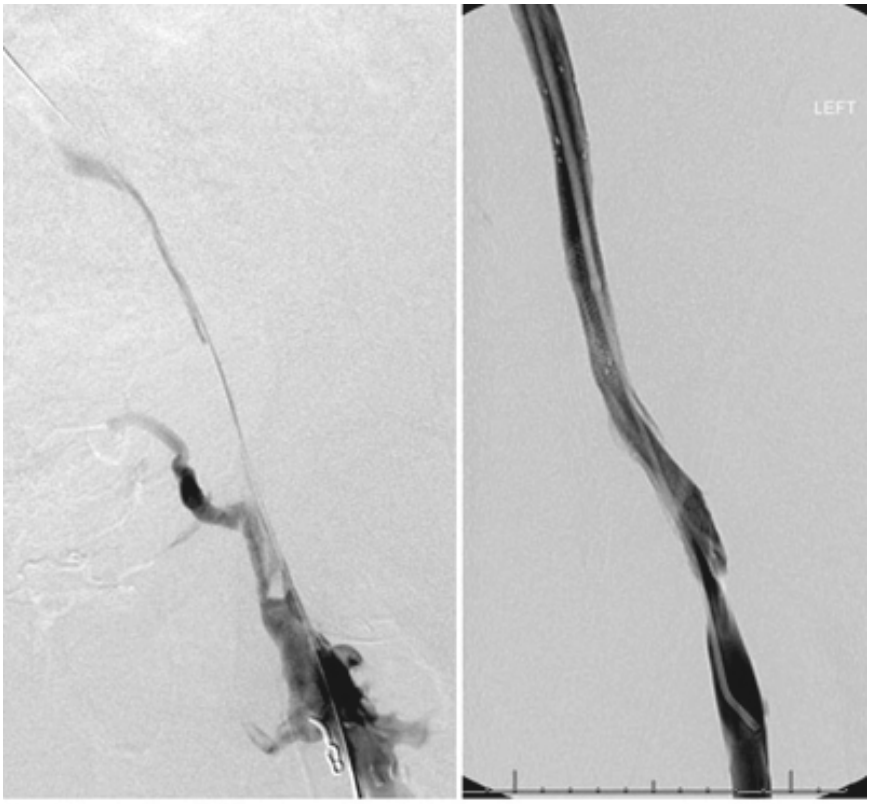
Introduction & Objectives: Iliac vein stenting can be a beneficial intervention in patients with venous hypertensive symptoms. However, it may not be feasible when the common femoral vein is involved in the occlusive process. We report our experience with a 61 y.o. active man who presented with chronic left iliofemoral DVT complicating abdominal surgery 3-months prior. He had debilitating leg pain and swelling not responsive to compression therapy. Duplex sonography and MR venography revealed left iliac vein occlusion with extensive synechial occlusive disease involving the common femoral vein extending to a short segment of the adjacent femoral vein.

Methods: The patient underwent groin exploration with thrombo-endovenectomy of the severely diseased common femoral vein and adjacent femoral vein and the ostium of the profunda femoris vein. The longitudinal venotomy was patch-closed using contralateral greater saphenous vein. The adjacent long-segment occlusion of the iliac vein was then endolumenally recanalized and stented. Post-operatively he was placed on full anticoagulation. Large hematoma with compression of the common femoral vein developed on POD-1, and was managed by evacuation and mechanical thrombectomy.

Results: The patient eventually did very well with resolution of his venous hypertensive symptoms. He was able to resume his prior active life style with normal duplex sonography on follow-up nearly two years later.

Conclusions: This hybrid approach towards iliac venous disease involving the common femoral vein may offer a viable option to the management of this very challenging grou of patient. It is also feasible in cases of chronic femoral vein occlusion, provided outflow from the limb can be maintained via the greater saphenous and profunda veins.

Full Program & Abstracts



post-patch
pre-stenting

post inline stenting

Full Program & Abstracts

3:50 pm – 4:00 pm **M11**

Case Report of An Anterior Trans-Abdominal Approach To A Type II Endoleak Repair

Douglas R. Stoddard*, Niten N. Singh, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: We describe the case of a successful anterior abdominal wall approach to the repair of a type II endoleak.

Methods: The patient is a 65 year old man who underwent an endovascular repair of a 5cm infrarenal abdominal aortic aneurysm four years ago with a Cook Zenith device. An enlarging type II endoleak was discovered post operatively that increased in size to 7.5cm over a two year period. During this time, the patient underwent an unsuccessful attempt at endoleak repair via a trans-arterial approach. Given his slender body habitus and the anterior location of his aneurysm sac, an anterior trans-abdominal approach under ultrasound guidance was used to repair the endoleak. The sac was injected anteriorly, feeding vessels were coil-embolized using microcoils, and an Amplatzer plug was used to secure the access site.

Results: The patient tolerated the procedure well, and there was no evidence of endoleak on subsequent six month follow-up.

Conclusions: In this patient, an anterior trans-abdominal approach to repair of a persistent type II endoleak was successful.

4:00 pm – 4:30 pm	Discussion
4:30 pm	Meeting Adjourns
5:00 pm – 7:00 pm	**WELCOME RECEPTION**

Full Program & Abstracts

Friday, February 1, 2013

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
7:00 am – 9:15 am	**SCIENTIFIC SESSION I** Moderators: Mark Conrad, MD & Katherine Gallagher, MD Opening Remarks: Ruth L. Bush, MD, MPH, President
7:00 am – 7:15 am	**1** **Comparison of Acute Versus Chronic Dynamic Intimal Flap Movement In Stanford Type B Aortic Dissections (ATBD) and the Effects of Thoracic Endovascular Stent Grafting** Frank R Arko, III, Aaron H Hurd*, Tzvi Nussbaum*, Christopher Boyes*, Stephen G Lalka*, Timothy S Roush - Sanger Heart and Vascular Institute, Charlotte, NC

Introduction & Objectives: To compare the intimal flap of the visceral aorta of acute and chronic Stanford Type B (TBD) dissections prior to and following TEVAR.

Methods: Nineteen patients with TBD, 11 chronic and 8 acute were evaluated with IVUS. Aortic flap movement at the SMA during one RR-interval of the ECG was recorded pre/post TEVAR . Flap movement index (FMI) and flap area index (FAI) were defined with measurements of the minimum and maximum aortic diameters (ADmin, ADmax), minimum and maximum true lumen diameters (TDmin, TDmax), and true lumen areas (TAmin, TAmax). FMI was defined as [(TDmax/ADmax-TDmin/ADmin)]/TDmin/ADmin x 100(%), FAI was defined as TAmax-TAmin/ TAminx100.

Results: Table I demonstrates all measurements. There was a significant increase in the TD and TA following TEVAR in the visceral aorta in those with acute compared to chronic. Furthermore, following TEVAR the FMI was significantly decreased by 8.9 +/-1.2 % in acute compared with 4.9 +/-1.9% in chronic dissections (p=0.002). The FAI was significantly increased in acute at 76.8+/- 17% compared to 17.6 +/- 4.3% with chronic (p=0.0001). All 8 patients had complete thrombosis of the false lumen, while those with chronic dissections had continued retrograde perfusion of the distal landing zone.

ACUTE (n=8)	PRE Thoracic Stent	Post Thoracic Stent	p-value
TD min (mm)	11.25 +/- 1.7	16.00 +/- 1.8	P=0.0001
TD max (mm)	14.50 +/- 1.29	19.25 +/- 2.2	P=0.0001
TA min (cm2)	1.38 +/- 0.21	2.97 +/- 0.33	P=0.0001
TA max (cm2)	2.70 +/- 0.42	3.53 +/- 0.22	P=0.0001
AD min (mm)	22.75 +/- 1.5	22.75 +/- 1.5	P=0.947
AD max (mm)	24.5 +/- 2.08	24.75 +/- 2.2	P=0.81
CHRONIC (n=8)			
TD min (mm)	11.3+/-3.5	12.0+/-3.61	P=0.6933
TD max (mm)	21.0+/-6.6	22.67+/-5.0	P=0.5774
TA min (cm2)	1.1+/-1.3	1.4+/-1.3	P=0.6515
TA max (cm2)	1.45+/-1.2	1.6+/-1.2	P=.8062
AD min (mm)	26.75 +/- 1.89	26.17 +/- 1.92	P=0.945
AD max (mm)	28.55+/-2.8	28.75 +/- 2.6	P=0.81

Conclusions: This is the first study to compare and characterize the dynamic aortic flap movement of the visceral aorta and the effects of TEVAR in TBD. Aortic morphologic changes occur immediately after stent graft placement in those with acute TBD with little change in the flap in those with chronic TBD. Early intervention was associated with complete thrombosis of the false lumen which may be a result of the acute changes seen with the flap after TEVAR.

Full Program & Abstracts

7:15 am – 7:30 am

2

Results of Routine Adjunctive Spinal Drainage and/or Left Subclavian Artery Bypass In Thoracic Endovascular Aortic Repair

Dean J. Arnaoutakis*, George J. Arnaoutakis*, Robert J. Beaulieu*, Christopher J. Abularrage*, James H. Black, III - The Johns Hopkins Hospital, Baltimore, MD

Introduction & Objectives: The adjunctive use of a preoperative cerebrospinal fluid (CSF) drain or left subclavian artery (LSA) bypass for thoracic endovascular aortic repair (TEVAR) to minimize neurologic complications remains controversial.

Methods: A retrospective review of a prospective database of patients undergoing TEVAR from 4/2005 through 8/2012 was conducted. CSF drainage was routinely performed under local anesthesia in a staged fashion prior to TEVAR. When possible, LSA bypass was performed prior to TEVAR. Adjunctive procedures were not performed for patients in emergent operations. Preoperative characteristics, operative variables, outcomes, neurologic complications, and survival status were recorded.

Results: Ninety patients underwent TEVAR at our institution during the study period. Mean age was 67.3 years (SD 13.8) and 48 (53%) were male. One (1%) patient had a connective tissue disorder. Sixty-six (73%) presented with degenerative aneurysm, 13 (14%) with chronic Type B dissection, 6 (7%) with pseudoaneurysm, and 5 (6%) with traumatic aortic pathology. Fourteen (16%) had acute ruptures. Sixty-seven (74%) patients underwent adjunctive procedures for TEVAR including a CSF drain (n=48, 53%), LSA bypass (n=7, 8%), or both (n=12, 13%). CSF drain placement was uncomplicated. Cerebral ischemia due to device migration occurred in 2 (2%) patients with resolution in both by common carotid stent. One (1%) patient developed hemispheric stroke but recovered. Delayed spinal cord ischemia (SCI) occurred in 3 (3%) patients and was reversed with hypertensive therapy in 2. The 30-day mortality was 4% and overall median survival was 23 months (IQR 8-90).

Conclusions: Our strategy of adjunctive procedures for TEVAR demonstrates better SCI results than prior reports of selective CSF drainage. This suggests routine adjunctive use of a CSF drain and/or LSA bypass in TEVAR patients is an effective means of reducing SCI and stroke. Furthermore, preoperative drain placement allows rapid therapy for SCI, and should be considered for all.

Full Program & Abstracts

7:30 am – 7:45 am **3**

Acute Complications After Balloon Assisted Maturation of AVF's

Anil Hingorani, Enrico Ascher*, Natalie Marks*, Andrea Carollo*, Pamela Boniviscage* - Lutheran Medical Center, Brooklyn, NY

Objective: Balloon assisted maturation (BAM) of A-V fistulae is a fairly new procedure used to accelerate the process of maturation. As with any procedure complications do arise. In this retrospective analysis of 336 office based BAM procedures, five major acute complications were analyzed and categorized as: formation of wall hematoma, extravasation/rupture, spasm, thrombosis, and formation of puncture site hematoma.

Methods: Data collected from 5/14/09-3/30/11 used to assess 336 office-based duplex-guided BAM procedures. Access site puncture and cannulation with short sheath, wire and balloon advancement and inflation were guided by duplex only. Vascular injuries were classified based on duplex assessment. All patients had follow-up duplex scans within a week after BAM.

Results: Of the 336 procedures the most common injury was formation of wall hematoma (135/336), followed by extravasation/rupture (31/336), spasm (26/336), formation of puncture site hematoma (13/336), and thrombosis (5/336). The injuries were further classified based on balloon size, ranging from 3mm-12mm [total amount: 3mm-6, 4mm-22, 5mm-54, 6mm-71, 7mm-69, 8mm-64, 9mm-27, 10mm-20, 11mm-0, 12mm-3]; entry position, retrograde (177 total) versus anterograde (159 total); and type of fistula, radial-cephalic (232 total), brachial-cephalic (64 total), or brachial-basilic (33 total). Injuries were nearly equal in all cases regardless of anterograde or retrograde insertion. Balloon sizes ranging from 5mm-10mm and 6mm-8mm accounted for 92.86% and 61.90% respectively, of all injuries combined.

Conclusion: The data suggest that office-based BAM procedures are fairly safe, but do carry a small percentage of complications. Except for wall hematoma formation (40.19%), all of the injuries occur in less than 10% of the procedures; extravasation/rupture (9.22%), spasm (7.74%), thrombosis (1.49%), and formation of puncture site hematoma (3.87%). None of the identified factors correlated with these acute complications.

Full Program & Abstracts

7:45 am – 8:00 am

4

Restenosis and Symptom Recurrence After Endovascular Therapy For Claudication: Does Duplex Ultrasound Correlate With Recurrent Claudication?

Douglas W Jones*, Ashley R Graham*, Peter H Connolly*, John K Karwowski*, Harry L Bush, Darren B Schneider, Andrew J Meltzer - New York Presbyterian Hospital - Weill-Cornell Medical Center, New York, NY

INTRODUCTION AND OBJECTIVES: After peripheral endovascular therapy (ET), surveillance duplex ultrasound(DUS) to detect restenosis guides clinical decisions and defines treatment failure. Prior reports have defined DUS-based criteria for failure based on angiography as the "gold standard" however, the correlation between DUS and symptom recurrence remains unclear. Accordingly, our objective was to examine the association between determination of treatment failure by DUS and symptom recurrence after ET for claudication.

METHODS: Retrospective review of a prospectively maintained institutional database identified patients undergoing ET for lifestyle-limiting claudication. From 2007-2010, patient-reported symptoms were paired with contemporaneous post-intervention surveillance DUS. The association between systolic velocity ratio (SVR) and symptom recurrence was assessed (t-test, Receiver Operating Characteristic curve analysis) and the appropriateness of threshold values analyzed (frequency distribution, Pearson chi-square).

RESULTS: 287 patients underwent 366 interventions for claudication. 183 post-operative clinic visits had clear documentation of clinical status and concomitant DUS after interventions in the femoropoliteal(62%) or iliac(38%) arteries. After femoropopliteal intervention, SVR(mean +/-SD) was higher in patients with symptom recurrence compared to asymptomatic patients(4.50+/-2.85 vs 2.07+/-1.25; p<0.001). After femoropopliteal intervention, elevated SVR or occlusion correlated with symptom recurrence (area under ROC curve[AUC]=0.82 [95% CI 0.74-0.89]; P < 0.0001), and SVR > 2.5 was 71% sensitive and 72% specific for symptom recurrence (Table). DUS after iliac intervention was weakly associated with recurrent claudication(AUC = 0.597).

CONCLUSIONS: After femoropoliteal ET for claudication, DUS-detected restenosis is highly associated with clinical deterioration; in the majority of patients, sustained patency is necessary to prevent recurrent claudication. These findings not only support post-intervention surveillance DUS to identify restenosis, but also validate objective criteria for treatment failure with respect to patient-centered outcomes such as symptom recurrence.

SVR	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)
1.5	97.9	40	54.7	96.3
2	87.5	55.4	59.2	85.7
2.5	70.8	72.3	65.4	77
3	50	87.7	75	70.4
3.5	47.9	93.8	85.2	70.9
AUC	**0.815**			

PPV, positive predictive value; NPV, negative predictive value

Full Program & Abstracts

8:00 am – 8:10 am

5 (RF)

Paroxysmal Nocturnal Hemoglobinuria: A Red Clot Syndrome

Jeffrey D Crawford, Victor W Wong*, Thomas Deloughery*, Erica L Mitchell, Timothy K Liem*, Gregory J Landry*, Gregory L Moneta* - Oregon Health and Sciences University, Portland, OR

Paroxysmal nocturnal hemoglobinuria (PNH) is a rare, acquired, non-malignant disorder of hematopoetic stem cells characterized by hemolysis, diminished hematopoesis and thrombophilia. We describe the case of a 65 year-old woman with known PNH who presented with ischemic rest pain and non-healing foot ulcers. This case highlights four key concepts relevant to managing surgical patients with PNH: 1. predisposition for arterial and venous thromboses; 2. hypercoagulabilty despite standard anti-coagulation regimens; 3. role of eculizumab (a monoclonal antibody against complement protein C5) in significantly reducing thrombotic complications; and 4. complications associated with eculizumab. PNH patients with limb threatening ischemia require aggressive anticoagulation, close monitoring of hemolysis and immunosuppression, more frequent surveillance post-surgical bypass and an awareness of potential complications associated with medical management of PNH.

Full Program & Abstracts

8:10 am – 8:20 am

6 (RF Video)

Videoscopic Basilic Vein Harvest For the Creation of Transposed Brachial-Basilic AV Fistulas: A Novel Protocol

John P Leone*[1], Alexander Glaser*[1], Rick Hufstetler*[2], Karl Illig[3] - [1]Tampa General Medical Group, Tampa, FL; [2]Tampa General Hospital, Tampa, FL; [3]University of South Florida/ Tampa General Hospital, Tampa, FL

Introduction & Objectives: Due to the extensive dissection required during the standard transposed brachial-basilic arterial venous fistula (BB-AVF) procedure and the potential for postoperative complications, many surgeons shy away from performing BB-AVFs. Less invasive videoscopic-vein harvesting has been described with good results, but this approach remains rarely used. We present our protocol for videoscopic BB-AVF creation.

Methods: We began a videoscopic-assisted BB-AVF protocol in selected patients at our institution in 2006. Vein harvesting from the antecubital fossa to the level of the axilla is performed by an experienced surgical technician under the guidance of a dialysis access surgeon. Peri-operative data and post-operative outcomes were retrospectively reviewed after IRB approval.

Results: From 2006 to 2011, we performed videoscopic-assisted BB-AVF in 21 selected pateints. Median age was 59 years and median BMI 30; women comprised 52% of the cohort. Previous vascular access procedures had been performed on 81% of patients. Of the 21 attempts with the video-assisted approach, only 1 required conversion to a standard open procedure. There were no significant intra-operative or post-operative surgical complications, median operative time was 159 minutes, and maximum length of stay was one night. Maturation sufficient for cannulation and use occurred in 80% of patients, with the median time to first access in patients who matured being 60 days. At 3 years follow up, 47% of fistulas that matured were still functional, with 33% lost to death or successful renal transplantation.

Conclusions: Videoscopic assisted transposition of the basilic vein is a reasonable option for BB -AVF placement. The procedure can be performed in an acceptably expeditious fashion with near elimination of infection, wound breakdown, lymph drainage and nerve injury and satisfactory maturation (80%) and patency rates. Technicians experienced in lower extremity vein harvest can perform this procedure successfully and assist the surgeon during the procedure.

Full Program & Abstracts

8:20 am – 8:30 am **7 (CR)**

IVUS As A Novel Tool For the Diagnosis of Endofibrosis

Danielle Campbell*, Katherine A Gallagher, Shipra Arya*, Tina Chen*, Dawn Coleman, Peter Henke, Jon L Eliason, John Rectenwald - University of Michigan, Ann Arbor, MI

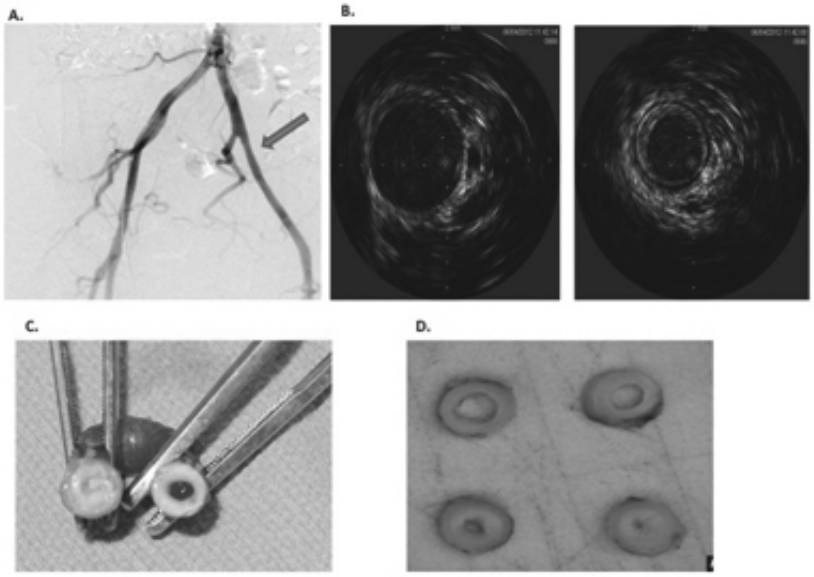
Objectives: Endofibrosis involves hypertrophy of the iliac vessels in endurance athletes and results in claudication with exercise. Given the rise of high-intensity sport athletes and the paucity of literature on endofibrosis, we describe a novel adjunctive technique to aid in diagnosis.

Methods: A 41 yo female triathlete presents exercise-limiting claudication. Her work-up for chronic compartment syndrome was negative. She had palpable pedal pulses on exam. ABI's were 1.0 bilaterally but decreased to .66 on the left at 1 min (10% incline/8mph). Lower extremity MRA was performed to evaluate for cystic adventitial disease (CAM) involving the popliteal/femoral vessels and this was negative. Provocative non-invasive testing with dorsiflexion and knee hyperextension that was negative. An angiogram was performed which suggested mild narrowing of the left external iliac artery. A drop in pressure across the subtle stenosis could not be obtained with papaverine. (Figure 1A) IVUS was used across the area of interest to determine if there was disease present. IVUS delineated a abnormal segment of proximal external iliac artery with medial hypertrophy. (Figure 1B) The patient underwent left external iliac replacement with a reversed saphenous interposition graft via a retroperitoneal approach without complication.

Results: Post-operative duplex demonstrated a patent bypass with no elevated velocities. Pathology demonstrated circumferential subendothelial fibrosis consistent with endofibrosis. (Figure 1C,D)

Conclusions: Endofibrosis is an uncommon disease and there is little literature describing optimal methods for diagnosis. Findings of endofibrosis on angiogram are subtle and easily missed. Creation of pressure gradients across suspected lesions with administration of vasodilators is inconsistent and not reliable in this group of athletes. IVUS provides a definitive diagnostic modality allowing for proper planning and operative treatment of these patients.

Figure 1.



Full Program & Abstracts

8:30 am – 8:45 am **8**

Post-Discharge Care Matters: The Relationship Between Quality of Diabetic Care, Readmission and Survival For Lower Extremity Revascularization

Benjamin S Brooke*, Randall R DeMartino*, Kristina A Giles*, Richard J Powell, David H Stone, Brian W Nolan, Philip P Goodney - Dartmouth-Hitchcock Medical Center, Lebanon, NH

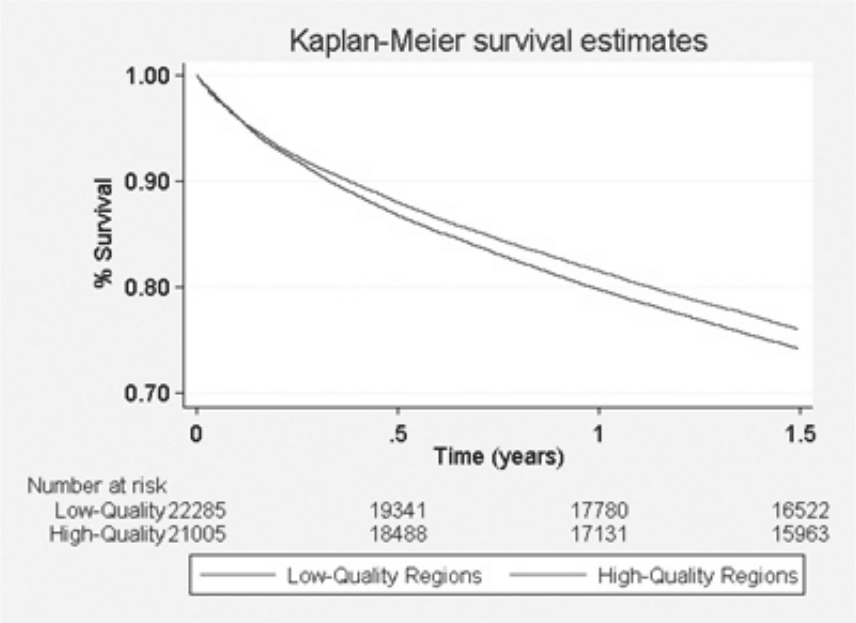
Introduction & Objectives: While quality improvement initiatives have placed considerable emphasis on the in-hospital management of diabetes, the effect of variation in the quality of diabetic care on post-discharge outcomes remains uncertain. We examined relationships between outpatient quality of diabetic care, readmission rates, and one-year survival following lower extremity revascularization.

Methods: We studied Medicare diabetics with critical limb ischemia (CLI) undergoing open and endovascular lower extremity revascularization (2004-2007), linked to HEDIS diabetic care quality measures (annual serum cholesterol and HgA1C). We divided all 306 U.S. hospital referral regions into quartiles, based on the region's quality of diabetic care. We then used regression models to examine the associations between quality of diabetic care, readmission, and survival.

Results: Overall, 84,653 diabetic patients (52% male, 15% black, mean age 76 years) with CLI underwent revascularization between 2004 and 2007. Annual rates of diabetic testing varied from 59% in low quality regions to 86% in high-intensity regions ($p<0.001$). Patients in regions with high-quality diabetic care were significantly less likely to be readmitted within 30-days (20.6% low vs. 22.5% high; $P<0.001$) or 1-year (61.9% low vs. 64.4% high; $P<0.001$). One-year survival was improved in regions with high-quality diabetic care (Figure, 84.5% in high-quality regions, 79.7% in low-quality regions, log-rank <0.001). Even after adjusting for differences in gender, age, race, and comorbidities, patients in regions with high-quality diabetic care were 7% less likely to be readmitted (OR:0.93;95%CI:0.88-0.98;$P<0.05$) and 11% (OR:0.89;95%CI:0.83-0.96;$P<0.05$) decreased 1-year mortality following their revascularization procedure.

Conclusions: Vigilant diabetic care was associated with decreased readmission rates and 1-year mortality. This data support the value of intensive diabetic care and may serve as an important quality improvement initiative for vascular surgery.

Full Program & Abstracts



Full Program & Abstracts

8:45 am – 9:00 am **9**

Surgical Complications of Radial Artery Catheterization

Karan Garg, Brittny S Williams-Howell, Stephanie Saltzberg, David Dexter, Todd L. Berland, Thomas S Maldonado, Caron B Rockman - NYU Langone Medical Center, New York, NY

Introduction: Cannulation of the radial artery is frequently performed for invasive hemodynamic monitoring, and now increasingly as access for coronary interventions. Complications arising from cannulating the radial artery are well described and can be broadly divided into ischemic and infections. However, their surgical management is not well reported. We reviewed our institutional experience in treating this clinical entity and propose an algorithm for managing such complications.

Methods: We conducted a retrospective review to identify patients who underwent surgical intervention for complications from radial artery cannulations from 1997 to 2011.

Results: We identified 31 patients who underwent interventions - 16 patients for ischemia and 15 with infections (3 for arterial thrombosis with abscess, 10 with pseudoaneurysms, and 2 with abscesses alone). Three patients required reinterventions; all in individuals initially presenting with ischemia developed recurrent thrombosis. There were no amputations in this series. The mortality in these series was 38.7%, none related to surgery itself, reflecting the severity of illness in this patient cohort.

Conclusion: Complications of radial artery cannulation are uncommon, however, not entirely inconsequential. These complications arise in a sicker cohort of patients with a high overall mortality, so the patient's clinical presentation should ultimately drive goals of care. Unstable patients may be best served with damage control. While majority of patients will tolerate sacrifice of the radial artery, the challenge lies in identifying those who will not. Therefore, intervention should aim to restore blood flow when feasible. In the presence of infection and sepsis, source control supersedes revascularization and may involve debridement/drainage along with intravenous antibiotics. Patients whose radial artery is sacrificed should be monitored closely for development of ischemia.

Table 1. Non-Ischemic Interventions

Patient Presentation (N)	Operation Peformed (n)
Pseudoaneurysms (8)	Aneurysmectomy and repair (6) Artery ligation (2)
Ruptured pseudoaneurysms (2)	Artery ligation (2)
Thrombosis with abscess (3)	Excision, ligation and I&D (3)
Abscess (2)	I&D alone (1) Excision, ligation & I&D (1)

I&D (Incision and Drainage)

Full Program & Abstracts

9:00 am – 9:15 am

10

Surgical Site Infections and Complications Following Vascular Groin Procedures

SreyRam Kuy*, Anahita Dua, Bhavin Patel*, Nader Tondravi*, Gary R Seabrook, Kellie R Brown, Brian D Lewis, Cheong J Lee, Peter J Rossi - Medical College of Wisconsin, Milwaukee, WI

Introduction & Objectives: To evaluate the incidence, epidemiology, and contributing factors of post-operative surgical site complications following vascular operations involving femoral artery exposure.

Methods: Retrospective cohort study of 118 patients who underwent femoral endarterectomy or extra-anatomic bypass at a tertiary referral hospital. Primary outcome was surgical site complications (infection, hematoma or seroma). Length of stay, reoperation, discharge disposition, and 30-day mortality were evaluated. Independent variables included patient demographics and operative variables (procedure type, transfusion, preoperative antibiotics, intraoperative vasopressors). Statistical analysis included log-rank testing and Wilcoxon models.

Results: Of the 118 patients who underwent femoral artery surgery, 28 (23.7%) developed surgical site complications; 61.9% were male, mean age was 62.4 years, 92.4% had elective procedures, and 5.9% had prior surgery at the surgical site. Comorbidities included hypertension (90.0%), dyslipidemia (62.7%), coronary artery disease (39.8%), and diabetes (23.7%). Most patients were smokers (47.5% active smokers and 32.2% former smokers). Procedures performed included femoral endarterectomy (56.8%) and extra-anatomic bypass (43.2%). Preoperative antibiotics, administered to 97.5%, included cefazolin (75%), clindamycin (15.3%) or vancomycin (3.4%). Mean length of hospital stay was 10.7 days (SD 8.5, range 1-43). The overall 30 day reoperation rate was 17.8% and 30 day mortality was 11%. Intraoperative vasopressors were administered to 48.3%. 23.7% required blood transfusion, mean 3 units (SD 2.3, range 1-12). Tissue flaps were raised in 5.1%. Factors significantly associated with surgical site infection or complications were advanced age, use of intraoperative vasopressors and use of statins use.

Conclusions: The overall incidence of surgical site infections or complications following vascular groin procedures is 23.7%, and significantly associated with the use of intraoperative vasopressors, advanced age, and statin usage. The use of intraoperative vasopressors is a modifiable perioperative factor that is associated with surgical site infections, and further studies of this relationship are warranted.

3:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks – Visit Exhibitors

Full Program & Abstracts

4:00 pm – 6:00 pm **SCIENTIFIC SESSION II**
Moderator: Jean Bismuth, MD

4:00 pm – 4:15 pm **11**

Open Mesenteric Interventions Are Equally Safe As Endovascular Interventions and Offer Better Long-Term Patency

Shipra Arya, Stephanie Kingman*, Jordan Knepper, Jonathan L Eliason, Peter K Henke, John E Rectenwald - University of Michigan, Ann Arbor, MI

Introduction: Endovascular techniques have been recently advocated as the preferred method for mesenteric interventions. This study compares our experience with treatment of mesenteric ischemia using endovascular and open techniques.

Methods: The medical records of open and endovascular mesenteric procedures performed at a single center were queried from 2002-2012. Demographic, peri-operative and follow-up data were extracted and analyzed.

Results: Thirty-eight patients underwent endovascular mesenteric interventions while 77 patients underwent open revascularization. The demographic and peri-operative characteristics for patients were similar (Table 1). Majority of the endovascular procedures (89.2%) comprised stenting while open procedures included 25 (32.1%) antegrade bypasses, 38 (48.7%) retrograde bypasses, 8 (10.3%) thromboembolectomies, 7 (9%) transaortic endarterectomies. Postoperative complications, overall 30-day morbidity and mortality were not significantly different in the open and endovascular groups for acute (AMI) or chronic mesenteric ischemia (CMI). Thirty-day mortality in AMI (N=34) was 38.2% (Endovascular: 45.5% vs open 34.8%; p-value=NS). There was no 30-day mortality in either group for CMI patients. Mean follow-up was much longer for the open procedures (34.9 vs 12.7 months, p=0.004). Primary and secondary patencies were better for open revascularization for CMI patients (Figure 1).

Conclusion: Open revascularizations are equally safe as endovascular interventions in similar patient populations for acute and chronic mesenteric ischemia. Patency of open revascularization for CMI is better than endovascular procedures.

Table 1. Demographic and peri-operative variables for mesenteric interventions.

Variable	All (N=115)	Endovascular (N=38)	Open (N=77)
Age in years	64.0 +/- 1.6	68.9 +/- 2.0	61.6 +/- 2.1*
Body mass index (BMI) in kg/m2	24.0 +/- 0.6	25.1 +/- 1.2	23.3 +/- 0.7
Active smokers	52 (46.9%)	13 (32.4%)	30 (54.1%)
Coronary artery disease (CAD)	51 (45.1%)	18 (48.7%)	33 (43.4%)
Congestive heart failure (CHF)	15 (13.4%)	7 (18.9%)	8 (10.7%)
Chronic renal insufficiency (CRI)	17 (15.0%)	8 (21.6%)	9 (11.8%)
COPD	36 (31.9%)	10 (27.0%)	26 (34.2%)
ASA class> 3	39 (38.2%)	16 (43.2%)	23 (35.4%)
Prior interventions	34 (29.6%)	8 (21.6%)	26 (33.3%)
Indication- CMI	81 (70.4%)	26 (68.4%)	55 (71.4%)
Emergency cases	30 (26.1%)	10 (27.0%)	20 (25.6%)
Presence of ischemic bowel	11 (9.6%)	3 (8.1%)	8 (10.3%)
Mesenteric territory			
Celiac artery	13 (11.3%)	6 (16.2%)	7 (9.0%)
Superior mesenteric artery (SMA)	63 (54.8%)	26 (70.3%)	37 (47.4%)
Multiple arterial territories	35 (30.4%)	3 (8.1%)	32 (41.0%)

*$p<0.05$ (comparison for endovascular and open group) COPD: Chronic obstructive pulmonary disease, ASA: American Society of Anesthesiologists, AMI: Acute mesenteric Ischemia, CMI: Chronic mesenteric ischemia.

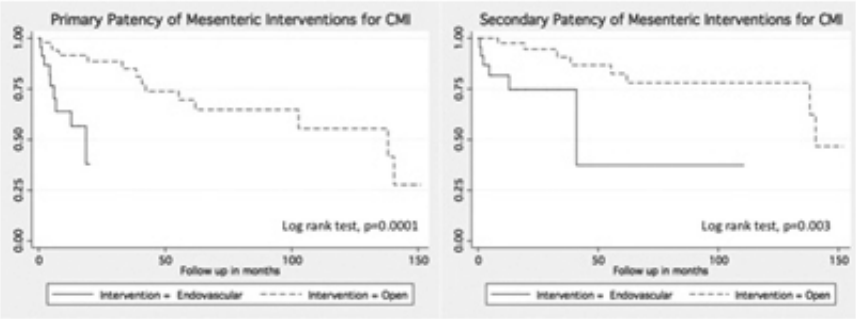


Figure 1: Primary and secondary patency of open and endovascular interventions for chronic mesenteric ischemia (CMI).

Full Program & Abstracts

4:15 pm – 4:30 pm **12**

Preliminary Experiences With Early Primary Closure of Foot Wounds Following Lower Extremity Revascularization

Neal R Barshes, Carlos F. Bechara, George Pisimisis, Panos Kougias - Baylor College of Medicine, Houston, TX

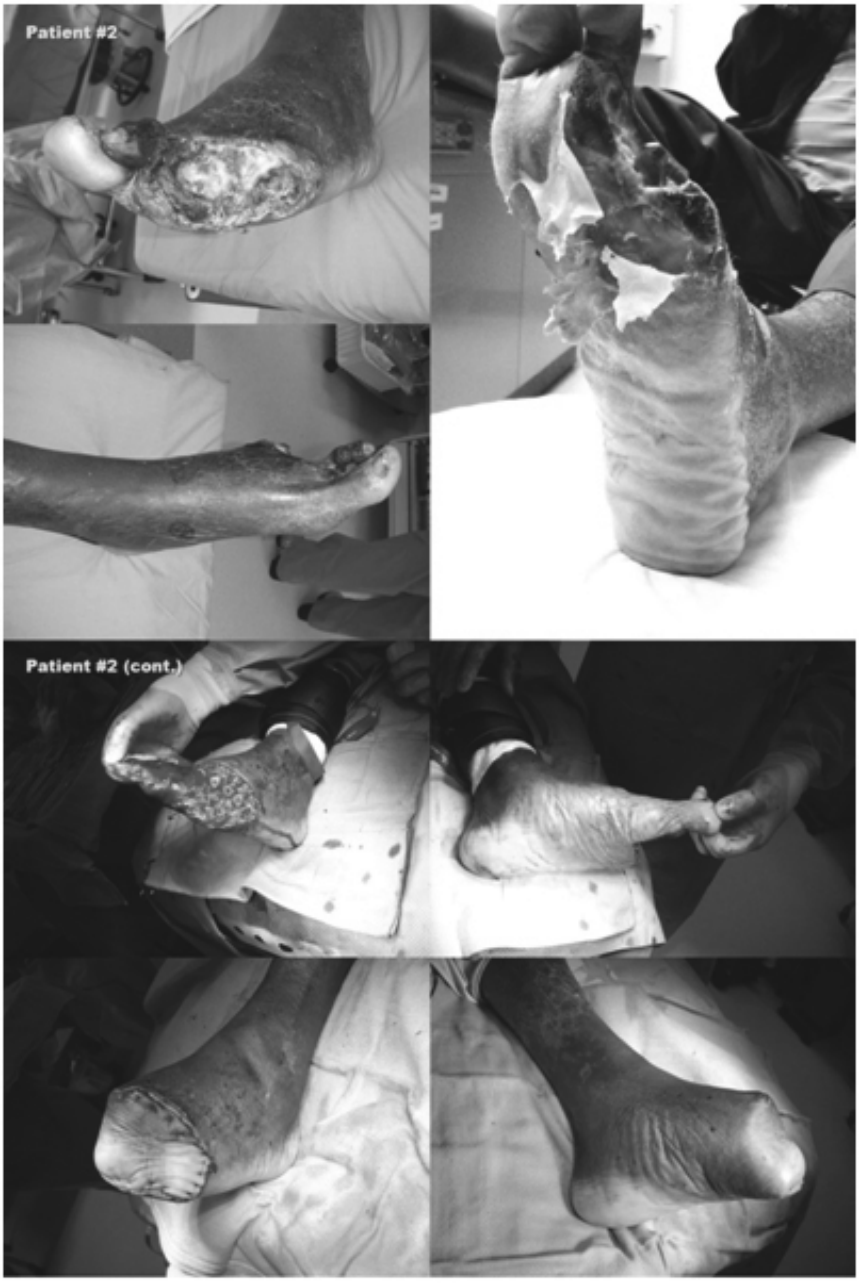
INTRODUCTION AND OBJECTIVES: The annual costs associated with local wound care averages $20,000, and previous work has suggested that early closure of foot wounds can be a source of cost-savings following revascularization for limb salvage. We sought to determine the safety and effectiveness of attempts to primarily close chronic foot wounds early after revascularization.

Methods: We reviewed the outcomes of patients in whom primary wound closure was attempted during the same hospitalization in which a successful limb revascularization (surgical bypass or endovascular intervention) was performed during the study period between August 2010 and August 2011.

Results: Seven patients underwent an attempt at early primary wound closure during the study period (Table 1). Five patients were diabetic, and six had been treated for active infection of the wound at some point prior to revascularization. Wounds were primarily closed at a median of 6 days (range, 3-8 days) following revascularization. Wound closure techniques included the use of toe/forefoot amputations (n=5), skin grafting (n=1), and pedicled rotational toe flaps (n=2) [see examples, Figure 1]. Three remained completely healed. Three remained partially healed, each with small residual open wounds that remained uninfected. One patient underwent above -knee amputation six weeks after revascularization.

Conclusions: An attempt to achieve primary wound closure early after revascularization appears safe and may be effective in reducing post-operative wound care needs and costs.

Full Program & Abstracts



Full Program & Abstracts

Table 1: Patient characteristics, management and outcome.

patient	age and gender	diabetes?	initial foot wound	revascularization	debridement & closure (no. stages)	interval between revascularization and primary closure attempt, days	outcome
patient 1	65 M	No	non-healing 1st toe amputation site	femoral to anterior tibial artery bypass using greater saphenous vein (GSV)	completion first toe amputation (one stage)	6	completely healed, alive
patient 2	73 M	Yes	abscess overlying metatarsal heads 3-5	femoral artery reconstruction, femoral to below-knee artery bypass using GSV	completion transmetatarsal amputation with pedicled rotational flap closure (one stage)	6	partially healed, alive
patient 3	68 M	Yes	infected medial heel ulcer & non-healing 1st toe ulcer	femoral to dorsalis pedis atery bypass using GSV	first toe amputation; skin grafting of ulcer (one stage)	8	completely healed, alive
patient 4	62 M	Yes	abscess overlying 5th metatarsal head	popliteal to dorsalis pedis artery bypass using lesser saphenous vein	completion 5th toe amputation	4	partially healed, alive
patient 5	60 M	Yes	plantar forefoot abscess after puncture wound	percutaneous balloon angioplasty of posterior tibial artery	foot debridement, amputation of 2nd & 3rd toes	3	partially healed, alive
patient 6	66 M	No	abscess overlying 4th metatarsal head	femoral to distal posterior tibial artery bypass using GSV	completion transmetatarsal amputation with pedicled rotational flap closure (one stage)	7	above-knee amputation, alive
patient 7	55 M	Yes	non-healing 1st toe ulcer with osteomyelitis	femoral to posterior tibial artery bypass using GSV	1st toe amputation (one stage)	3	completely healed, alive

Full Program & Abstracts

4:30 pm – 4:45 pm

13

Do PSVR Ratios Correlate With ABI Value and Symptoms After SFA Intervention? Lessons From the VIBRANT Trial

Patrick Geraghty[1], Mark W. Mewissen*[2], Gary M Ansel*[3], Michael R Jaff*[4] - [1]Washington University Medical School, Saint Louis, MO; [2]St. Luke's Hospital, Milwaukee, WI; [3]Riverside Methodist Hospital, Columbus, OH; [4]Harvard Medical School, Massachusetts General Hospital, Boston, MA

Introduction & Objectives: Following superficial femoral artery implantation, nitinol stents (NS) develop diffuse in-stent restenosis, whereas stent-grafts (SG) develop focal edge stenoses. Sonographic restenosis is currently characterized by elevated peak systolic velocity ratio (PSVR) within the treated segment. Given the different patterns of restenosis between devices, we interrogated the VIBRANT trial database to evaluate whether increasing PSVRs within NS and SG accurately correlate with ankle-brachial index (ABI) and patient-reported symptoms from the Intermittent Claudication Questionnaire (ICQ).

Methods: The multicenter VIBRANT trial randomized participants with complex SFA disease to NS implantation (n=76) or SG implantation (n=72). PSVR within treated arterial segment, ABI, and ICQ scores (ICQ range: 0=best, 100=worst) were collected at 1, 6, 12, 24, and 36 months post procedure. All complete patient follow-up visits were included. We grouped PSVR values into three categories (PSVR <2.0, 2.0-3.0, or >3.0). Within each ascending PSVR category, we analyzed differences in ABI and ICQ scores between study arms.

Results: No significant differences in ABI or ICQ score were noted between study arms for participants with PSVR<2.0 or PSVR 2.0-3.0. However, NS recipients with PSVR>3.0 experienced a significant decline in ABI in comparison to those receiving SG (Table), and a trend toward worsening (increased) ICQ scores, 20 ± 19.3 for SG versus 33 ± 20.8 for NS.

Conclusions: As PSVRs increase above 3.0, ABI values and quality of life scores worsen in NS recipients, but remain stable in SG recipients. PSVRs accurately characterize the worst focal stenosis within a treated arterial segment, but fail to accurately quantify the hemodynamic and symptomatic impairment caused by long-segment disease that may accompany focal stenosis, as in the case of failing NS.

PSVR Effect on ABI Values			
	Viabahn	**Nitinol Stent**	***p*-value**
PSVR < 2.0			
N	139	156	
ABI (StDev)	0.99 (0.13)	1.00 (0.15)	0.379
PSVR 2.0-3.0			
N	29	25	
ABI (StDev)	0.96 (0.11)	0.94 (0.150	0.690
PSVR > 3.0			
N	30	28	
ABI (StDev)	0.94 (0.15)	0.79 (0.210	0.005

Full Program & Abstracts

4:45 pm – 5:00 pm **14**

Retrograde Popliteal Access Is Safe and Effective - It Should Be Added To the Vascular Surgeon's Portfolio

Houssam K Younes*, Abindra Sigdel*, Charudatta S Bavare*, Mitul S Patel*, Hosam F El-Sayed, Jean Bismuth, Eric K Peden, Alan B Lumsden, Mark G Davies - Methodist DeBakey Heart and Vascular Center, Houston, TX

Introduction & Objectives: The aim of the study is to review the outcomes of superficial femoral artery (SFA) interventions with retrograde popliteal access approach after failed antegrade recanalization.

Methods: A database of patients undergoing endovascular treatment of the SFA between 2008-2011 was retrospectively queried, and those with transpopliteal artery retrograde access were analyzed. Outcomes were determined by Kaplan-Meier survival analyses, and the Cox proportional hazard model was used for time-dependent variables.

Results: Total of sixteen patients (75% men; mean age 61 ± 9 years) underwent retrograde popliteal access after failed antegrade attempts. Patients had the multiple CV co-morbidities with a modified cardiac index was 3 ± 1.9. The reason for intervention was claudication in 81% cases and tissue loss in the remainder. Retrograde ultrasound guided puncture of the popliteal artery was successful in all of cases. Recanalization was successful in 88% cases. One uncomplicated perforation (7%) was encountered during attempted recannulization. There was no perioperative morbidity or 30 days mortality. The MACE, MALE and 30day amp rate were 0%. On long term follow up 14% of patients developed restenosis and 7% occlusion. The primary patency was 66±9%, assisted patency 81±9% and secondary patency 87±8% at 2years. 94% of patients reported improvement of symptoms. Limb salvage was 100% with 14% of patient requiring either a digit or transmetarsal amputation.

Conclusions: For failure of antegrade recanalization of SFA occlusions, the retrograde popliteal access is a safe and successful technique with good long term results.

Full Program & Abstracts

5:00 pm – 5:10 pm

15 (RF)

Supervised Exercise Programme Improves Aerobic Fitness In Patients Awaiting Abdominal Aortic Aneurysm Repair

Hashem Barakat*, Yousef Shahin, Peter McCollum, Ian Chetter - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

Introduction & Objectives: Aerobic fitness is an important predictor of postoperative outcomes in major surgery. In this study we aimed to assess the effect of a period of preoperative exercise on aerobic fitness as measured by Cardiopulmonary exercise testing (CPET) in patients scheduled for AAA repair.

Methods: Patients listed for AAA repair were enrolled in a supervised exercise programme of 4 week duration. Treadmill CPET parameters were measured before and after the period of exercise preoperatively. CPET parameters measured were: peak oxygen uptake (VO2 max), anaerobic threshold (AT), and ventilator equivalents for oxygen and carbon dioxide (VE/VO2 and VE/VCO2 respectively). Total exercise time and the time at which AT was achieved were also recorded.

Results: Some 16 patients with AAA (13 men, mean age 75.7 +/- 4.8) were included in this study.

50% had a past history of ischaemic heart disease, 25% of obstructive airway disease and 19% had cerebral vascular events. 69% were previous smokers, 19% are current smokers and 12% never smoked. 94% of patients were on both Aspirin and Statins.

Median (IQR) VO2 max at baseline was 18.1 (14.9-19.9) ml/kg/min, and after exercise 20.0 (17.3-22.4) (p=.002). Median AT at baseline was 11.65 (9.9-12.8), and 12.57 (11.6-14.3) after exercise (p=0.02). Time of exercise tolerated also improved from a median of 419 seconds to 603 seconds (p=.003). No significant changes were seen in ventilator equivalents of Oxygen (VE/VO2), carbon dioxide (VE/VCO2) or the time at which AT was achieved.

Conclusions: This study shows that cardiopulmonary aerobic fitness improves after a period of supervised exercise programme in patients scheduled for AAA repair. This is justification for a randomised trial to assess whether this affects morbidity and mortality following AAA repair.

Full Program & Abstracts

5:10 pm – 5:20 pm

16 (CR Video)
Use of the Artis-Zeego iGuide Program To Perform A Translumbar Glue Embolization of A Type-2 Endoleak: A Video Case Report

Mikel Sadek*, Todd L Berland, Thomas S Maldonado, Firas F Mussa, Caron B Rockman, Genn R Jacobowitz, Patrick J Lamparello, Mark A Adelman, Frank J Veith, Neal S Cayne - New York University Langone Medical Center, New York, NY

Introduction & Objectives: Translumbar access may be utilized for the treatment of Type-2 endoleaks (T2E) in expanding aneurysms following endovascular aortic aneurysm repair. This study sought to assess the safety and efficacy of the Artis-Zeego iGuide program for performing translumbar embolization of T2Es.

Methods: This was a retrospective review of consecutive patients treated for T2Es using the iGuide program from 6/2011-8/2012. Non-contrast rotational imaging was performed using the Zeego system, and the image was aligned with the preoperative contrast image using bony landmarks. The iGuide program was used to generate a digital line that originated at the patient's skin and terminated within the nidus of the endoleak (Figure). The translumbar needle was directed into the endoleak using the pathway generated by the iGuide program. Treatment was performed at the discretion of the operator, typically n-butyl cyanoacrylate (nBCA) glue (2.5 -3:1 oil:glue) ± coils.

Results: Ten patients were evaluated with an average follow-up of 68days (range 1-249days). The average age was 79.0±9.5years (70% male). The approach was from the left side in 90% of patients. Technical success was achieved in 100% of cases, and there were no procedure related complications. Operating room time averaged 43.2±12.8min (range 24-61min). Fluoroscopy time averaged 5.5±4.9min (range 1.6-13.2min), and the average amount of contrast used was 13.1±10.2mL (range 9-30mL). All of the patients were treated using glue embolization, and one patient also underwent coil embolization. The amount of glue mixture utilized averaged 4.7±0.7mL. The aneurysm sacs remained stable in size on follow-up.

Conclusions: This study suggests that the Artis-Zeego iGuide program is a useful adjunct for the treatment of T2Es. It allows for rapid and safe access using the translumbar approach.

Full Program & Abstracts

Full Program & Abstracts

5:20 pm – 5:30 pm

17 (CR)

Pulmonary Emboli and Internal Jugular Vein Aneurysm In A Patient With Neurofibromatosis 1

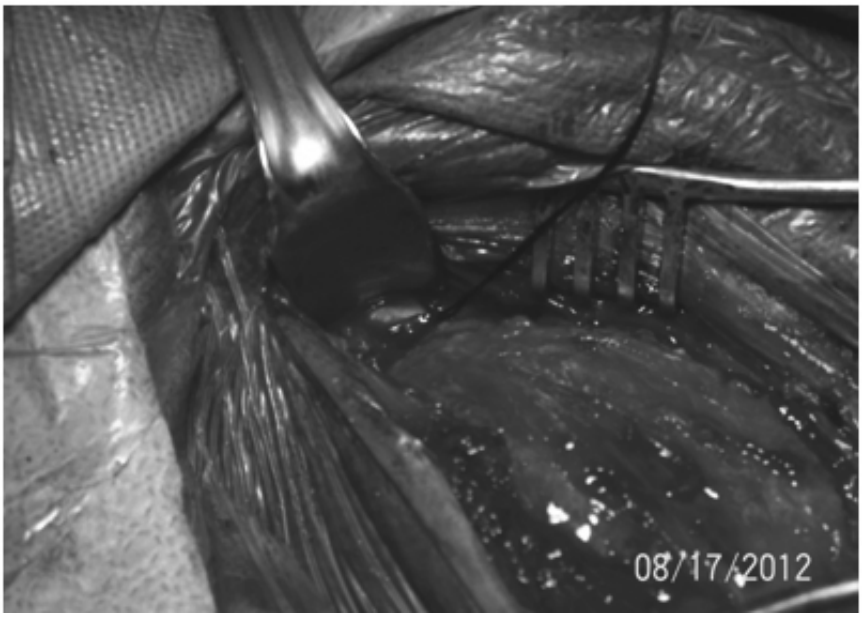
Brian Santin, Sara McKeever*, Chris Paprzycki*, Matt Recht* - Good Samaritan Hospital, Cincinnati, OH

Introduction and Objectives: Neurofibromatosis Type 1 (NF1), also known as von Recklinghausen disease, is an autosomal dominant condition characterized by proliferation of neural crest cell elements, such as neurofibromas and café au lait spots. Venous malformations, specifically those of the internal jugular vein are extremely rare and have only been reported in three patients. We present a case of a large, 6.5cm fusiform aneurysm of the right internal jugular vein in a NF1.

Methods: The patient who presented with bilateral pulmonary emboli (PE). The patient had a history significant for two previous neck dissections for neurofibromal removal twenty years prior and presented with a two week onset of an enlarging neck mass. Imaging of the mass consisted of both a CT of the neck and MRA as well as duplex ultrasound.

Results: The right internal jugular vein was ligated both proximally and distally to the aneurysm and was subsequently evacuated and over sewn. The estimated blood loss for the procedure was less than 50ml. The vein wall histology demonstrated inflammation of the adventitia. Postoperatively the patient had an uneventful recovery and was therapeutically anticoagulated secondary to the PE.

Conclusions: Internal jugular vein aneurysms are extremely rare and have universally been treated by ligation. Due to an increased incidence of severe bleeding caused by vessel friability, great care must be taken to avoid entering the aneurysm sack prior to ligation.



Full Program & Abstracts

5:30 pm – 5:45 pm

18

Heparin Bonding Does Not Improve Patency of PTFE Arteriovenous Grafts

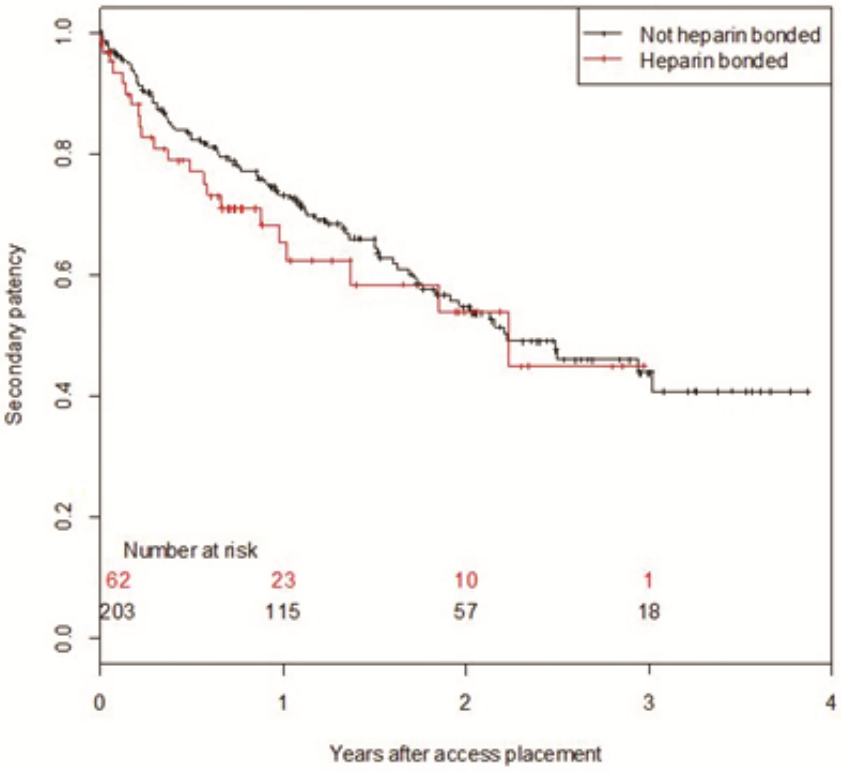
Matthew T Allemang*[1], Brian Schmotzer*[2], Virginia L. Wong*[1], Alex Chang*[1], Ryan Lakin*[1], Kenneth Woodside*[1], John Wang*[1], Vikram S. Kashyap[1] - [1]University Hospitals Case Medical Center, Cleveland, OH; [2]Case Western Reserve University, Cleveland, OH

Introduction & Objectives: To compare the patency of arteriovenous grafts (AVG) for dialysis access with and without heparin bonding in a tertiary care setting.

Methods: Records of patients who had a AVGs placed from January 2008 until June 2011 were retrospectively reviewed. Outcomes were assisted primary patency and secondary patency. Marginal survival models (to account for correlation of accesses within subjects) utilizing Cox proportional hazard regression were used for statistical comparisons.

Results: A total of 223 patients with 265 Grafts. Of these 62 (23%) were heparin bonded. The average age was 65.9 ± 15.3 for heparin and 59.2 ± 16.7 for control ($p<0.01$). Of the heparin group, 39% were male, 81% were black, 63% were diabetic, and 81% had a tunneled catheter at the time of access placement. Of the control group, 35% were male, 85% were black, 56% were diabetic, and 83% had a tunneled catheter. Heparin bonded grafts were no different in either assisted primary or secondary patency (HR: 1.39 CI: (0.98, 1.96) and HR: 1.20 CI: (0.73, 1.96) respectively). Kaplan-Meier estimates for secondary patency are shown in the Figure. There was no significant difference in the number of interventions ($p>0.30$). To correct for inequalities, a multivariable model including age, diabetes, PVD, ever used tobacco, previous access placement, and tunneled catheter found HR for heparin bonded grafts was again not significantly different than standard grafts in either assisted primary patency or secondary patency (HR: 1.35 CI: (0.91, 1.99) and HR: 1.15 CI: (0.62, 2.16) respectively).

Conclusions: In this retrospective review, heparin bonded grafts did no better in long-term patency or number of interventions. Prospective studies are needed to confirm these results.


Not heparin bonded
Heparin bonded
Secondary patency
1.0
0.8
0.6
0.4
0.2
0.0
Number at risk
62
23
10
1
203
115
57
18
0
1
2
3
4
Years after access placement

Full Program & Abstracts

5:45 pm – 6:00 pm

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Is There Benefit To Universal Carotid Artery Duplex Screening Prior To Cardiac Surgery?

Brian C Adams*[1], Ross M Clark*[1], James M Goff, Jr.[1,2] - [1]University of New Mexico School of Medicine, Albuquerque, NM; [2]Raymond G. Murphy VA Medical Center and the University of New Mexico School of Medicine, Albuquerque, NM

Introduction & Objectives: Perioperative stroke is a devastating complication following cardiac surgery. To avoid this complication, cardiac surgeons routinely order carotid duplex studies prior to cardiac surgery to assess for significant carotid stenosis. We hypothesize that the routine screening of preoperative cardiac surgery patients with carotid duplex detects few patients who require carotid intervention or reliably predicts stroke risk from the carotid artery bifurcation following cardiac surgery.

Methods: A retrospective review identified 394 patients who underwent cardiac surgical procedures from January 2007 to September 2010. Data collected included patient demographics, comorbidities, history of prior stroke, preoperative carotid duplex results, location of post-operative stroke, and carotid endarterectomy prior to, in conjunction with, or after cardiac surgery. Statistical methods included univariate and Chi square analysis.

Results: Eleven perioperative strokes were identified (2.8%) and 3 patients (0.76%) underwent carotid endarterectomy prior to or in conjunction with cardiac surgery. In the 10 post-operative stroke patients for whom there is complete carotid duplex data, no significant carotid stenosis (>70%) was detected preoperatively. Post-operative strokes occurred in the anterior cerebral circulation (55%), posterior cerebral circulation (27%), or both (18%). Two patients underwent carotid endarterectomy (0.51%) following cardiac surgery. No patient comorbidities, preoperative carotid duplex screening velocities, or type of cardiac surgical procedure was predicative for stroke.

Conclusions: Routine carotid duplex screening detects few patients who benefit from carotid endartectomy prior to or in conjunction with cardiac surgery. The vast majority of post-operative strokes following cardiac surgery are not related to extracranial carotid artery disease and they are not detected by preoperative carotid duplex screening. Universal carotid duplex screening cannot be recommended and a selective approach should be adopted.

6:00 pm – 6:30 pm **PVSS MEMBER BUSINESS MEETING**
(Members Only)

6:30 pm - Free Evening

Full Program & Abstracts

Saturday, February 2, 2013

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
7:00 am – 9:00 am	**SCIENTIFIC SESSION III** Moderators: W. Darrin Clouse, MD & Ravi Rajani, MD
7:00 am – 7:15 am	**20** **The Impact of Gender On Angioplasty and Primary Stenting For Femoropopliteal Occlusive Disease: Results of the DURABILITY II Trial** Rami O Tadros[1], Peter L. Faries[1], Krishna J Rocha-Singh[2], Sung yup Kim*[1], Victoria Teodorescu[1], Sharif H Ellozy[1], Michael L Marin1, Ageliki G Vouyouka[1] - [1]The Mount Sinai Medical Center, New York, NY; [2]St. John's Hospital, Springfield, IL

Introduction & Objectives: This study investigates the impact of gender on angioplasty and primary stenting for the treatment of claudicants with femoropopliteal occlusive disease (FPOD).

Methods: The 287 patients enrolled in the DURABILITY II trial (a prospective, non-randomized, core lab audited, and independently adjudicated investigational device exemption (IDE) trial) were stratified by gender (190 Men and 97 Women) and reviewed.

Results: Women presented with FPOD at an older age than men (71.3±11.2vs.65.9±9.9years,p<0.001,Table). Men were more likely to be hyperlipidemic (89.5% vs.79.4%,p=0.030). No other statistically significant differences were observed in peri-procedural comorbidities and demographics. Clinically, women presented more often with severe claudication (64.9%vs.51.1%,p=0.033) as compared with men that exhibited more moderate claudication (44.2%vs.29.9%,p=0.022). The incidence of rest pain and tissue loss was low and did not vary between genders. Angiographically, women had smaller reference vessels (4.4±0.8mm vs.5.0±0.9mm,p<0.001). Longer lesion lengths (91.6±46.8mm vs.87.8±43.9mm) and higher primary (79.0%vs.76.5%), primary assisted (90.6%vs.85.1%), and secondary patency (90.6%vs.85.7%) rates in women did not achieve statistical significance (Graph,p=NS). Mean percent stenosis and occlusion rates were similar between groups, but men were more likely to have severe calcification (47.9%vs.34.0%,p=0.020). TASC II classifications were similar between groups. The target lesion revascularization (TLR), major adverse event (MAE), and mortality rates were similar between groups.

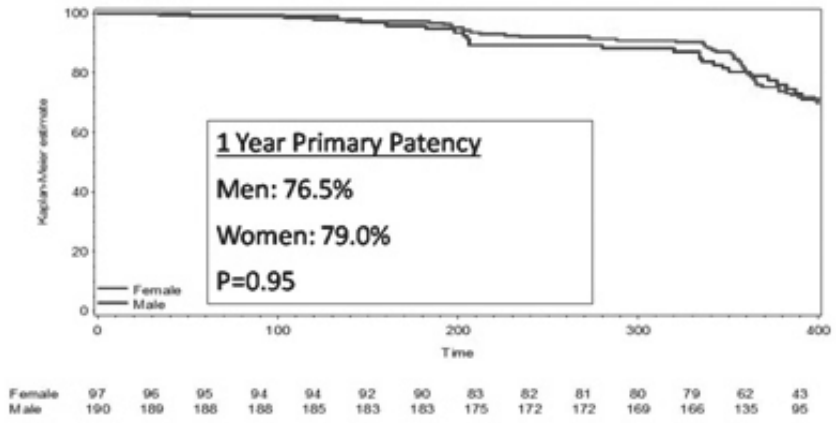
Conclusions: Despite presenting with FPOD at a later age, with more severe claudication and smaller vessels than men, women achieved equal patency rates utilizing angioplasty and primary stenting with similar TLR, MAE, and mortality rates.

Table: Summary of Results

Variable	Men (N=190)	Women (N=97)	P
Age at presentation	65.9±9.9 years	71.3±11.2 years	<0.001
Hyperlipidemia	89.5%	79.4%	0.030
Moderate Claudication, Rutherford class 2	44.2%	29.9%	0.022
Severe Claudication, Rutherford class 3	51.1%	64.9%	0.033
Ischemic rest pain, Rutherford class 4	4.2%	5.2%	NS
Minor tissue loss, Rutherford class 5	0.5%	0.0%	NS
Reference vessel diameter	5.0±0.9mm	4.4±0.8mm	<0.001
Lesion length	87.8±43.9mm	91.6±46.8mm	NS
Mean percent stenosis	85.5%±16.2%	86.2%±16.2%	NS
Total Occlusions	46.8%	50.5%	NS
Severe Calcification	47.9%	34.0%	0.020
Primary patency (12 month)	76.5%	79.0%	NS
Primary assisted patency (12 month)	85.1%	90.6%	NS
Secondary patency (12 month)	85.7%	90.6%	NS
Target lesion revascularization (12 month)	11.9%	18%	NS
Major adverse events (30 days)	0%	0%	NS
All-cause Mortality (30 days)	0%	0%	NS

Full Program & Abstracts

Graph: Primary Patency at 12 Months



Female	97	96	95	94	94	92	90	83	82	81	80	79	62	43
Male	190	189	188	188	185	183	183	175	172	172	169	166	135	95

Full Program & Abstracts

7:15 am – 7:30 am **21**

Patient-Centered Outcomes and Risk-Adjusted Hospital Mortality In Major Vascular Surgery

Micah E Girotti*, Jonathan L Eliason, Justin B Dimick*, Peter K Henke* - University of Michigan, Ann Arbor, MI

Introduction & Objectives: Patient-centered outcomes have captured the interest of policy-makers, health services researchers, and vascular surgeons. However, it is unknown to what degree patient perception correlates with other important measures of technical quality such as risk-adjusted hospital mortality.

Methods: We used national Medicare claims data to study all patients undergoing open abdominal aortic aneurysm repair and lower extremity bypass in 2000-2008. We first assessed hospital-level performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey. These questions included patient perceptions of overall hospital ranking, likelihood of recommendation of the hospital, and quality of physician communication. We defined the best and worst hospitals as the top and bottom quartiles, respectively. Hospital performance on each of the three questions was then compared to risk-adjusted 30-day mortality rates.

Results: Significant variability existed in patient perception of overall hospital quality. In the worst group of hospitals, 60% of patients rated the hospital "9 or 10 out of 10", compared to 77% of patients in the best hospitals ($p<.001$). Similarly, 62% of patients said they would "definitely recommend the hospital to family or friends" in the worst hospitals compared to 81% in the best hospitals ($p<.001$). Ultimately however, disparate performance on these questions provided little discrimination between hospitals with the best and worst mortality rates. Of the hospitals in the best performance group by patient surveys, 24% were in the group of worst hospitals according to rankings by mortality rates. Similarly, 27% of hospitals in the best mortality group were in the worst group by patient rankings.

Conclusions: There is significant variability in patient perceptions of hospital quality, but these variations fail to significantly correlate with measures of technical quality such as hospital mortality rates. As the focus on patient-centered outcomes increases, consideration of multiple domains of hospital quality is important.

Full Program & Abstracts

7:30 am – 7:45 am **22**

Use of Anti-Xa Levels To Monitor Heparin Therapy - A Failed Trial In A Hospitalized Population

Joann M Lohr, Thomas Panke, Thomas Imhoff, Janice Miller, Angela N Fellner* - Good Samaritan Hospital, Cincinnati, OH

Introduction and Objectives: Demonstrate that Anti-Xa monitoring of hospitalized patients treated with heparin does not consistently correlate with therapeutic PTT levels.

Methods: Eighteen hospitalized patients being treated with therapeutic heparin were monitored by simultaneous Anti-Xa and PTT levels.

Results: Seventy-eight simultaneous PTT and Anti-Xa levels were analyzed. PTTs ranged from 24.9-190 (mean, 65.7). Anti-Xa levels ranged from 0.10-1.00 (mean, 0.36). Peripheral draw sites were most common (87%). Patients were classified as very sick (17%), recovering (43%) or well (blood clot only issues, 40%). Samples were spun within one hour of being drawn 97.6% of the time. PTT was therapeutic 63.4% of the time, while Anti-Xa was in therapeutic range 68% of the time. For the entire group there was a significant mismatch in therapeutic status. Non-therapeutic Anti-Xa levels were associated with therapeutic PTT levels 16.7% of the time while therapeutic Anti-Xa levels were associated with non-therapeutic PTT levels 52.1% of the time (p=.007). For mismatches by patient status, non-therapeutic Anti-Xa levels were associated with therapeutic PTT levels 14.3, 28.6 and 0% of the time in the very sick, recovering and well, respectively. Therapeutic Anti-Xa levels were associated with non-therapeutic PTT levels 83.3, 45.0 and 50.0% of the time in the very sick, recovering and well, respectively.

Conclusions: Anti-Xa level monitoring in hospitalized patients is not reliable. Patients may be over or under treated and cases of serious bleeding and PE resulted. The hospital policy of using Anti-Xa levels was discontinued after six weeks. Serious complications have been reported locally. Potential etiologies for the variations will be presented.

Full Program & Abstracts

7:45 am – 8:00 am **23**

Outcome Predictors of Limb Salvage In Traumatic Popliteal Artery Injury

Anahita Dua*, Jaecel O Shah, Robert E Lasky, Kristofer Charlton-Ouw, Ali Azizzadeh, Anthony Estrera, Hazim J Safi, Sheila M Coogan - University of Texas-Houston, Houston, TX

Introduction & Objectives: This study aims to identify predictors of limb salvage in a civilian cohort from a level I trauma center who sustained traumatic popliteal artery injury.

Methods: A single institution, retrospective review was performed of 68 patients presenting from January 2002-June 2009 with traumatic popliteal artery injury. Data was compiled utilizing the institutional trauma registry; demographics, mechanism of injury, associated injury fasciotomy, mangled extremity severity score (MESS), and injury severity score (ISS) were documented. Statistical analysis included descriptive statistics, univariate and multivariate analysis.

Results: 70 traumatic popliteal artery injuries were identified in 68 patients. Mean age was 33 years (range, 5-88). The majority of patients were male (57, 81%) and 73% sustained blunt injury. Associated venous injury was present in 16 (23%) cases. Associated orthopedic injuries included 19 (27%) dislocations and 49 (70%) fractures. Median MESS was 5 (range, 2-9) and median ISS was 9 (range, 4-41).

Revascularization was performed in 62 cases (89%). 23% of patients developed compartment syndrome. 56% of patients underwent fasciotomy. 15 (21%) patients required amputation and of those 11% were primary and 10% secondary. Univariate analysis was calculated for each predictor variable. Four variables were significantly associated with amputation: MESS (OR=2.4, P<.0001), ISS>10 compared to ISS<9 (OR=7.4, P<.045), blunt injury (OR=10.7, P=.009), and fractures (OR=0.13, P<.045). Using multiple exact logistic regression, MESS (P<.05) was the only significant predictor of amputation. The increased odds of amputation were similar for both primary (OR=2.6, P=.001) and secondary (OR=2.4, P=.002) amputations.

Conclusions: Patients with traumatic popliteal artery injury are at high risk for amputation. Blunt injury, associated fractures, MESS and ISS >9 were significantly associated with amputation. MESS was a significant predictor of amputation and should be considered along with the clinical picture prior to revascularization attempts in these patients.

Full Program & Abstracts

8:00 am – 8:10 am

24 (RF)

The Endovascular Management of Arterial Injuries Associated With Posterior Knee Dislocation

Zachary K. Baldwin, Rishi Roy*, Andrea Barker - University of Mississippi Medical Center, Jackson, MS

Introduction: Traumatic knee dislocations are associated with popliteal artery injury in approximately 50% of cases. Timely revascularization of the affected limb is critical, and conventional management typically involves arterial bypass. However, due to the affected patient population, these procedures are often difficult and complex secondary to difficult exposure, traumatic soft tissue injury, venous injury and vasospasm. Endovascular management of these difficult to treat injuries may be an effective and alternative method for revascularization. And yet, there are no reports in the literature of primary endovascular repair for this pathology. This report details our experience managing posterior knee dislocations treated through endovascular means.

Methods: Patients with popliteal artery injury related to traumatic knee dislocation were retrospectively evaluated. Six patients met criteria. Of the five patients who underwent revascularization, all had an initial attempt at endovascular repair. In two patients, the wire was unable to traverse the injury and the artery was subsequently found to be completely severed on open exploration. In three patients, the wire successfully traversed the injury and revascularization was performed utilizing combinations of mechanical thrombectomy, thrombolysis, angioplasty and stenting.

Results: All patients treated endovascularly were successfully revascularized. One patient required prophylactic fasciotomies at the time of revascularization. Follow-up was notable for no re-occlusions, though one patient did require angioplasty of in-stent restenosis two years after injury.

Conclusions: Management of popliteal artery injury secondary to knee dislocation can be challenging given the patient population and associated anatomy. For this reason, endovascular repair may be beneficial for early and effective revascularization. This less invasive option has the potential to minimize wound-related complications and speed recovery. Though the long-term patency of these endovascular repairs is a potential drawback, open repair remains a future option and can be performed in an optimal setting remote from the traumatic injury.

Full Program & Abstracts

8:10 am – 8:20 am

25 (RF)

Assessment of Initial Wound Healing Following Amputations

Amani D Politano*, Jennifer Wang*, Mehul S Patel*, Kenneth J Cherry*, Gilbert R Upchurch*, Jr.*, Margaret C Tracci* - University of Virginia, Charlottesville, VA

Introduction: Amputations are common procedures in vascular surgery for which wound non-healing can lead to prolonged wound care, infections, and need for revision, often to a higher level, an outcome associated with increased mortality risk. In surgical settings, comorbid conditions such as diabetes or chronic steroid use predispose patients to wound non-healing following surgery. In this study, the association of patient characteristics and comorbidities with initial wound non-healing following amputation was investigated.

Methods: Operating room records were reviewed for lower extremity amputations on any service and for all indications between August 2007 and August 2011. Medical records, including operative notes and clinic visits, were reviewed for operative details, pre-operative infections, antibiotic use, medical comorbidities, wound healing, and need for further intervention. Analyses were performed using SPSS 20.

Results: 407 amputations were identified. At first post-operative clinic visit, 25% of amputations demonstrated non-healing. Patients with non-healing wounds were more often diabetic ($p=0.06$) and on hemodialysis ($p=0.02$), had increased duration of antibiotics ($p=0.04$) and more frequent interventions for infection ($p<0.001$). Multivariate logistic regression analysis identified dialysis dependence ($p=0.005$, OR 2.5) and Rutherford category 6 or grade III status ($p=0.047$, OR 2.6 and 0.040, 3.8) as independent predictors of wound non-healing. Factors associated with a change in level of amputation include prior outflow/runoff revascularization, pre-operative infection, increased Rutherford stage, dialysis dependence, and peripheral arterial disease. By multivariate analysis, dialysis dependence, peripheral arterial disease, age, and Rutherford class were predictive of a change in level of amputation ($p<0.02$ for all).

Conclusions: Our data show that among multiple risk factors examined, dialysis dependence and Rutherford classification were independent predictors of early non-healing. Although significant in this amputation population, this model will have to be validated in a larger sample. Understanding these outcomes may guide preoperative risk modification and inform shared decisionmaking by patient and surgeon.

Full Program & Abstracts

8:20 am – 8:30 am **26 (RF)**

When To Call It A Day: Incremental Risk of Amputation After Multiple Revascularization

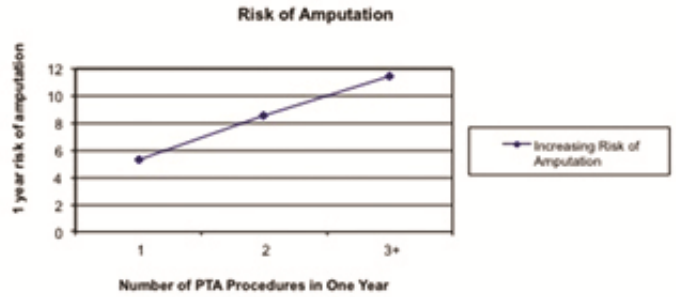
Alexander T. Hawkins*, Maria J. Schaumeier*, Ann D. Smith*, Nathanael D. Hevelone*, Louis L. Nguyen* - Brigham and Women's Hospital, Boston, MA

Introduction & Objectives: Patients with Peripheral Vascular Disease often undergo revascularization prior to amputation. The exact relationship between increased procedures and increased risk of amputation is unclear. We sought to determine the increased risk of amputation for each additional revascularization.

Methods: We searched the Statewide Inpatient Databases for California (2007-2009), identifying patients who underwent one or more lower extremity angioplasty ± stent (PTA) or peripheral bypass graft (PBG) within a one-year period. We analyzed crude risk of 1-year amputation or death along with a test of deviation from linearity and multivariable-adjusted outcomes of in-hospital mortality and major amputation.

Results: Out of 5,147,981 patients, we identified 14,793 (0.2%) who underwent one or more PTA and/or PBG within a 1-year period. The mean age was 68.44. In a 1-year period, 555 (3.8%) underwent amputation and 1375 (9.3%) died. The crude risk of amputation (1 PTA: 5.3%, 2 PTA: 8.5%, 3+ PTA 11.4%; P-value: < 0.001) increased with multiple PTA. The risk increases appear to be linear (P=0.842). The risk of amputation (1 PBG : 8%, 2+ PBG: 13.1%; P-value: < 0.001) increases with multiple PBG. In a multivariate analysis, the odds of amputation significantly increased with multiple PTA (1 vs 2 PTA- OR: 1.50 (1.21-1.87) P<0.001; 1 vs 3+ PTA - OR: 1.82 (1.29-2.56) P<0.001) and multiple PBG (1 vs 2 PBG- OR: 1.62 (1.24-2.25); P=0.001).

Conclusions: The crude risk of amputation increases in a linear fashion with increasing PTA procedures. Risk adjusted odds for amputation increase with increasing revascularization procedures.



Multivariate Analysis (OR with 95% CI and P value) – A single procedure is the referent.

	PTA in 1 year (n=10789)			PBG in 1 year (n=5365)		PTA+PBG in 1 year (n=14793)			
	1 (9030)	2 (n=1388)	3+ (n=371)	1 (n=4857)	2+ (n= 508)	1 (n=11669)	2 (n=2356)	3 (n=585)	4+ (n=183)
Amp	1	**1.50 (1.21-1.87); P<0.001**	**1.82 (1.29-2.56); P<0.001**	1	**1.62 (1.24-2.25); P=0.001**	1	**1.72 (1.45-2.03); P<0.001**	**2.46 (1.90-3.19); P<0.001**	**2.14 (1.36-3.37); P=0.001**
Death	1	1.17 (0.98-1.40); P=0.082	1.14 (0.84-1.56); P=0.400	1	0.78 (0.54-1.12); P=0.175	1	1.14 (0.98-1.31); P=0.090	1.23 (0.95-1.60); P=0.120	1.16 (0.74-1.84); P=0.521

8:30 am – 8:45 am **27**

A Cost-Effectiveness Analysis of Revascularization For Limb Salvage Among Patients With Marginal Baseline Functional Status

Neal R. Barshes[1], Panos Kougias[1], C. Keith Ozaki[2], George Pisimisis[1], Carlos F. Bechara[1], Helene K. Henson*[1], Michael Belkin[2] - [1]Baylor College of Medicine, Houston, TX; [2]Brigham and Women's Hospital, Boston, MA

Introduction & Objectives: Revascularization and limb salvage efforts are typically offered to acceptable-risk patients with good functional status. We evaluated the utility of limb salvage efforts for elderly patients with marginal baseline function through a formal cost-effectiveness analysis.

Methods: A probabilistic Markov model with deterministic sensitivity analyses was used to simulate outcomes during a 10-year period under various strategies for managing chronic limb ischemia with non-healing wounds. Clinical and functional outcomes were modeled on PREVENT III and VSGNE data that represented a patient population with limited lifespan, increased perioperative mortality and marginal functional status (see Table 1). Estimates of the total long-term direct and indirect costs (including secondary amputations, wound care, nursing home costs, etc.) were obtained from our previous single-center study. The primary endpoint was cost per year of preserving ambulatory ability (either through limb salvage or with a limb prosthesis).

Results: The total long-term costs of endovascular and surgical revascularization strategies were much lower than the costs of local wound care alone or primary amputation (see Table 2). Revascularization also produced more health benefits as measured in years of ambulation, years of limb salvage, or quality-adjusted life-years. In none of the scenarios modeled in sensitivity analyses did primary amputation prove to be more cost-effective than revascularization strategies.

Conclusions: Revascularization and limb salvage efforts may provide significant cost-savings (i.e. increased health benefits and lower total costs) when compared to local wound care alone or to primary amputation when done for patients with marginal functional status and elevated mortality risk.

Full Program & Abstracts

Table 1: Selected clinical and functional parameters used in the model.

parameter	surgical bypass	endovascular intervention	wound care only	primary amputation
annual (baseline) mortality, %	18.0	18.0	18.0	18.0
additional periprocedural mortality, %	5.2	3.9	0	7.9
annual rate of major amputation during year 1, %	10.8	12.2	38.0	N/A
annual rate of major amputation during years 2-10, %	2.6	2.6	38.0	N/A
annual rate of wound healing, %	90.0	60.3	41.0	84.0
rate of vascular reintervention, %	22.7	26.0	0	0
proportion initially remaining ambulatory (with limb salvage or with limb prosthesis), %	72.1	72.1	100	37.9
proportion with initial discharged to rehabilitation facility, %	30.6	30.6	0	30.6
proportion that remain independently living, %	82.5	82.5	100	63.8
health utility with unhealed foot wound or amputation stump	0.52	0.52	0.42	0.48
health utility with healed foot wound or amputation stump	0.62	0.62	0.64	0.54

Table 2: Long-term costs and health benefits associated with various management strategies.

strategy	median 5-year patient survival, %	median 5-year limb salvage, %	median total costs, 2011 USD	median years of ambulation	median years of limb preservation	median quality-adjusted life-years
endovascular intervention; endovascular reintervention as needed	34.5	80.5	104,118	2.468	3.031	1.762
initial endovascular revascularization; surgical bypass as needed for failures	34.4	80.3	108,794	2.459	3.015	1.769
surgical bypass; endovascular revisions as needed	33.7	79.8	110,910	2.410	2.941	1.781
surgical bypass; surgical revisions as needed	33.7	79.8	113,944	2.410	2.941	1.781
wound care only; major amputation as needed	34.9	27.9	129,651	0.834	1.473	1.644
primary amputation	33.5	0	185,955	1.585	0	1.520

Full Program & Abstracts

8:45 am – 8:55 am

28 (CR)
Re-Entry Device Aided EVAR In Patients With AAA and Unilateral Iliac Artery Occlusion
Jason T Lee, George K. Lee, Vinit Varu*, Shu Chang* - Stanford University Medical Center, Stanford, CA

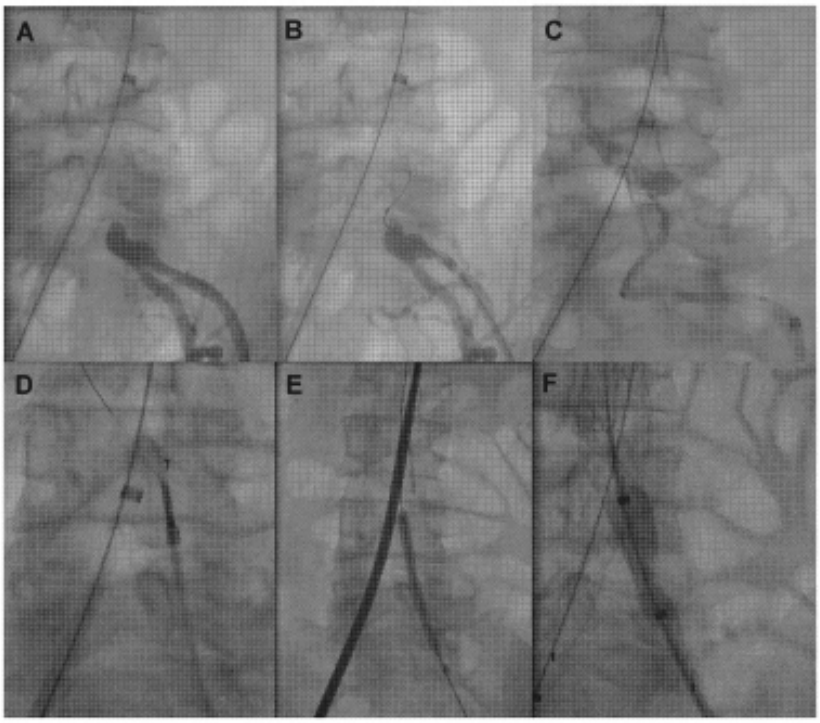
Introduction & Objectives: We report two cases of patients undergoing EVAR utilizing re-entry devices to re-canalize unilateral iliac artery occlusions and complete a bifurcated endovascular repair.

Methods: Patient 1 was a 74-year old male with an enlarging 5.5 cm AAA and severe left leg claudication (ABI 0.4) with L common iliac occlusion. Patient 2 was a 69-year old man with an asymptomatic 6.7 cm AAA and occluded L common iliac (ABI 0.7) and minimal leg symptoms.

Results: Both patients underwent elective percutaneous EVAR along with left iliac artery revascularization. Initial angiography in both cases showed a blind ending of the left common iliac artery (FIGURE A). Retrograde sub-intimal dissection through the occluded iliac segment was attempted but in both cases the wire was unable to traverse back into the true aortic lumen (B,C). Using either the Outback LTD or Pioneer re-entry catheter, direct visualization of the true aortic lumen was obtained to re-enter the true lumen (D,E). The sub-intimal iliac tract was then pre-dilated to facilitate routine EVAR in both cases (F). Both patients were discharged the following day, and one-year follow-up imaging revealed aneurysm exclusion, no endoleak, and patent bilateral common iliac arteries with resolution of claudication symptoms and normal ABIs.

Conclusions: Management of peripheral arterial occlusions using re-entry catheters to facilitate sub-intimal angioplasty and re-canalization has been well described. To our knowledge, these are the first cases in the literature describing the use of re-entry catheters to facilitate EVAR. The ability to cross the iliac occlusions and place a bifurcated graft in these patients precluded the need for aorto-uni-iliac configuration and avoided the potential morbidity of a crossover fem-fem bypass.

Full Program & Abstracts



8:55 am – 9:05 am	Introduction of the President
9:05 am – 9:35 am	**PRESIDENTIAL ADDRESS** **I Have But One Candle of Life To Burn…** Ruth L. Bush, MD, MPH
12:00 pm – 1:00 pm	**SKI-IN/SKI-OUT LUNCH**
3:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks Last Chance To Visit Exhibitors

Full Program & Abstracts

4:00 pm – 6:00 pm **SCIENTIFIC SESSION IV**
Moderators: Peter Nelson, MD & Brian DeRubertis, MD

4:00 pm – 4:15 pm **29**

Concomitant Intracranial Aneurysm and Carotid Artery Stenosis: An Institutional Review of Patients Undergoing Carotid Revascularization

Matthew J Borkon, Han Hoang*, Caron Rockman, Firas Mussa, Jafar J Jafar, Thomas Riles, Frank J Veith, Mark A Adelman, Thomas S Maldonado - New York University Langone Medical Center, New York, NY

INTRODUCTION AND OBJECTIVES: The incidence of concomitant carotid artery stenosis and intracranial aneurysm has been reported to be between 3-5%. In these patients treatment strategies must balance the risk of stroke with the risk of aneurysmal rupture. Several studies have examined the natural course of small intracranial aneurysms (<10mm) in the setting of carotid revascularization; however, the final recommendations are not uniform. The purpose of this study was to review our institutional experience with concomitant intracranial aneurysms and carotid artery stenosis.

METHODS: We performed a retrospective review of all patients with carotid artery stenosis who underwent carotid artery endarterectomy (CEA) or carotid artery stenting (CAS) at our institution between 2003-2010. Only patients with preoperative imaging demonstrating intracranial circulation were included. Charts were reviewed for specific patient demographic data, duration of follow up, and aneurysm size and location. Patients were divided into two groups: carotid stenosis with intracranial aneurysm and carotid stenosis without intracranial aneurysm.

RESULTS: 305 patients met the inclusion criteria and had a total of 316 carotid procedures (CAS or CEA) performed. 11 patients (3.61%) were found to have intracranial aneurysms prior to carotid revascularization. The male and female incidence was 2.59% and 5.26% (p=0.22), respectively. Patient demographics did not differ significantly between the two groups. The average aneurysm size was 3.25±2.13 mm, and the most common location was the cavernous segment of the internal carotid artery. No patient in the study suffered from aneurysm rupture, and the mean follow up time was 26.5 months for the carotid stenosis with intracranial aneurysm group.

CONCLUSIONS: Concomitant carotid artery stenosis and intracranial aneurysm is a rare entity. Carotid revascularization does not appear to increase the risk of rupture for small aneurysms in the midterm. Although not statistically significant, there was a higher incidence of aneurysms in females in our patient population.

Full Program & Abstracts

4:15 pm – 4:30 pm

30

Endovascular Popliteal Artery Aneurysm Repair: A Decade of Experience

Jeffrey Jim, Enjae Jung, Brian G Rubin, John A Curci, Luis A Sanchez, Patrick J Geraghty - Washington University in St. Louis, St. Louis, MO

Objective: To evaluate a single center experience of endovascular popliteal artery aneurysm repair (EVPAR) over the past decade.

Method: A retrospective review at a single institution was performed for patients treated with EVPAR from 2002 to 2011. Demographics, preoperative imaging, surgical technique, and patient outcomes were analyzed.

Results: During the study period, 38 limbs (37 males, 97%) with a mean age of 71.7 years (range 55-85) were treated electively. The mean aneurysm diameter was 2.68 cm with 6 (16%) symptomatic limbs. All patients underwent EVPAR with the use of Viabahn endoprosthesis. Aneurysm exclusion was achieved in 100% of cases. There were 5 adjunctive procedures (3 patch repairs of access vessel; 1 bare metal stent placement for stent graft infolding, 1 outflow thrombectomy). There were 2 periprocedural complications (percutaneous access site hematoma and device misdeployment both requiring open repair). The mean length of stay was 1.3 (range 0-3) days. On follow-up, there were no instances of limb loss. Secondary interventions were performed on 3 (7.5%) limbs for thrombosis, type I or III endoleaks. Overall, five (12.5%) patients developed stent-graft thrombosis (mean 23.6 months) with four requiring open bypass. Seven (17.5%) patients died (mean 43.0 months) with intact limbs. The remaining 28 patients are doing well with a mean follow-up of 45.3 months.

Conclusions: EVPAR is technically feasible and associated with low rates of periprocedural complications and short hospital stay. EVPAR may be considered a preferred option in select patients with popliteal artery aneurysms.

Full Program & Abstracts

4:30 pm – 4:45 pm **31**

Disparate Preoperative Surveillance and Rupture of Abdominal Aortic Aneurysm For the Elderly Poor

Matthew W Mell, Laurence C Baker*, Mark A Hlatky* - Stanford University, Stanford, CA

Objective: To determine the factors, with specific emphasis on the role of preoperative surveillance, contributing to increased rate of ruptured abdominal aortic aneurysms (AAA) for the elderly poor.

Methods: Medicare claims were analyzed for patients who underwent AAA repair for previously diagnosed AAA from 2006 to 2009 (n=14,948), with preoperative abdominal imaging collected for up to 5 years. Repair for ruptured versus intact AAA was the primary outcome measure. We used logistic regression to determine the relationship between Medicaid eligibility and the risk of rupture, sequentially adding variables related to patient characteristics, socioeconomic status, receipt of preoperative AAA surveillance, and hospital AAA volume. We then estimated the proportional effect of each factor.

Results: Poor patients were 83% more likely to present with ruptured AAA (OR 1.83, 95% CI 1.36 - 2.47). These differences were more pronounced in men (OR 2.41, 95% CI 1.65 - 3.52), who comprised 75% of the cohort. Poor patients were 50% more likely to have gaps in preoperative AAA surveillance (OR 1.50, 95% CI 1.22 - 1.83). After adjusting for variability in preoperative surveillance, patient factors, socioeconomic status and hospital factors, the disparity in risk of rupture was no longer significant (OR 0.88, 95% CI 0.53 - 1.544). We estimate that 47% of the observed disparity in rupture for the elderly poor is explained by patient factors, 34% by gaps in preoperative image surveillance, 7% by socioeconomic factors and 12% by hospital factors.

Conclusions: Gaps in preoperative surveillance is a key contributor to increased rupture of AAA in the elderly poor. Efforts aimed at improving disparities must include systems to provide reliable preoperative surveillance.

Risk of Ruptured AAA for the Poor		
Model	OR (95% CI)	Proportion of Disparity Explained (%)
Unadjusted	1.83 (1.36 - 2.47)	--
Adjusted for:		
Socioeconomic status	1.76 (1.23 - 2.34)	7
Hospital factors	1.70 (1.23 - 2.34)	12
Surveillance	1.51 (1.08 - 2.11)	34
Patient factors	0.88 (0.53 - 1.44)	47

4:45 pm – 5:00 pm **32**

Postoperative and Long-Term Outcomes Following Open Repair of Ruptured Abdominal Aortic Aneurysms In Octogenarians

Hashem M Barakat*, Yousef Shahin, Ian Chetter, Peter McCollum - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

Introduction & Objectives: The purpose of this study is to evaluate morbidity, mortality and survival in octogenarians undergoing open repair of ruptured abdominal aortic aneurysm (RAAA) in comparison to the younger population.

Methods: A retrospective analysis of a prospectively maintained database. All consecutive RAAA patients who underwent open repair from 1990 to 2011 were included.

Results: Overall 463 patients were identified of which 138 (30%) were octogenarians with a mean age 84+/-0.47 and 96 (69%) males. Median long term survival for octogenarians (group 2) was 78 days compared to 3017 days in the below 80 years population (group 1), p<0.001. There were more females in group 2 (31%) compared to group 1 (14%), p0.05. Median preoperative Hb (p<0.001) and creatinine (p=0.031) were significantly different between the groups. 30 day mortality for group 2 was 45.3% compared to 28.1% for group 1, p<0.001. There was no significant difference between the two groups in terms of postoperative complications and length of hospital stay.

Conclusions: Based on the findings of this study, perioperative variables and postoperative complications were comparable between octogenarians and younger patients and do not explain the difference in long term survival between the two groups. Increasing age and female gender might have contributed to this difference in survival.

Full Program & Abstracts

5:00 pm – 5:10 pm **33 (CR)**

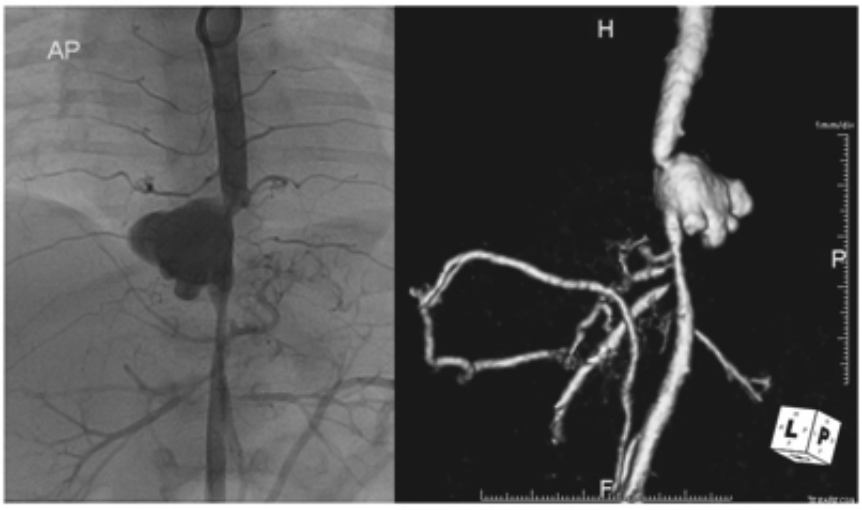
Endovascular Management of Middle Aortic Syndrome With Associated Saccular Aneurysm In A Newborn

Siddharth Patel, Dennis Kim*, Ravi Veeraswamy - Emory University, Atlanta, GA

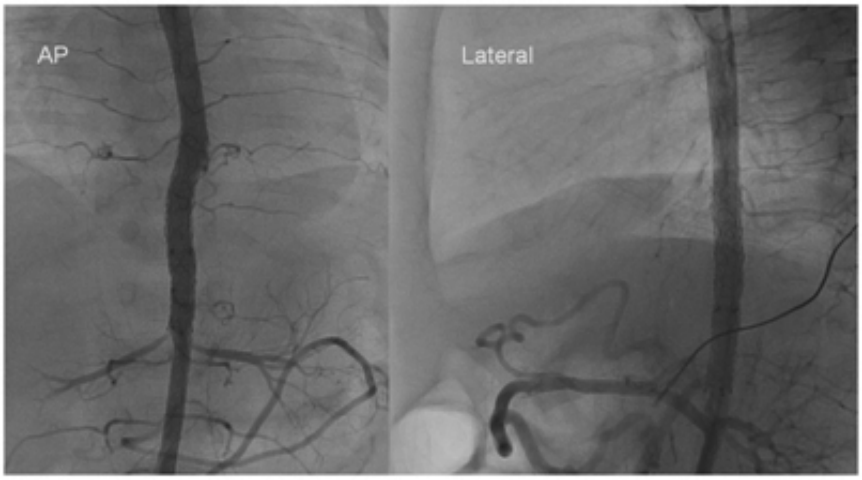
Introduction: Middle aortic syndrome refers to segmental narrowing of the distal thoracic/ abdominal aorta, often with involvement of the visceral vessels. We describe successful endovascular treatment in a newborn who presented with lower extremity ischemia secondary to severe, segmental narrowing of the supraceliac aorta and an associated saccular aneurysm.

Case Report: A 2 week old, 4.3kg male presented with episodes of transient, acute bilateral lower extremity ischemia during feeding. CT angiogram demonstrated severe stenosis of the distal thoracic aorta and an associated saccular aneurysm. Additionally, the celiac and superior mesenteric arteries had severe stenoses at their origins and were perfused via large collateral arteries. The pressure gradient between the thoracic and infrarenal aorta was 52mm. The aorta was accessed via surgical exposure of the left common carotid artery. Two overlapping 5mm x 22mm PTFE covered stent-grafts (iCast, Atrium, inc.) were deployed across the aneurysmal segment with good resultant seal. An additional 5mm x 14mm bare metal stent (Paramount, Bard, inc.) was placed across the residual coarctation. Completion angiography demonstrated excellent flow across the stented segment with retrograde filling of the SMA and celiac artery via the pre-existing collateral. At one moth follow-up, angiography demonstrated continued aneurysm exclusion and brisk visceral arterial flow, and the patient was growing appropriately.

Conclusions: Endovascular management of complex aortic pathology in the neonatal period is safe and effective. Reinterventions are anticipated for restenoses and size mismatch as patients grow. Long-term follow-up is needed to determine the effectiveness of this strategy in comparison to open surgical therapy.



Full Program & Abstracts



Full Program & Abstracts

5:10 pm – 5:20 pm

34 (CR)

Coil Embolization of Ascending Aortic Pseudo-Aneurysm Post Open Repair of Type A Aortic Dissection

Vikalp Jain*, Luis Gruberg*, Thomas V Bilfinger*, Apostolos K Tassiopoulos, Shang A Loh - Stony Brook University Medical Center, Stony Brook, NY

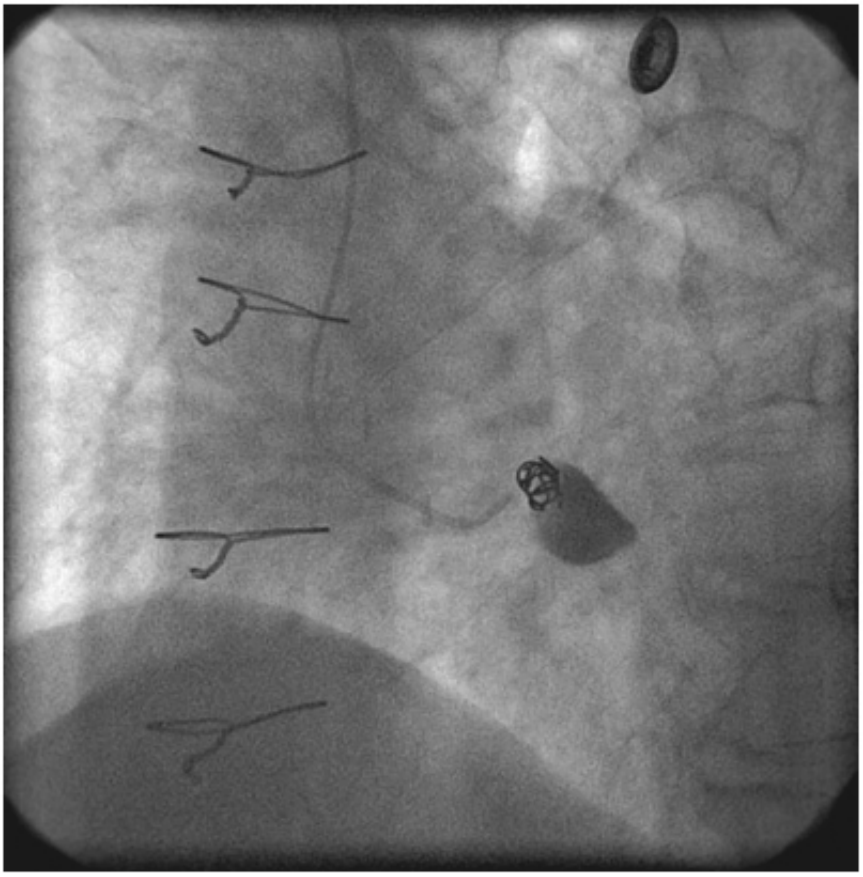
Introduction and Objectives: Anastomotic pseudoaneurysms represent an uncommon and challenging complication of open aortic repair with prosthetic graft. First characterized by Clayton et. al. in 1956, they affect approximately 1.4 - 4% of arterial anastomoses. These pseudoaneurysms are the result of many factors, foremost of which are infection, integrity of the host tissue, surgical technique, and location of the anastomosis.

Pseudoaneurysms were traditionally treated with open resection of the pseudoaneurysm and revision of the anastomosis. This case presents a novel approach to the treatment of pseudoaneurysms in a difficult location.

Methods/Results: The patient is a 77 year-old male status post repair of a Type A aortic dissection with a dacron tube graft. Follow up imaging eighteen months post op showed a 1.6 cm x 1.7 cm pseudoaneurysm off of the posteromedial proximal suture line. Through a right brachial artery approach, a diagnostic angiogram was performed demonstrating a bi-lobed pseudoaneurysm. A Judkins left 3.5 catheter and 0.035" angled Glidewire was used to engage the orifice of the pseudoaneurysm. Two 4 mm x 6 cm Boston Scientific Interlock coils were then deployed into the pseudoaneurysm sac. Completion angiogram demonstrated complete exclusion of the pseudoaneurysm. The patient did well and was discharged the following day. Follow up CT scan at 3 months showed regression and complete thrombosis of the pseudoaneurysm.

Conclusion: Traditional operative repair of anastomotic pseudoaneurysms can lead to long operations, high blood loss, and increased morbidity and mortality as a result of their reoperative nature. Coil embolization is a safe and effective approach for the treatment of anastomotic pseudoaneurysms in difficult locations.

Full Program & Abstracts



Full Program & Abstracts

5:20 pm – 5:30 pm **35 (RF)**

A Novel Approach To EVAR Simulation Using Patient Specific Modeling

Gavin R Davis, Murray L Shames, Karl A Illig, George Yang*, Thu -Hoai Nguyen* - USF, Tampa, FL

Intoduction and Objectives: The Simbionix Angiomentor Procedure Rehearsal Studio (PRS) offers accurate virtual anatomy for measurement, stent graft selection and deployment of endovascular AAA (EVAR) devices.

Methods: Selected Gore Excluder EVAR cases from our EVAR database were reviewed and DICOM data loaded into the Symbionix Angiomentor simulator using PRS software. Using centerline measurements created on PRS neck diameter (D_1), length from lowest renal artery to each iliac bifurcation (L_l and L_r) and common iliac artery diameter (D_l and D_r) were recorded. All measurements for device selection were made based on data recorded on the simulator. Simulated EVAR was then performed using PRS on a dual limb endovascular simulator. Changes in device selection based on intraoperative measurements and use of 3D anatomic overlay were recorded. The devices actually used for successful repair were considered gold standard for comparison. Simulations were rated by an experienced vascular surgeon for realism, imaging quality, final product on a 5 point scale.

Results: 10 cases were identified with complete operative data and available CT scans. 50% of cases (5/10) had changes in device length when using the "in-vivo" 3D volume filled model and angiographic measurements. When changes were made the devices inserted it resulted in correction of limb length to that of inserted devices in 100% (5/5) of cases. Review of simulation scoring showed ratings of diminished realism (average 2.3/5) due to unrealistic ease of wire passage and gate cannulation, however, simulation imaging and final product were scored favorably (3.7 and 3.4 respectively).

Conclusion: PRS offers an approach to simulation for EVAR that allows for case variability not seen in other simulation modalities. The use of centerlines, angiographic measurements and 3D modeling within the PRS software predicts real life device selection and represents an opportunity for high fidelity patient specific preoperative EVAR practice.

5:30 pm – 5:45 pm

36

Validated Assessment Tool Paves the Way For Standardized Evaluation of Trainees On Anastomotic Models

Cassidy Duran[1], Murray L Shames[2], Jean Bismuth[1], Jason T Lee[3], APDVS Committee for Education and Simulation - [1]The Methodist DeBakey Heart & Vascular Center, Houston, TX; [2]University of South Florida Health, Tampa, FL; [3]Stanford University School of Medicine, Stanford, CA

Objective: Duty hour restrictions that limit operative exposure and declining numbers of open operations have raised concern about open technical skills acquisition. Simulation modules allow for the safe practice of techniques and are becoming important in the shift towards education for integrated vascular residents. There is an unquestionable need to standardize the evaluation of trainees on these simulation models. We sought to validate such an assessment tool for performance of basic open anastomosis.

Methods: Vascular fellows, residents, and students attending SCVS, IAVS, and Boot Camp in 2012 were asked to participate in simulations using multiple anastomotic models (Limbs & Things, Vascular International, Lifelike Biotissue) and given 20 minutes to complete an end-side anastomosis. Trained observers assessed subjects using the tool and graded performance on a 5-point global assessment scale with 8 parameters. Self-assessment was also performed by each trainee.

Results: 96 trainees participated. Scores on the global assessments correlated with experience and were higher for the senior trainees, with median global summary scores increasing by PGY (PGY1-3=2, PGY4-6=3, PGY7-8=5). For those that performed self-assessment, there was poor correlation between grades given by the expert observers and the trainee, but good correlation between scores assigned by trained observers (Table 1). Assessment of appropriate hemostasis was poor, likely reflecting the difficulty of evaluating this parameter in an inanimate model.

Conclusions: Performance on an open simulation model correlates to trainee experience level. This initial work confirms the ease, validity, and applicability of the grading tool. The portability, reproducibility, and validity of our grading tool will continue to be developed towards the final goal of a technical skills curriculum available for vascular trainees in the US.

Table 1: Median score on Global Rating Scale (5-point Likert) for performance of open anastomosis.

Score on Global Rating Scale	Respect for Tissue	Time and Motion	Instrument Handling	Hemostasis	Knot Tying and Suturing	Use of Assistant	Procedural Flow	Quality of Final Product	Global Summary Level
Trained Observer (Median)	4	3	3.5	3.5	4	4	4	4	3
Correlation between Trained Observers (R-value)	0.66	0.80	0.77	0.43	0.73	0.77	0.64	0.67	0.70
Self Assessment (Median)	4	3.5	4	4	4	4	4	3	3
Correlation self/trained Observer (R-value)	0.50	0.67	0.53	0.46	0.26	0.58	0.55	0.62	0.61

5:45 pm – 6:00 pm Q & A, Discussion

7:00 pm – 10:00 pm **PRESIDENT'S DINNER**
All attendees are welcome to purchase tickets to attend this separate subscription event.

Full Program & Abstracts

Sunday, February 3, 2013

6:30 am – 7:00 am	Continental Breakfast
6:30 am – 9:00 am	Registration
7:00 – 9:00 am	**SCIENTIFIC SESSION V** Moderators: Ravi Veeraswamy, MD & Christopher Smolock, MD
7:00 am – 7:15 am	**37** **Risk Factors Associated With the Abdominal Aortic Aneurysm Diagnosis In Patients Screened At A Regional Veterans Affairs Health Care System** Kevin C Chun*[1], Kai Y. Teng*[1], LeAnn A. Chavez*[1,2], Elyse N. Van Spyk*[1], John G. Carson*[1,2], Eugene S. Lee*[1,2] - [1]VA Northern California Health Care System, Mather, CA; [2]University of California, Davis, Sacramento, CA

Introduction & Objectives: An active abdominal aortic aneurysm (AAA) screening program at a regional Veterans Affairs (VA) health system identifies patients at risk for AAA. The purpose of this study is to evaluate unique risk factors associated with AAA diagnosis upon AAA screening examination to identify the most at risk patients for AAA.

Methods: Data were extracted from a regional VA health care system to identify patients who underwent AAA screening within a 3-year period. An aortic diameter ≥ 3.0 cm was defined as AAA. Patient risk factors: age, body mass index, total cholesterol, serum creatinine, hypertension, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), statin use, and active smoking were evaluated. Risk factors were compared between AAA and non-AAA groups.

Results: A total of 6,329 patients (72.8 ± 5.3 years old) were screened for AAA from January 2007 to December 2009. A total of 478 patients (7.6%) with AAA were identified. The following risk factors were significantly associated (P< .001) with the AAA diagnosis after adjusting for Bonferonni correction: age (73.9±6.6 years old vs. 72.7±5.2 years old), creatinine (1.3±0.7 mg/dl vs. 1.1±0.7 mg/dl), CAD (42.7% vs. 28.5%), COPD (25.9% vs. 16.5%), PVD (16.2% vs. 7.6%), and active smoking (23.2% vs. 15.3%). Diabetes (P< .001) and elevated cholesterol levels (P= .002) were found to be significantly associated against the AAA diagnosis.

Conclusions: These results confirm previous findings that AAA is typically identified in higher risk patients. Novel findings such as renal insufficiency increasing risk, as well as diabetes and cholesterol decreasing risk, may provide further insight into AAA development and expansion, leading to refined AAA surveillance guidelines.

7:15 am – 7:30 am **38**

Mini-Incision Thoracobifemoral Bypass In the Endovascular Era

Amy E Reppert*, Omid Jazaeri*, Ashok Babu*, Mark Nehler*, Brett T Reece* - University of Colorado, Aurora, CO

Introduction & Objectives: Endoluminal revascularization has generally supplanted open techniques for aortoiliac occlusive disease. Today, patients undergo open surgery following a history of multiple endovascular failures or complete aortoiliac occlusions. In addition, hostile abdomens, calcified aortic anatomy, and tenuous pelvic circulation with significant inferior mesenteric artery contribution make the abdominal reconstruction suboptimal. Given the constraints in these patients, we prefer a minimally invasive thoracobifemoral (mini-TBF) approach to aortic bypass.

Methods: Mini-TBF bypasses were performed in high risk patients with aortoiliac occlusive disease and critical limb ischemia. Outflow was constructed from the distal descending aorta via a ≤8 cm thoracotomy. The left limb was tunneled retroperitoneally over the psoas and the right limb anterior to the abdominal fascia below the umbilicus to the groin. Eleven patients (mean age 64, 82% male) underwent mini-TBF bypass between 2009 and 2012. Three had previous endovascular failures, 1 had failed prior aortic and extra-anatomic bypass, three required IMA preservation and the remaining had an unclampable aorta or hostile abdomen.

Results: Median length of stay was 8 days. Mean preoperative ABI was 0.23 and 0.38 for the right and left respectively. Post operatively, mean ABI was 0.81 on the right and 0.78 on the left. There was no perioperative mortality. Postoperative complications occurred in 5 patients: 1 stroke, 2 pulmonary (both contralateral lung issues), and 2 limb occlusion secondary to outflow disease. At median follow up of 18 months, 2 patients required amputations, both from preexisting tissue loss.

Conclusions: The mini-TBF bypass has become an innovative approach for patients requiring revascularization after failed intervention, infrarenal occlusive disease, or hostile abdomen. This approach provides a hemodynamically sound inflow with preservation of tenuous pelvic circulation with complex femoral reconstructions.

Full Program & Abstracts

7:30 am – 7:45 am

39

CEAP Classification Relationship To VLU Closure: A Retrospective Analysis of A Prospective Randomized Controlled Trial of VLU Treatment With A Novel Spray-Applied Cell Therapy

Jamie A Schwartz*[1], Cynthia Gendics*[1], Robert S Kirsner*[2], Herbert B Slade*[3], John C Lanits, III[1] - [1]St Luke's- Roosevelt Hospital Center, New York, NY; [2]University of Miami, Miami, FL; [3]University of North Texas Health Science Center, Fort Worth, TX

Introduction & Objectives: The Clinical Etiology Anatomy Pathophysiology (CEAP) classification was revised in 2004. The exact outcomes of the 6 lesions as defined by the CEAP categories are not well delineated. Therefore, in order to determine the relationship of CEAP classification on Venous Leg Ulcers (VLU) with regard to healing progress and potential need for vascular intervention, we assigned CEAP classifications to a placebo-controlled trial of VLU undergoing treatment therapy.

Methods: HP802-247 is a novel investigational spray-applied cell therapy that was employed in a phase 2, double-blind, randomized, placebo-controlled trial to treat 205/228 adult patients with a chronic VLU over a 12 week study period at 28 outpatient centers in USA and Canada. All groups received four-layer compression therapy in conjunction with cell treatment or vehicle alone. A retrospective review of 76% (173/228) of subjects enrolled was undertaken to evaluate the association of VLU healing to the CEAP classification of the ulcers.

Results: In the vehicle only cohort the healing rate was 52% over the 12 week study period. In this cohort, unlike the treatment group, not finding a perforator or deep vein involvement was associated (RR >1.0) with non-healing. Additionally, combination venous disease was associated with better than average closure rates ($A_{d,p}$ 83%; $A_{s,d,p}$ 75%). Completely obstructive etiology was associated with 0% closure versus 57% for the reflux group ($P<0.05$).

Conclusions: Not surprisingly the prospective study of healing rates showed the postphlebitic obstruction was associated with very poor healing rates. Interestingly, deep vein and perforator reflux was noted to have the best healing rates. This may have implications for a more aggressive attempt at vascular reconstructive procedures in the patient with deep venous occlusion, or possible superficial interventions in the combination group, while the average closure rate for patients with superficial reflux supports the ESCHAR trial data.

Full Program & Abstracts

7:45 am – 8:00 am

40

Does Pulse Volume Recording Aid In Peripheral Arterial Disease Stratification?

Benjamin A Eslahpazir*[1], Matthew T Allemang*[2], Ryan O Lakin*[2], John C Wang[2], Teresa L Carman[2], Virginia L Wong[2], Henry R Baele[2], Vikram S Kashyap[2] - [1]Case Western Reserve University School of Medicine, Cleveland, OH; [2]University Hospitals Case Medical Center, Cleveland, OH

Introduction & Objectives: Non-invasive vascular laboratory determinations for peripheral arterial disease (PAD) often combine pulse volume recordings (PVR), segmental pressure readings (SP) and Doppler waveform traces (DW). Our objective was to assess the corresponding diagnostic values for each test.

Methods: Over 2000 non-invasive diagnostic reports were reviewed through our institutional database. Data from non-invasive records with corresponding angiograms performed within 3 months led to a cohort of 76 patients (89 limbs) for analysis. Four vascular specialists, blinded to the angiographic results, stratified the noninvasive studies as representative of normal, <50% "sub-critical" or >50% "critical" stenosis at the upper thigh, lower thigh, popliteal and calf segments using four randomized non-invasive modalities: (1) PVR alone; (2) SP alone; (3) SP+DW; and (4) SP+DW+PVR. The angiographic records were independently graded by another three evaluators and used as a standard to determine the non-invasive diagnostic values and interobserver agreements.

Results: Interobserver variance for all modalities except SP was high (Figure 1). Sensitivity (range 25-75%) was lower than specificity (range 50-84%) for all modalities. Accuracy for detecting a critical or sub-critical stenosis with SP+DW was significantly higher than PVR alone (Figure 2). However, when only assessing critical stenoses, no statistically significant relationships were found between any modalities for sensitivity, specificity or diagnostic accuracy.

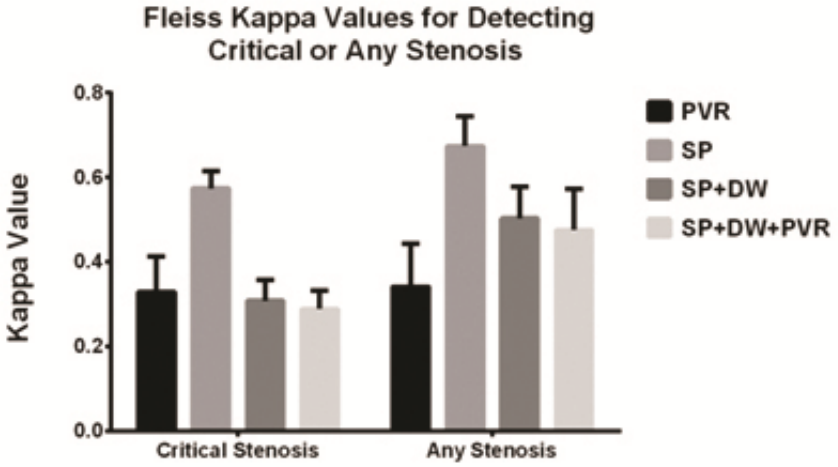


Figure 1: Fleiss Kappa agreement values for 4 interpreters (Mean between segments with SD).

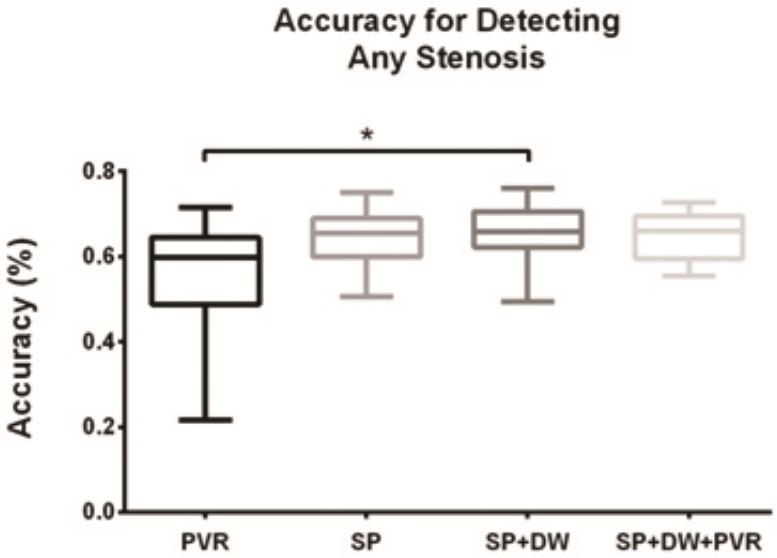


Figure 2: Diagnostic accuracy values of each modality for detecting critical or sub-critical stenosis. (Box margins indicating interquartile range, whiskers indicating minimum and maximum, and bar indicating median of segments determined by 4 interpreters; *P < 0.05 by Kruskal-Wallis ANOVA and Dunn's multiple comparison test)

Conclusions: SP has the greatest interobserver agreement in evaluation of PAD. Given the lower accuracy of PVR for detecting either sub-critical and critical disease, PVR tests could be omitted from the non-invasive vascular exam without significant reductions in overall diagnostic value.

Full Program & Abstracts

8:00 am – 8:10 am

41 (CR)

Endovascular Management of Chronic SVC Syndrome With SVC Occlusion

Robert W Fincher*, Magdiel Trinidad* - University of Arizona, Tucson, AZ

Introduction & Objectives: SVC syndrome occurs from benign and malignant causes. The presentation can be acute or chronic. For patients with chronic, symptomatic SVC syndrome from benign causes, few trials regarding treatment have been published. Controlled trials of endovascular therapy versus surgery for symptomatic SVC occlusion remain unpublished. We present a case of chronic, type III SVC syndrome treated with thrombolytic therapy, angioplasty, and stenting, followed by a review of the literature. Endovascular therapy should be considered first line management in symptomatic patients with chronic SVC occlusion.

Methods: A 56-year-old female with a history of AML, chronic graft versus host disease, with a right indwelling internal jugular access port, presented with a 6-week history of face and arm swelling, headaches, visual impairment, and increasing prominence of her chest veins. CT thorax revealed occlusive thrombus of the SVC, left brachiocephalic vein, and left subclavian vein. Venography revealed complete SVC occlusion, right innominate venous occlusion, and reversal of flow in the azygous vein (Type III SVC Syndrome). An infusion catheter was placed across the occluded SVC and the patient was started on thrombolytic therapy. Forty-eight hours post-lysis, completion venography revealed persistent clot at the atriocaval junction. Angioplasty and stenting of the SVC was performed. Completion venography revealed patent flow from the innominate veins through the SVC into the right atrium.

Results: The patient was subsequently discharged on oral anticoagulation with complete resolution of her symptoms on postoperative day three. At two weeks, duplex venous ultrasound of the neck was negative for residual internal jugular thrombus, and the patient remained asymptomatic.

Conclusions: Angioplasty and stenting of the SVC for symptomatic benign SVC syndrome has excellent primary and secondary patency in several published series. It should be considered first line therapy in patients with chronic SVC syndrome with SVC occlusion secondary to benign causes.

Full Program & Abstracts

8:10 am – 8:20 am **42 (CR)**

Percutaneous Retrieval of An Inferior Vena Cava Filter Causing Right Ureter Obstruction

Kristina Thornburg*, Amber Batool*, Melissa Obmann, Shivprasad Nikam*, David Mariner* - Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA

Introduction & Objectives: Retrievable inferior vena cava filters (IVCF) have been available in the United States since 2003. Although retrieval rates have improved over the last several years, they are still low. A number of severe late complications have been reported, including aortic and duodenal perforations. We present a case of percutaneous retrieval of a Bard Recovery filter causing right ureteral obstruction 6 years after placement.

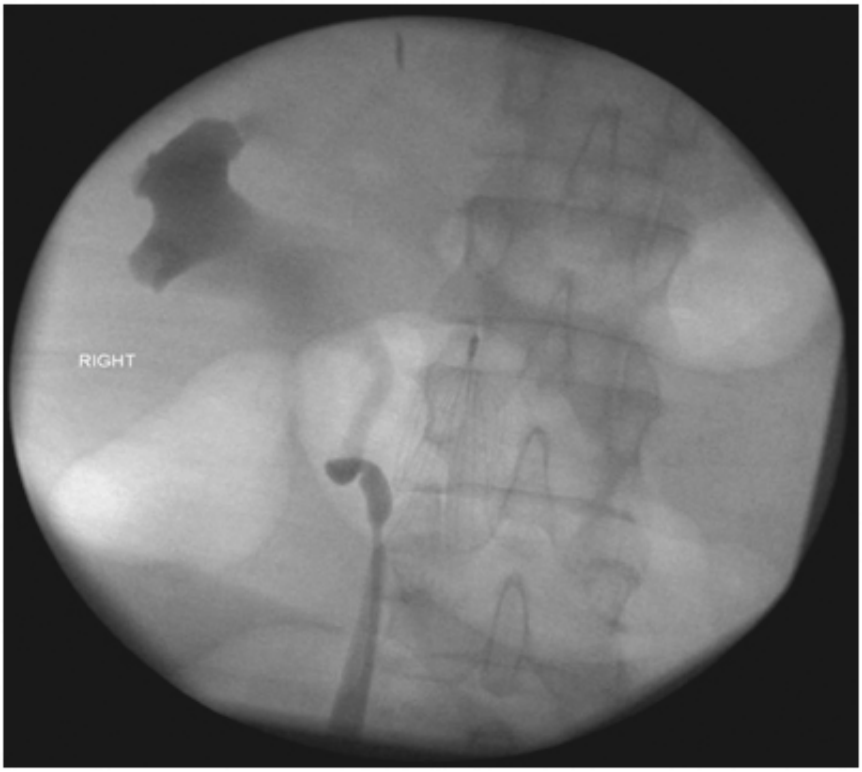
Methods: A 44 year old female presented to the emergency department with abdominal pain, nausea, and vomiting. A CT scan abdomen/pelvis showed right ureter obstruction by an IVCF strut and resultant hydronephrosis. She underwent cystoscopy with placement of a JJ stent. She then underwent percutaneous retrieval of the IVCF several days later.

Results: The patient tolerated both procedures well and had relief of her symptoms. There was no evidence of contrast extravasation noted on completion venogram. She had a follow-up cystoscopy with removal of her stent 1 month later and there were no inflammatory changes within the ureter.

Conclusions: We believe this is the first reported case of percutaneous retrieval of an IVCF causing right ureter obstruction. Although percutaneous retrieval becomes more difficult over time due to endothelial overgrowth of the filter struts, it may be reasonable to attempt retrieval before committing a patient to major surgery. More vigilant retrieval registries in institutions with a high volume of retrievable filter placement may help decrease late complications.

Full Program & Abstracts

Full Program & Abstracts



Full Program & Abstracts

8:20 am – 8:30 am

43 (RF) - *Unable To Attend Meeting*

Isolated Axillary Artery Aneurysm In A Patient With A Patent Ipsilateral Arteriovenous Fistula

Yan T. Ortiz-Pomales*, Jennifer B Smith*, Jeffrey S Weiss, Kevin Casey - Naval Medical Center San Diego, San Diego, CA

Introduction & Objectives: Axillary artery aneurysms (AxAAs) are rare entities commonly associated with trauma or repetition injuries. Less recognized associations include connective tissue, mycotic, or atherosclerotic processes. Treatment is warranted to avoid limb threatening complications such as distal embolization and aneurysm thrombosis. We herein report a case of a rare tortuous AxAA causing neurologic symptoms in a woman without any identifiable risk factors.

Methods: A 58 year-old non-smoker, normotensive female who is 10 years status post brachio-cephalic fistula presented complaining of a 5-month history of progressively worsening ipsilateral upper arm pain and hand paresthesia. She denied any significant personal or family history. Physical examination revealed a tender pulsatile mass proximal in the left axilla and normal distal pulses. Computed tomographic angiogram confirmed a highly tortuous and ectatic dilation of her left axillary artery causing compression of her median nerve (Fig 1).

Results: The patient underwent surgical exploration which identified an extremely tortuous and aneurysmal vessel that was carefully dissected free from surrounding nerves, excised in its entirety, and replaced with an 8-mm Dacron interposition graft. The fistula was not ligated due to the potential need for future hemodialysis access. The patient did well and had complete resolution of her symptoms.

Conclusions: AxAAs are rare findings often associated with trauma from repetitive motions in competitive athletes, crutch-related iatrogenesis, or penetrating trauma. This is a rare tortuous AxAA in a renal transplant patient with a patent but unused brachio-cephalic arteriovenous fistula. We successfully repaired our patient's aneurysm with an interposition graft allowing for complete resolution of her symptoms. Future studies are warranted to identify a possible relationship between upper extremity fistulas and proximal vessel aneurysms.

Full Program & Abstracts

Full Program & Abstracts

8:30 am – 8:45 am **44**

Short- and Mid-Term Results of Iliac Artery Flush Occlusion Stenting With the Assistance of An Occlusive Contralateral Iliac Artery Balloon

Carlos F Bechara, Neal R Barshes, George Pisimisis, Peter H Lin, Panagiotis Kougias - Baylor College of Medicine, Houston, TX

Introduction & Objectives: Endovascular treatment of flush iliac artery occlusion remains a challenge and most are treated by open surgery. We report the outcomes of 10 cases successfully recanalized enodvascularly with the assistance of a contralateral occlusive balloon.

Methods: Retrospective review of patients undergoing iliac artery stenting was performed at a single institution. Technical success, short and midterm patency as well as 30- day complications were reported.

Results: A total of 10 patients were identified. Technical success was 100% when a brachial approach was used. Retrograde recanalization was attempted in 3 cases. Re-entry into the aorta could not be achieved in one case. The aorta was entered above the IMA in the other 2 cases and the decision was made to attempt from a brachial approach to avoid stenting to above the IMA. There were no dissections or perforations. 2 patients developed brachial access complications, but only one required operative repair for a pseudoaneurysm. Nine patients (90%) remain patent at a mean f/u of 10.4 months (3-16). One patient presented 8 months later with iliac stent and lower extremity bypass thrombosis requiring an amputation. There was no immediate or long-term death in this series.

Conclusion: Iliac stenting for flush iliac artery occlusion can be achieved with this technique with encouraging short- and mid-term results and with minimal morbidity.

8:45 am – 9:00 am	Q & A/Discussion
9:00 am	Winter Annual Meeting Adjourns

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*Senior Member

Active Membership Roster 2012

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Centura Health/St. Anthony Hospital
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ZUNIGA, CARLOS
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Peru
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Geographical Listing of Active Members

ALABAMA

Birmingham
Jordan, William D.
Matthews, Thomas C.
Passman, Marc A.
Patterson, Mark A.
Quinney, Brent E.
Sampson, James Buchanan
Taylor, Steven M.
Whitley, W. David

Dothan
Pfeiffer, Ralph B.

Huntsville
Roberts, Rick M.

Mobile
Esses, Glenn E.
McPhillips, Frank

Winfield
Manord, Jeffrey D.

ARKANSAS

Little Rock
Ali, Ahsan T.

ARIZONA

Oro Valley
Westerband, Alex

Phoenix
Caparrelli, David J.
Carlon, Douglas J.
Erickson, Curtis A.
Moinuddeen, Khaja

Scottsdale
Fowl, Richard
Money, Samuel R.

Tucson
Berman, Scott S.
Hughes, John D.
Leon, Luis R.
Lucas, Layla C.
Mills, Joseph L.
Quick, Rhonda C.
Trinidad, Magdiel
Twena, Mordechai F.

CALIFORNIA

Burlingame
Lin, Stephanie C.

Daly City
Scribner, Robert G.

Fresno
Hadcock, William

Glendale
Acosta, Ignacio

La Jolla
Rayan, Sunil S.
Sedwitz, Marc M.

Laguna Hills
Duensing, Robert A.

Lancaster
Petrik, Pavel

Loma Linda
Abou-Zamzam, Ahmed M.
Chiriano, Jason T.
Teruya, Theodore H.

Los Angeles
Cole, C. William
DeRubertis, Brian G.
Gelabert, Hugh A.
Jimenez, Juan Carlos
Keushkerian, Simon
Ochoa, Christian J.
O'Connell, Jessica B.
Quinones-Baldrich, William J.
Rigberg, David A.
Rowe, Vincent L.
Wagner, Willis H.
Woo, Karen

Mather
Noll, Robert E.

Geographical Listing of Active Members

Napa
Goldstein, Lawrence J.
Loftus, John P.
Wolford, Heather Y.

Northridge
Austin, Joseph Patrick

Orange
Ballard, Jeffrey L.
Charney, Kim J.
Fujitani, Roy M.
Lane, John S.

Panorama City
Cerveira, Joaquim J.

Pasadena
Kohl, Roy D.

Rancho Palos Verdes
Torres, Gustavo A.

Riverside
Kim, Sung K.

Sacramento
Carson, John G.
Clouse, W. Darrin
Dawson, David L.
Hedayati, Nasim
Lee, Eugene S.
Pevec, William C.

Salinas
Rudo, Neil D.

San Diego
Angle, Niren
Casey, Kevin M.
Hodgkiss-Harlow, Kelley D.
Kansal, Nikhil
Owens, Erik L.

San Francisco
Conte, Michael S.
Groeger, Eugene C.

San Leandro
Gingery, Robert O.
Paxton, Lamont D.

Santa Monica
Mueller, Mark P.
Wagmeister, Robert

Stanford
Al-Khatib, Weesam Kassim
Harris, E. John
Lee, Jason T.
Mell, Matthew
Zhou, Wei

Torrance
Chauvapun, Joe
Donayre, Carlos E.
Marrocco, Christopher J.

Whittier
Kronson, Jeffrey W.

COLORADO
Aurora
Peyton, Brian

Colorado Springs
Corry, David C.
Crepps, J. Thomas
Hurlbert, Scott N.

Denver
Annest, Stephen J.
Johnnides, Christopher G.
Rehring, Thomas F.

Lakewood
Ziporin, Scott J.

CONNECTICUTT
Bloomfield
Greenwald, Lori L.

Danbury
Dietzek, Alan M.

Darien
Gagne, Paul J.

Geographical Listing of Active Members

Glastonbury
Bulger, Christopher M.

Hartford
Gallagher, James J.
Ruby, Steven T.

Manchester
Maru, Sandip T.

New Haven
Dardik, Alan
Indes, Jeffrey
Ochoa Chaar, Cassius Iyad

South Weymouth
Kwasnik, Edward M.

DISTRICT OF COLUMBIA
Washington
Beavers, Frederick P.
Deaton, David H.
Hughes, Kakra
Laredo, James

DELEWARE
Newark
Ierardi, Ralph P.

FLORIDA
Aventura
Johr, Bernardo

Bay Pines
Wilson, Jeffrey S.

Del Ray Beach
Rosa, Patricio

Ft. Lauderdale
O'Donnell, Sean D.

Gainesville
Feezor, Robert J.
Nelson, Peter R.

Jacksonville
Dennis, James W.
Ellison, Robert G.
Moore, Erin M.

Maitland
Adcock, G. Kendrix
Winter, Robert P.

Melbourne
Dovgan, Peter S.
Esemuede, Nowokere
Ramadan, Fuad M.

Miami
Goldstein, Lee J.

Ocoee
Horowitz, John D.

Orange Park
Rifkin, Kerry V.

Orlando
Thompson, Charles S.
Varnagy, David

Pensacola
Harlin, Stuart A.

Sarasota
Lepore, Michael R.

South Miami
Pereda, Juan Carlos

St. Petersburg
Almond, Brett A.
Collins, P. Steven
Williams, Larry R.

Tallahassee
Brumberg, Robert S.
Hoyne, Robert F.

Geographical Listing of Active Members

Tampa
Back, Martin
Gonzalez, Alberto Jose
Illig, Karl A.
Johnson, Brad L.
Kerr, Thomas M.
Shames, Murray L.
Valentin, Marlene D.

West Palm Beach
Cires, Giancarlo

Weston
Grove, Mark K.
King, Terry A.

GEORGIA
Albany
Morgan, Joe H.

Athens
Pearce, Jeffrey D.
Sailors, David M.
Woody, Jonathan D.

Atlanta
Best, Irwin M.
Brewster, Luke P.
Corso, J. Eduardo
Duwayri, Yazan
H'Doubler, Peter B.
Methodius-Rayford, Walaya Chiyem
Miller, Jay S.
Poindexter, James M.
Rajani, Ravi
Reeves, James G.
Rheudasil, J. Mark
Ricotta, Joseph J.
Veeraswamy, Ravi K

Dalton
Hamilton, Ian N.

Gainesville
Procter, Charles D.

Lawrenceville
Moomey, Charles B.

Macon
Schroder, William B.

Marietta
Wyble, Charles W.

Newnan
Wellons, Eric

Savannah
Cohn, Edward J.

Tucker
Adeduntan, Azeez P.

IOWA
Cedar Rapids
Lawrence, David M.

Iowa City
Kresowik, Timothy F.
Nicholson, Rachael
Sharafuddin, Mel J.
Sharp, William J.

West Des Moines
Borromeo, Jose R.M.
Matsuura, John H.
Park, W. Michael

IDAHO
Boise
Tullis, Michael J.

ILLINOIS
Abbott Park
Schwartz, Lewis B.

Arlington Heights
Painter, Thomas A.

Buffalo Grove
Clark, Elizabeth T.

Geographical Listing of Active Members

Chicago
Durham, Joseph R.
Eskandari, Mark K.
Keldahl, Mark L.
Morasch, Mark D.
Rodriguez, Heron E.

Decatur
Trachtenberg, Jeffrey D.

Downers Grove
Wright, J. Gordon

Maywood
Aulivola, Bernadette
Halandras, Pegge
Milner, Ross

Mt. Vernon
Verta, Michael J.

Northfield
Golan, John F.

Rockford
Klazura, Paul J.

Skokie
Desai, Tina R.
Gupta, Navyash
Morcos, Omar C.

Springfield
Lambert, Andrew D.

INDIANA
Evansville
Patterson, Donald Edward

Indianapolis
Cikrit, Dolores F.
Dalsing, Michael C.
Jacob, Dennis M.
McCready, Robert A.
Motaganahalli, Raghunandan L.
Sawchuk, Alan P.
Shafique, Shoaib

KANSAS
Wichita
Hutchinson, Steven A.

KENTUCKY
Lexington
Endean, Eric D.
Minion, David J.
Newton, Wm. Dennis
Sorial, Ehab E.
Stewart, John D.
Xenos, Eleftherios

Louisville
Bergamini, Thomas M.
George, Salem M.
Jung, Matthew T.
Klamer, Thomas W.
Lambert, Glenn E.
Rachel, Elizabeth S.
Thomas, Bradley G.
Yancey, Andrea E.

Pikeville
Poliquin, James R.

LOUISIANA
Baton Rouge
Conners, Michael S.
McNeil, James W.
Olinde, Andrew J.
Perkowski, Paul E.
Schellack, Jon V.

Lafayette
Ingram, James C.

Mandeville
Mena, Jose

Marrero
Batson, Robert

New Iberia
Dauterive, Edward

Geographical Listing of Active Members

New Orleans
Adinolfi, Michael F.
Bazan, Hernan A.
Smith, Taylor A.
Sternbergh, W. Charles

MASSACHUSETTS
Boston
Chaikof, Elliot L.
Conrad, Mark F.
Hamdan, Allen D.
Kwolek, Christopher J.
Mackey, William C.
Pomposelli, Frank B.
Schermerhorn, Marc L.

Burlington
Welch, Harold J.

Framingham
Simosa, Hector F.

Lawrence
Muto, Paula M.

North Chelmsford
Burke, Paul M.

Springfield
Hirko, Mark K.
Kaufman, Jeffrey L.
Rhee, San Won

Wellesley
Ciocca, Rocco G.
Iafrati, Mark D.

West Roxbury
Gupta, Naren

Winchester
Breckwoldt, William L.

Worcester
Aiello, Francesco A.
Baril, Donald T.
Robinson, William P.

MARYLAND
Annapolis
Stanziale, Stephen F.

Baltimore
Black, James H.
Buchbinder, Dale
Coll, David
Freischlag, Julie A.
Guzzo, James L.
Harthun, Nancy L.
Lilly, Michael P.
Lucas, Paul R.
Lum, Ying Wei
Mackrell, Peter J.
Malas, Mahmoud
Monahan, Thomas S.
Queral, Luis
Zatina, Michael A.

Bel Air
Gonze, Mark D.
Reichman, Wayne

Cockeysville
Parra, Jose R.

Columbia
Feinberg, Richard L.

Fredrick
McNeill, Paul M.

Glen Burnie
Neschis, David G.

Owings
Pietropaoli, John A.

Rockville
Salander, James M.

Silver Spring
Fox, Charles J.

Geographical Listing of Active Members

MAINE

Bangor
Cambria, Robert A.
Sherwood, Andrew J.

MICHIGAN

Ann Arbor
Criado, Enrique
Eliason, Jonathan L.
Escobar, Guillermo A.
Gallagher, Katherine
Rectenwald, John E.

Bingham Farms
Brown, O. William

Detroit
Lin, Judith C.
Rits, Yevgeniy
Rubin, Jeffrey R.

Flint
Wilson, David B.

Flushing
Shuster, Thomas A.

Grand Rapids
Chambers, Christopher M.
Cuff, Robert F.
Mansour, M. Ashraf

Kalamazoo
Jain, Krishna M.
Munn, John S.
Vaddineni, Sarat K.

Lansing
Granke, Kenneth

Norton Shores
Smith, Vance H.

Petoskey
Kazmers, Andris

Pontiac
Hernandez, Diego A.

Royal Oak
Shanley, Charles J.

Southfield
Nolan, Kevin D.

Troy
Engle, Jennifer S.

Ypsilanti
Heidenreich, Michael J.

MINNESOTA

Duluth
Bunch, Christopher T.
Eginton, Mark T.

Edina
Roland, Christopher F.

Minneapolis
Rizvi, Adnan Z.
Santilli, Steven M.
Sullivan, Timothy M.

Rochester
Ballinger, Beth Ann
Bower, Thomas C.
Duncan, Audra A.
Fleming, Mark D.
Oderich, Gustavo S.

MISSOURI

Liberty
Deiparine, Michael K.

Springfield
Schmittling, Zachary C.

Geographical Listing of Active Members

St. Louis
Curci, John A.
Geraghty, Patrick J.
Jim, Jeffrey
Pennell, Richard C.
Peterson, Brian G.
Raman, Kathleen G.
Sanchez, Luis A.
Smeds, Matthew R.
Wittgen, Catherine M.
Zakhary, Emad M.A.

MISSISSIPPI
Greenville
Trotter, Michael C.

Hattiesburg
Thompson, J. Keith

Jackson
Baldwin, Zachary K.
O'Mara, Charles S.
Rushton, Fred W.

Vicksburg
Ferris, Eugene B.

NORTH CAROLINA
Asheville
Douglas, Michael G.

Chapel Hill
Farber, Mark A.

Charlotte
Arko, Frank R.
Roush, Timothy S.

Durham
Cox, Mitchell Wayne
Mureebe, Leila
O'Brien, Patrick Joshua
Shortell, Cynthia K.

Fayettville
Roulhac, Maurice R.

Gastonia
Eze, Augustine R.

Greensboro
Dickson, Christopher S.
Early, Todd F.
Hayes, P. Gregory

Greenville
Bogey, William M.
Stoner, Michael C.

Lenoir
Purcell, Peter N.

New Bern
Bell, William H.

Pinehurst
Atkinson, Clinton K.

Winston-Salem
Corriere, Matthew A.
Edwards, Matthew S.
Hansen, Kimberley J.
Hurie, Justin
Moore, Phillip S.
Thomason, Robert Bradley

NORTH DAKOTA
Fargo
Bakken, Andrew

NEBRASKA
Omaha
Baxter, B. Timothy
Johanning, Jason Michael
Longo, Gernon Matthew
Ramos, Tammy K.
Waltke, Eugene A.
Wattenhofer, Scott P.

NEW HAMPSHIRE
Lebanon
Goodney, Philip P
Nolan, Brian W.

Nashua
Rodriguez, Christian C.

Geographical Listing of Active Members

NEW JERSEY
Browns Mills
Winkler, Gabor A.

Camden
Alexander, James B.

Gradell
Geuder, James W.

Hackensack
Simonian, Gregory T.
Wilderman, Michael J.

Monroe Township
Franco, Charles D.

Montclair
Weiswasser, Jonathan M.

Morristown
Ombrellino, Michael

New Brunswick
Graham, Alan M.
Haser, Paul B.
Rao, Niranjan V.
Vogel, Todd R.

Newark
Curi, Michael A.
Padberg, Frank T.

Princetown
Goldman, Kenneth A.

Short Hills
Sales, Clifford M.

Somers Point
Gosin, Jeffrey S.
Herrington, James W.

Somerville
Drascher, Gary A.

Toms River
Haque, Shahid N.

Voorhees
O'Neill, Alissa Brotman

Westfield
Levison, Jonathan A.

NEW MEXICO
Albuquerque
Goff, James M.
Ketteler, Erika
Langsfeld, Mark
Marek, John M.
Paolini, David J.

NEVADA
Las Vegas
Luh, Eddy H.

Nellis AFB
Jones, Wilmer T.

NEW YORK
Albany
Chang, Benjamin B.
Darling, R. Clement
Hnath, Jeffrey C.
Kreienberg, Paul B.
Mehta, Manish
Ozsvath, Kathleen J.
Paty, Philip S.K.
Roddy, Sean P.
Saltzberg, Stephanie
Sternbach, Yaron
Taggert, John B.

Bronx
Greenstein, Stuart
Lipsitz, Evan C.
Suggs, William D.

Brooklyn
D'Ayala, Marcus
Hingorani, Anil
Shah, Hemal

Buffalo
Cherr, Gregory S.
Dosluoglu, Hasan H.

Geographical Listing of Active Members

Cooperstown
Cooper, Shelby

Fayetteville
Surowiec, Scott M.

Flushing
Landis, Gregg S.

Great Neck
Panetta, Thomas
Purtill, William A.

Greenlawn
Gennaro, Mark

Hawthorne
Laskowski, Igor A.

Lake Success
Doscher, William
Frankini, Larry A.
Rosca, Mihai
Schwartz, Mark A

Mineolo
Wain, Reese A.

Mount Kisco
Sun, Lucy

New Hyde Park
Giangola, Gary

New Rochelle
Karanfillian, Richard

New York
Adelman, Mark A.
Benvenisty, Alan I.
Berland, Todd
Bernik, Thomas R.
Cayne, Neal S.
Connolly, Peter
Dayal, Rajeev
Fantini, Gary A.
Faries, Peter L.
Fishman, Eric
Harrington, Elizabeth
Jacobowitz, Glenn R.
Lantis, John C.
Maldonado, Thomas
Marin, Michael L.
McKinsey, James F.
Mendes, Donna M.
Morrissey, Nicholas J.
Mussa, Firas F.
Nalbandian, Matthew M.
Rockman, Caron B.
Schneider, Darren B.
Yang, Paul M.

Port Washington
Patetsios, Peter

Rochester
Chandra, Ankur
Ellis, Jennifer
Gargiulo, Nicholas J.
Geary, Kevin J.
Gillespie, David L.
Kim, Jason K.
Rhodes, Jeffrey M.
Riggs, Patrick N.
Singh, Michael J.

Setayjet
Kvilekval, Kara H.V.

Staten Island
Deitch, Jonathan S.
Schor, Jonathan A.

Stony Brook
Tassiopoulos, Aopstolos K.

Syracuse
Amankwah, Kwame S.
Costanza, Michael J.
Gahtan, Vivian

Utica
Lauterbach, Stephen R.

OHIO
Chillicothe
Jepsen, Stephen J.

Geographical Listing of Active Members

Cincinnati
Annenberg, Alan J.
Giglia, Joseph S.
Lohr, Joann M.
Muck, Patrick E.
Zenni, Gregory C.

Cleveland
Clair, Daniel G.
Eagleton, Matthew J.
Greenberg, Roy K.
Kashyap, Vikram S.
Kelso, Rebecca L.
Lyden, Sean P.
Mastracci, Tara M.
McLaughlin, Daniel J.
Moise, Mireille A.
O'Hara, Patrick J.
Srivastava, Sunita D.

Columbus
Franz, Randall W.
Go, Michael R.
Haurani, Mounir J.
Kulwicki, Aaron D.
Litzendorf, Maria E.
Pin, Richard

Duncan Falls
Katz, Sherman A.

Garfield Heights
Alvarez-Tostado, Javier A.

Lancaster
Mannava, Krishna

Marietta
Parmer, Shane S.

Maumee
Whalen, Ralph C.

Mayfield Heights
Rizzo, Anthony

Toledo
Comerota, Anthony J.
Nazzal, Munier
Pigott, John P.
Russell, Todd E.
Seiwert, Andrew J.

Willoughby
Rollins, David L.

Youngstown
Delatore, Jason R.
Kollipara, Venkata S.K.

Zanesville
Campbell, Jessica B.

OKLAHOMA
Edmund
Foteh, Kousta I.

Tulsa
Yeary, II, Edwin C.

OREGON
Portland
Mitchell, Erica L.

Silverton
Waters, Harris J.

PENNSYLVANIA
Abington
Sullivan, Theodore R.

Allentown
Berger, Alan
Goodreau, James J.
McCullough, James L.
Welkie, John F.

Bellefonte
Simoni, Eugene J.

Bethlehem
Ivarsson, Bengt
Rosenfeld, Joel C.

Geographical Listing of Active Members

Camphill
Razzino, Richard A.

Danville
Elmore, James R.
Franklin, David P.

Easton
Fisher, Jay B.
Lipscomb, Amy L.

Hershey
Aziz, Faisal
Han, David C.
Reed, Amy B.

Philadelphia
DiMuzio, Paul J.
Eisenberg, Joshua A.
Soundararajan, Krish
Weingarten, Michael S.

Pittsburgh
Chaer, Rabih A.
Healy, Dean A.
Jeyabalan, Geetha
Muluk, Satish C.
Rhee, Robert Y.
Tillman, Bryan W.
Wu, Timothy

Plains
Yavorski, Chester C.

Sayre
Larson, Robert A.
Marica, Silviu C.
Sampson, Lawrence N.

West Reading
Brigham, Robert A.
Coffey, James A.
Jaxheimer, Eric C.

Wilkes-Barre
Obmann, Melissa A.

Williamsport
Adams, Eric D.

Wynnewood
Bigatel, David A.

PUERTO RICO
Coto Laurel
Martinez, Jorge L.

RHODE ISLAND
Providence
Carney, Wilfred I.
Garcia-Toca, Manuel
Marcaccio, Edward J.
Patterson, Robert B.
Slaiby, Jeffrey M.

SOUTH CAROLINA
Charleston
Garg, Nitin
Hart, Joseph P.
Keefer, Adam James
Morrison, Edward C.
Tonnessen, Britt H.

Florence
Stonerock, Charles E.

Greenville
Carsten, Christopher G.
Cull, David L.
Langan, Eugene M.
Taylor, Spence M.
York, John W.

Greenwood
Hobson, John R.
Lanford, Jeffrey E.

Rock Hill
Taormina, Martin V.

Spartanburg
Calton, William Cuyler

SOUTH DAKOTA
Rapid City
Orecchia, Paul M.

Geographical Listing of Active Members

TENNESSEE

Alcoa
Reisser, John

Chattanooga
Collins, David E.
Collins, John T.
Hogan, Michael B.
Joels, Charles S.
Phade, Sachin V.
Sprouse, Larry R.

Columbia
Piercy, K. Todd
Richardson, James W.

Franklin
Pulliam, Cary W.

Jellico
Wilkens, Todd H.

Knoxville
Akers, Donald L.

Nashville
Dattilo, Jeffery B.
Edwards, William
Faulk, JimBob
Naslund, Thomas C.

Oak Ridge
Long, David D.

TEXAS

Amarillo
Irwin, Chance L.

Arlington
Senkowsky, F. Jon

Austin
Apple, Jeffrey M.
Church, Phillip J.
Politz, John K.
Seidel, Scott A.
Stewart, Mark T.

Dallas
Gable, Dennis R.
Grimsley, Bradley R.
Iliya, Charles A.
Kohn, James S.
Shutze, William P.

Denton
Ortega, Raul E.

El Paso
Cook, Patrick

Fort Sam Houston (San Antonio)
Arthurs, Zachary M.
Kauvar, David
Rasmussen, Todd E.

Fort Worth
Bloemendal, Lee C.
Paladugu, Ramesh

Fredericksburg
Bowser, Andrew

Galveston
Choi, Lorraine

Garland
Stephanian, Edic

Houston
Barshes, Neal R.
Bechara, Carlos F.
Bismuth, Jean
Coselli, Joseph S.
Davies, Mark G.
El-Sayed, Hosam F.
Gilani, Ramyar
Huynh, Tam Thi Thanh
Kougias, Panos
Lin, Peter H.
Lumsden, Alan B.
Naoum, Joseph J.
Peden, Eric K.

Geographical Listing of Active Members

Humble
Bhatia, Devinder S.
Coogan, Sheila M.
Pickett, Taylor K.

Lackland AFB
Crutchley, Teresa A.

Nacogdoches
Brown, Lyle L.
Randel, Mark A.

Round Rock
Bush, Ruth L.

San Antonio
Davenport, Phyllis
Macris, Demetrios N.
Pearce, Benjamin J.
Peck, Michael A.
Sheehan, Maureen K.
Sykes, Mellick T.
Tamez, Daniel D.
Toursarkissian, Boulos

Temple
Bohannon, W. Todd
Warren, Thomas R.

UTAH
Murray
Whitten, Matthew G.
Wirthlin, Douglas J.

Provo
Smilanich, Robert

Salt Lake City
Goodman, Greg R.
Ihnat, Daniel M.
Kraiss, Larry W.

South Ogden
Erdoes, Luke S.

VIRGINIA
Christiansburg
Downing, Lamiere J.

Falls Church
Busuttil, Steven J.

Hampton
Deshmukh, Deepak

Lynchburg
Widmeyer, Jeffrey H.

Mechanicsville
Brown, Jeff A.

Norfolk
Panneton, Jean M.

Richmond
Bosher, L. Paul
Levy, Mark M.
Makhoul, Raymond G.

Virginia Beach
Parent, F. Noel

WASHINGTON
Bellevue
Ferris, Brian L.

Bellingham
Sohn, Michelle E.

Bremerton
Sundaram, Shankar M.

Milton
Andersen, Charles A.

Puyallup
Osborne, Robert

Renton
Kasirajan, Karthik

Seattle
Meissner, Mark H.
Quigley, Terence M.
Quiroga, Elina
Starnes, Benjamin W.

Geographical Listing of Active Members

Spokane
LaSalle, Andre

Tacoma
Singh, Niten

WISCONSIN
Appleton
Vogt, Philip A.

Green Bay
Grazziotin, Marcelo U.
Hutto, John D.

Madison
Hoch, John R.
Tefera, Girma

Milwaukee
Brown, Kellie R.
Rossi, Peter J.
Seabrook, Gary

Wauhesha
Schmitt, David D.

WEST VIRGINIA
Charleston
Stone, Patrick A.

AUSTRALIA
Bedford Park
Puckridge, Phillip J.

St. Leonards
Mohabbat, Walid

CANADA
Barrie, Ontario
McDonald, Sandy I.

London, Ontario
De Rose, Guy
Forbes, Thomas L.

New Market, Ontario
Lossing, Alan G.
Gupta, Deepak

Niagra Falls, Ontario
Rammohan, Surianarayanan

Ottawa, Ontario
Harris, Kenneth A.
Hill, Andrew B.

Toronto, Ontario
Huseynova, Khumar

COLOMBIA
Bogota
Molina, Alejandro

EGYPT
October City
Bassiouny, Hisham

FRANCE
Paris
Koskas, Fabien F.

IRELAND
Galway
Sultan, Sherif

ISRAEL
Jerusalem
Rubinstein, Chen

Geographical Listing of Active Members

NETHERLANDS
Utrecht
Moll, Frans L.

PERU
Lima
Zuniga, Carlos

PUERTO RICO
San Juan
de Jesus, Gustavo Alberto
Joglar, Fernando L.

SWEDEN
Stockholm
Wahlgren, Carl-Magnus

TRINIDAD AND TOBAGO
St. Joseph
Maharaj, Dale A.

TURKEY
Istanbul
Calik, Mustafa K.

Mugla
Yolyapan, Aykut

UNITED KINGDOM
Hull
Chetter, Ian C.

Notes

PVSS Bylaws

Article I - Name

The name of this organization shall be the "Peripheral Vascular Surgery Society" (hereinafter the "Society").

Article II - Objectives

1) The objectives of this Society shall be:
   a) To improve the science and art of vascular surgery and endovascular therapies and the interchange of medical knowledge and information thereon;
   b) To promote basic and clinical research for improving the quality and safety of vascular surgical and endovascular procedures and vascular care in general;
   c) To engage in scientific or educational purposes, and to promote important issues, as the Executive Committee, from time to time, may determine to be beneficial to the membership as a whole or to society in general;
   d) To provide a forum for the young vascular surgeon (active members, see Article IV) to promote the field of vascular and endovascular surgery through education, scholarship, advocacy, and leadership.
   e) To do any and all things which may be necessary or incidental to these Bylaws.

2) The Society shall not carry on any other activities not permitted to be carried on:
   a) By a corporation exempt from Federal income tax under Section 501 (C) (3), of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law), or;
   b) By a corporation, contributions to which are deductible under Section 170; Furthermore, no part of the net income of the Society or its property or assets shall at any time inure to the benefit of any individual member, or of any private individual, or be used to promote the candidacy of any person seeking political office.

Article III - Meeting

The annual meeting of the Society shall be held at the time and place, which shall be designated by the Executive Committee. Special meetings may be called at any time by the president, or a simple majority of the Executive Committee, or by a written call signed by no less than one hundred (100) members.

Article IV - Membership

1) Active Membership of this Society shall be limited to physicians of good professional standing who have completed have completed an ACGME-approved vascular surgical residency or fellowship, or equivalent foreign advanced training, who have a sustained major interest and active practice in peripheral vascular surgery and who are certified by the American Board of Surgery or its equivalent.
2) There shall be five types of membership:
   a) Active
   b) Senior
   c) Honorary
   d) Candidate; see Article XV
   e) Associate

PVSS Bylaws

Membership will be granted to senior surgeons who have been in practice for greater than 15 years Active members who become senior members after 15 years can also choose to remain active.

Active Senior Members complete terms of elected office, receive Society correspondence, pay dues, attend meetings, sponsor papers for fellows and residents, participate in the business meeting as well as vote, but do not present papers and are not eligible for election as Peripheral Vascular Surgery Society officers.

Inactive Senior Members receive no correspondence, pay no dues, do not attend meetings, do not propose new members and do not sponsor papers and presentations. Inactive Senior Members may become Active Senior Members by requesting in writing reactivation and paying all back dues or three times the current year's dues.

Associate members of this society shall be limited to non-vascular trained physicians and surgeons with either an MD or DO degree, scientists active in vascular medicine or surgical research, physician extenders in vascular specialties (RN's, PA's, NP's) and vascular technologists. These members shall pay half dues, have no voting rights, cannot be elected as officers of the society, but may submit abstracts and papers to the meetings.

The Executive Committee may select honorary members.

Article V - Election of Members

The process of election of active members to the Society shall be as follows:

1) The society office shall supply application forms for membership.
2) Completed application forms signed by the candidate shall be sent to the Society office by March 1 of the year before the Spring meeting at which time the candidate shall be considered for election. One letter of recommendation from an active society member is required to complete the application.
3) The names of the candidates recommended for membership by the Executive Committee shall be submitted to the members at the annual meeting.
4) Election to membership shall be by secret ballot, by a three-fourths (3/4) affirmative vote of the membership present.
5) A candidate who fails to be elected at one meeting may be reconsidered at the next two annual meetings of the Society.

Article VI - Officers: Elections and Duties

1) The officers of this Society shall consist of a president, president-elect, secretary, treasurer, and recorder; all to be elected as provided in these bylaws.
2) The president shall preside at Executive Committee meetings and the annual meeting. Successors to vacated offices of the Peripheral Vascular Surgery Society shall be appointed by the president until the position is filled at the next annual meeting.
3) The president and president-elect of the Peripheral Vascular Surgery Society shall be elected for terms of one year each. The secretary, treasurer, recorder, and councilors-at-large shall be elected for three-year terms.
4) The president-elect, in the absence or incapacity of the president, shall perform the duties of the president's office.
5) In the absence of both the president and president-elect, the chair shall be assumed by a president pro tem, elected by such members of the Executive Committee as are present.

6) The secretary shall keep minutes at the meetings of the Peripheral Vascular Surgery Society and the Executive Committee, update the executive committee on membership database and new applicant files and conduct correspondence of the Peripheral Vascular Surgery Society. The secretary will issue an annual written report at the annual meeting.
7) The treasurer shall receive all monies and funds belonging to the Peripheral Vascular Surgery Society, pay all bills, render bills for dues and assessments, and report to the membership at the annual meeting. The treasurer will prepare an annual report for audit.
8) The recorder shall receive all papers presented before the Society. The recorder shall be responsible for assuring prompt editorial review of manuscripts in concert with other Society members.
9) The councilors-at-large shall be elected for three-year terms, with election of one councilor occurring annually so as to provide overlapping terms.

Article VII - Executive Committee

1) There shall be an Executive Committee consisting of the president, president- elect, secretary, treasurer, recorder, councilors-at-large, and the two most recent past presidents.
2) The program committee chairman, the scholarship committee chairman, the fund raising committee chairman, membership committee chairman, by-laws committee chairman, and the communications committee chairman shall be non- voting members of the Executive Committee.
3) The Executive Committee shall be the governing body of the Society and shall have full power to manage and act on all affairs of the Society.
4) Executive Committee meetings shall be held at the call of the president of the Peripheral Vascular Surgery Society.
5) A majority of the members of the Executive Committee shall constitute a quorum for the transaction of business.
6) The Executive Committee will meet prior to the annual meeting to nominate officers, councilors, representatives and other committee members for presentation to the membership at the annual meeting.
7) The Executive Committee will appoint a program chairman at its June meeting for the annual meeting, which will take place in two years. The program chairman will be a non-voting member of the Executive Committee through the appointed annual meeting.

Article VIII – Committees and Representatives

1) Standing committees of the Society shall consist of a nominating committee, a program committee, a scholarship committee, a fund raising committee, a bylaws committee, a membership committee, and a communications committee.
2) The nominating committee shall consist of the current president in office, the president-elect and the two most recent past presidents. Its function shall be to make up a slate of officers, committee members and representatives to be presented to the executive committee at the annual meeting.
3) The program committee shall solicit papers and other presentations from members and other individuals and make up the program for the upcoming meeting. The winter program chairman shall be the president-elect (or other designate). The executive committee as per Article VII, item 7, shall appoint the spring program committee chairman. Each program chairman will select six other society members to assist in this task. The Spring meeting program chair shall serve for 2 years. Three

new program committee members shall be selected each year to serve a 2 year-term for a total of 6 program members in addition to one chair.

4) The scholarship committee shall consist of six members, a chairman, selected by the nominating committee, 3 Councilors-at-Large, and 2 remaining at-large committee members selected by the committee chairman. This committee shall serve for two years. Its function shall be to review educational grant award applications and to report award recipients to the executive committee at the annual meeting.

5) The fund raising committee shall consist of ten members. Its function shall be to research and implement comprehensive fundraising campaigns to support the society, organize and sponsor programs to enhance the awareness and treatment of vascular disease, to evaluate diagnostic and therapeutic tools manufactured by industry, and to enhance the rapid and proficient transfer of new knowledge and techniques to its members with assistance from our industry partners. A committee chairman shall be appointed by the nominating committee at the annual spring meeting to serve a three-year term. The chairman will also serve on the executive committee for the duration of the appointed term. Other committee members shall be the president-elect, the treasurer, the secretary and the newly appointed councilor-at-large. The committee chairman will select up to 4 additional society members to assist with this task. In addition, the current society president shall be an Ex-Officio member.

6) The bylaws committee shall consist of three members to serve overlapping terms of three years each. A new member shall be appointed annually by the President. The most senior member of the By-Laws Committee shall serve as Chair. The By- Laws Committee shall review By-Laws from time to time as directed by the Council and when appropriate, make recommendations regarding amendments.

7) The membership development committee shall consist of four members to serve overlapping terms of four years each. The Secretary shall serve as ex-officio. A new member shall be appointed annually by the President. The most senior member of the Membership Committee shall serve as Chair. The committee shall review all applications for membership and shall present their nominations for Active, Associate and Candidate membership to the Executive Committee for review and ratification at the Annual Business Meeting. The Membership Development Committee shall also assist the Secretary with membership development and expansion campaigns.

8) The communications committee shall consist of one Chair serving a three year term, and is responsible for organizing, coordinating, and implementing all communication to the PVSS membership and along with the Secretary will oversee subcommittee functions. The Communication Chair is appointed by the Nominating Committee for a maximum three year term renewed annually. The Communication Committee shall consist of three subcommittees: 1) Website sub- committee consisting of one chair serving a two year term and two sub-committee members appointed for 2 year terms, and is responsible for all web-based and electronic communication, and maintenance of the Society website. 2) Newsletter sub-committee consisting of one chair serving a two year term and a minimum of two sub-committee members appointed for 2 year terms, and is responsible for a membership newsletter at intervals defined by the Communication Chair. 3) Correspondence sub-committee consisting of one chair serving a two year term and two sub-committee members appointed for 2 year terms, and is responsible for organizing, coordinating and implementing all membership correspondence. All Communication Sub-Committee members shall be appointed by the President at appropriate intervals and renewed annually.

9) Representatives shall be appointed by the nominating committee in concert with the executive committee to serve on American College of Surgeons Board of Governors, American College of Surgeons Advisory Council for Surgical Specialties and the council of the American Association for Vascular Surgery. Each representative shall serve a three-year term unless otherwise noted by the executive committee at its annual Spring meeting. From time to time, other organizations may seek representation from the Society. Additional representatives shall be appointed in the same manner outlined above.

Article IX - Meetings

1) The annual meeting of the Peripheral Vascular Surgery Society shall be held at a time and place selected by the Executive Committee.
2) The business meeting of the Peripheral Vascular Surgery Society shall be conducted during the annual meeting. Officers of the Peripheral Vascular Surgery Society shall be elected by a majority vote of active members present at the business meeting.
3) All active members are encouraged to attend the annual meeting one year out of every three years. There is no attendance requirement for honorary or senior members.
4) A local arrangements chairman shall be appointed by the executive committee to serve in this capacity for the annual spring meeting to be held two years later. The immediate past president will serve as local arrangements chairman for the following winter meeting.

Article X - Dues and Fees

1) Dues and assessments shall be levied by the Executive Committee and approved by the membership at the annual meeting.
2) Any member whose dues remain unpaid for a period of two years shall be dropped from membership, provided that notification of such lapse is given at least three months prior to its effective date. The member may be reinstated on approval of the Executive Committee following payment of the dues in arrears.

Article XI - Resignations, Expulsions

1) Resignations of members otherwise in good standing shall be accepted by a majority vote of the Executive Committee.
2) Charges of unprofessional or unethical conduct against any member of the Peripheral Vascular Surgery Society, if proffered in writing and submitted to the Executive Committee, must be acted upon within one year. The Executive Committee's concurrence of disallowance of the charges shall be presented to the membership at the annual meeting. The three-fourths (3/4) affirmative vote of the members present shall be required for expulsion.

Article XII - Quorum

1) The members present at any official meeting of the society shall constitute a quorum necessary to change the constitution and bylaws of the Peripheral Vascular Surgery Society, to make assessments, to authorize appropriations or expenditures of money other than those required in the routine business of the Peripheral Vascular Surgery Society, to elect officers and members, and to expel members.

Article XIII - Alterations, Repeal

Bylaws may be altered or repealed at the annual meeting by a two-thirds (2/3) affirmative vote

of the members present.

Article XIV - Procedure

Proceedings of the Peripheral Vascular Surgery shall be conducted under Robert's Rules of Order.

Article XV - Candidate Group

There will be a Candidate group of the society consisting of participants who are in good professional standing in an RRC accredited general surgery, vascular surgery residency, or other vascular residency recognized by the Peripheral Vascular Surgery Society. Also students in accredited osteopathic and allopathic medical schools can participate in this membership group. Participants in the Candidate Group will submit an application to the society office including the name and email address of an active PVSS member who endorses the application and may attend the scientific meetings at no cost as well as:

1) Present papers, if sponsored by a Society member
2) Attend the annual banquet.
3) Receive meeting notices and routine correspondence.
4) Have no voting rights

Candidate members shall be promoted to active membership upon completion of their vascular surgery residency (or equivalent) and upon receipt by the society office of a copy of the vascular surgery training certificate (or equivalent). At this time, the newly promoted active member will be bound by the requirements of active membership in the society.

Amended – June, 2012

Travel Award

2003 **Thomas F. Lindsay, MD**
Toronto General Hospital, Toronto, Ontario, Canada

2004 **Vikram S. Kashyap, MD**
Cleveland Clinic Foundation, Cleveland, OH

2005 **Vivian Gahtan, MD**
Upstate Medical University, Syracuse, NY

2011 **Judith Lin, MD**
Henry Ford Hospital, Detroit, MI

2012 **Karen Woo, MD**
University of Southern California, Los Angeles, CA

Academic Award

2007 **Brian W. Nolan, MD**
Dartmouth-Hitchcock Medical Center, Lebanon, NH

2008 **FACULTY**
Philip Goodney, MD
Dartmouth-Hitchcock Medical Center, Lebanon, NH

RESIDENT
Matthew Corriere, MD
Wake Forest University School of Medicine, Winston-Salem, NC

2009 **FACULTY**
Eugene Lee, MD
University of California, Davis, Sacramento, CA

RESIDENT
Keri Seymour, MD
SUNY Upstate Medical University, Syracuse, NY

2010 **FACULTY**
Tara Marie Mastracci, MD
Cleveland Clinic, Cleveland, OH

RESIDENT
Sara Runge, MD
UCSF, San Francisco, CA

2011 **FACULTY**
Guillermo A. Escobar, MD
University of Michigan, Ann Arbor, MI

RESIDENT
Bjoern Suckow, MD
University of Utah, Salt Lake City, UT

2012 **FACULTY**
John Curci, MD
Washington University, St. Louis, MO

RESIDENT
Kathleen Lamb, MD
Thomas Jefferson University Hospital, Philadelphia, PA

Norman M. Rich Military Vascular Surgery Award

2009 **Cpt. Wayne Causey, MD**
Madigan Army Medical Center, Tacoma, WA
Vascular Surgery Knowledge and Exposure Obtained During Medical School and the Potential Impact On Career Decisions

2010 **Cpt. Heather Hancock, MD**
Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, TX
Dose Response To Hind Limb Ischemia Reperfusion In A Porcine Model of Functional Limb Salvage

2011 **Cpt. Marlin Wayne Causey, MD**
Madigan Army Medical Center, Tacoma, WA
Microarry and Functional Cluster Analysis Implicates Transforming Growth Factor Beta 1 In A Swine Hemorrhagic Shock Model

2012 **Cpt. Carole Villamaria, MD**
U.S. Army Institute for Surgical Research, Ft. Sam Houston, TX
Microvascular Porcine Model For the Optimization of Composite Tissue Autotransplantation

Member Update Form

Please help the PVSS keep your membership information current. We require an email address from all members for communication purposes, as well as your preferred mailing address.

Please return to the PVSS Registration Desk or fax to the National Office at 978-927-7872.

MEMBER INFORMATION (Required For All Members)

_____
Name

_____
Institution City State

_____
Email Address

MAILING INFORMATION

Preferred Mailing Address: ☐ Work ☐ Home

Please provide preferred mailing address below:

_____
Mailing Address

_____
Mailing Address (cont.)

_____
City State Postal Code Country

_____
Daytime Telephone

Thank you!