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VESS Executive Council 2014 - 2015

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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 providership of the American College of Surgeons and the Vascular and Endovascular Surgery Society. The American College of Surgeons is accredited by the ACCME to provide continuing medical education for physicians.



AMA PRA Category 1 Credits™ (Annual Meeting)

The American College of Surgeons designates this live activity for a maximum of 11.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA PRA Category 1 Credits™ (Vascular Lab Review)

The American College of Surgeons designates this live activity for a maximum of 5.00 *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 vascular surgeons. Upon completion of this course, attendees should be able to: 1) Describe the indications for and results of intervention for lower extremity arterial disease; 2) Discuss the indications for and complications of dialysis access; 3) Understand the indications for EVAR for abdominal aortic aneurysms; 4) Describe changes in vascular training secondary to the new 0-5 paradigm; and 5) Discuss the management of venous disease.

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.

Educational Grant Acknowledgment

The Vascular and Endovascular Surgery Society wishes to recognize and thank the following companies for their ongoing support through educational grants:

Boston Scientific
Cook Medical
Medtronic

Marketing Acknowledgment

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

W. L. Gore & Associates

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
2013	Park City, UT	Ruth L. Bush, MD, MPH
		W. Darrin Clouse, MD
2014	Steamboat Springs, CO	Vikram S. Kashyap, MD

Schedule-At-A-Glance

Thursday, January 29, 2015

7:00 am – 9:00 am	Executive Council Meeting
7:00 am – 5:00 pm	Registration
9:00 am – 12:15 pm	COOK FELLOW LUMINARIES (By Invitation)
10:30 am – 11:00 am	Coffee Break
12:15 pm – 1:15 pm	Fellows Lunch
1:30 pm – 3:30 pm	TECHNOLOGY FORUM Podium Presentations
3:30 pm – 6:30 pm	TECHNOLOGY FORUM Hands-On
6:30 pm – 8:00 pm	WELCOME RECEPTION All registered attendees, guests & exhibitors are welcome.

Friday, January 30, 2015

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
7:00 am – 9:15 am	SCIENTIFIC SESSION I
7:00 am – 7:12 am	1 Translational Therapy Targeting Epigenetic Enzymes May Improve Wound Healing In Patients With Type 2 Diabetes Huiting Chen, Amrita Joshi, Danielle C. Horne, Anna M. Eliassen, Scott T. Robinson, Dawn M. Coleman, John E. Rectenwald, Steve Kunkel, Katherine A. Gallagher - University of Michigan, Ann Arbor, MI
7:12 am – 7:24 am	2 Population Based Study of Amputations Due To Diabetes and Peripheral Arterial Disease Using Statewide Data Misty Humphries, Ann Brunson, Patrick Romano, Nasim Hedayati, Joy Melnikow - University of California Davis Medical Center, Sacramento, CA
7:24 am – 7:36 am	3 Snorkel/Chimney Stent Morphology Predicts Renal Dysfunction After Complex EVAR Kenneth Tran, Brant Ullery, Jason T. Lee - Stanford University, Stanford, CA

Schedule-At-A-Glance

7:36 am – 7:48 am	4 Outcomes of Bypass Support Use During Inferior Vena Cava Resection and Reconstruction Natalia O. Glebova ¹ , Caitlin W. Hicks ² , Kristen M. Piazza ² , Kristine C. Orion ² , Ying Wei Lum ² , Christopher J. Abularrage ² , James H. Black, III ² - ¹ University of Colorado Denver, Aurora, CO; ² Johns Hopkins Hospital, Baltimore, MD
7:48 am – 7:56 am	5 (RF) Renal Injury After EVAR Portends Shortened Survival Devin S. Zarkowsky ¹ , Caitlin W. Hicks ² , David H. Stone ¹ , Daniel J. Bertges ³ , Jeffrey E. Indes ⁴ , Jeffrey A. Kalish ⁵ , Philip P. Goodney ¹ - ¹ Dartmouth-Hitchcock Medical Center, Lebanon, NH; ² Johns Hopkins Hospital, Baltimore, MD; ³ University of Vermont College of Medicine, Burlington, VT; ⁴ Yale University School of Medicine, New Haven, CT; ⁵ Boston Medical Center, Boston, MA
7:56 am – 8:04 am	6 (RF) Urban Blunt Carotid and Vertebral Artery Injury: A 12 Year Comparison Mark E. Lytle, James West, Jason N. Burkes, Tammy Fisher, Yahya Daoud, William P. Shutze, Sr. - Baylor University Medical Center in Dallas, Dallas, TX
8:04 am – 8:12 am	7 (CR) Caval Reconstruction For Lower Extremity Sarcoma Metastasis Trapped Within An IVC Filter Lidie Lajoie, Joseph Benevenia, Michael Curi - Rutgers/ NJMS, Newark, NJ
8:12 am – 8:24 am	8 Thrombomodulin Demonstrates Critical Beneficial Direct Effects On Smooth Muscle Cell Physiology Heather Bass, Richard Beard, Sarah Yuan, Peter R. Nelson - University of South Florida Morsani College of Medicine, Tampa, FL
8:24am – 8:35 am	9 The Incidence of Ischemic Colitis After Repair of Ruptured Abdominal Aneurysms Is Decreasing In the Endovascular Era Sarasijhaa Desikan, Niten Singh, Nam Tran, Elina Quiroga, Ty Garland, Benjamin W. Starnes - University of Washington Medical Center, Seattle, WA

Schedule-At-A-Glance

8:35 am – 8:47 am	10 Series of Non-Contrast Time of Flight MRAs To Predict Problems With AVF Maturation Aaron J. Gonzalez, Kevin Casey, Benjamin Drinkwine, Jeffrey Weiss - Naval Medical Center San Diego, San Diego, CA
8:47 am – 8:55 am	11 (CR) Staged Approach To Repair of Large Femoral Pseudoaneurysm Caused By Infected Femoral Stents Lindsay Bools, Joshua Arnold - University of Tennessee, Knoxville, TN
8:55 am – 9:03 am	12 (CR) Osteosarcoma Masquerading As A Subclavian Artery Pseudoaneurysm Max Wohlaer, Michael Park - Cleveland Clinic, Cleveland, OH
9:30 am - 12:00 pm	SVM VASCULAR LAB REVIEW COURSE - PART 1 (Separate Subscription)
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks – Visit Exhibitors
4:00 pm – 6:00 pm	SCIENTIFIC SESSION II
4:00 pm – 4:12 pm	13 Median Arcuate Ligament Syndrome Is Not A Vascular Disease John M. Weber, Mena Boules, Kathryn Fong, Kevin El-Hayek, Matthew Kroh, Woosup M. Park - Cleveland Clinic Foundation, Cleveland, OH
4:12 pm – 4:24 pm	14 Clinical Outcomes Are More Sustainable In Men Than Women Following Femoropopliteal Stenting: 3 Year Results of the DURABILITY II Trial Daniel K. Han, Christine Chung, Marvin V. Weaver, Rami O. Tadros, Peter L. Faries, Ageliki G. Vouyouka - Mount Sinai, New York, NY
4:24 pm – 4:36 pm	15 Mesenteric Ischemia With Limb Malperfusion Requiring Peripheral Bypass Portends A Poor Outcome In Patients With Acute Aortic Dissection Samuel S. Leake, Katie Jeffress, Harleen K. Sandhu, Charles C. Miller, III, Tom C. Nguyen, Ali Azizzadeh, Anthony L. Estrera, Hazim J. Safi, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

Schedule-At-A-Glance

4:36 pm – 4:48 pm	16 Pneumatic Compression Improves Quality of Life In Patients With Lower Extremity Lymphedema Sheila Nafula Blumberg, Todd Berland, Caron Rockman, Firas F. Mussa, Allison Brooks, Neal Cayne, Thomas Maldonado - NYU Langone Medical Center, New York, NY
4:48 pm – 4:56 pm	17 (CR) Endovascular Management of Aortic Stump Pseudoaneurysm Inkyong K. Parrack ¹ , Hasan Aldailami ² , Heather L. Gill ² , Peter H. Connolly ¹ , Darren B. Schneider ¹ , Andrew J. Meltzer ¹ - ¹ NY Presbyterian-Cornell University, New York, NY; ² McGill University, Montreal, QC, Canada
4:56 pm – 5:04 pm	18 (RF) Surgical Revascularization of Iliac Occlusive Disease: A Contemporary Series Rose An, Mohammed M. Moursi, Guillermo A. Escobar, Ahsan T. Ali, Matthew R. Smeds - University of Arkansas for Medical Sciences, Little Rock, AR
5:04 pm – 5:12 pm	19 (RF) A Validated Method For Automatic Data Extraction From Electronic Medical Records To Increase the Ease and Accuracy of Retrospective Chart Review Matthew E. Bennett, Thomas M. Loh, Jean Bismuth - Houston Methodist Hospital, Houston, TX
5:12 pm – 5:24 pm	20 Assessing the Validity of the Procedure Based Assessment Tool During Vascular Cadaveric Simulation Training: Results From An Un-Blinded Observational Study Lucy Green, Christina K. Moody, Rachel Barnes, Ian C. Chetter - Hull York Medical School, Hull, United Kingdom
5:24 pm – 5:36 pm	21 Risk Factors For Long-Term Mortality and Amputation After Open and Endovascular Treatment of Acute Limb Ischemia Elizabeth A. Genovese, Rabih A. Chaer, Ashraf G. Taha, Luke K. Marone, Efthymios Avgerinos, Michel S. Makaroun, Donald T. Baril - University of Pittsburgh Medical Center, Pittsburgh, PA

Schedule-At-A-Glance

5:36 pm – 5:48 pm	22 The Prevalence of Bovine Aortic Arch Configuration In Adult Patients With and Without Thoracic Aortic Pathology Pamela A. Moorehead, Ann Kim, Tejas V. Kashyap, Daniel E. Kendrick, Vikram S. Kashyap - University Hospitals Case Medical Center, Cleveland, OH
5:48 pm – 6:00 pm	23 Preoperative Frailty Increases Risk of Non-Home Discharge After Elective Vascular Surgery In Home-Dwelling Patients Shipra Arya ¹ , Chandler Long ¹ , Reshma Brahmabhatt ¹ , Susan Shafii ¹ , Luke P. Brewster ¹ , Ravi Veeraswamy ¹ , Theodore M. Johnson, II ¹ , Jason M. Johanning ² - ¹ Emory University, Atlanta, GA; ² University of Nebraska Medical Center, Omaha, NE
6:00 pm – 7:00 pm	VESS MEMBER BUSINESS MEETING
7:15 pm	Free Evening

Saturday, January 31, 2015

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
6:48 am – 9:00 am	SCIENTIFIC SESSION III
6:48 am - 7:00 am	33* Maximizing the Versatility of Endovascular Robotics Using Dynact Image Fusion Guidance To Facilitate Navigation Cassidy Duran ¹ , Alan B. Lumsden ¹ , Ponraj Chinnadurai ² , Jean Bismuth ¹ - ¹ The Methodist DeBakey Heart & Vascular Center, Houston, TX; ² Seimen, Hoffman Estates, IL
7:00 am – 7:12 am	24 Contemporary Outcomes For Autogenous Infrainguinal Bypass In the Endovascular Era Mahmoud B. Malas, Isibor J. Arhuidese, Tammam Obeid, Alaa Khaled, Karren Massada, Caitlin Hicks, Umair Qazi, Thomas Reifsnyder - Johns Hopkins Medical Institutions, Baltimore, MD

*Please Note: This paper is being presented earlier and out of sequence to accommodate additional programming.

Schedule-At-A-Glance

7:12 am – 7:24 am	25 Influence of Gender On Abdominal Aortic Aneurysm Repair In the Community Daiva Nevidomskyte, Sherene Shalhub, Singh Niten, Nam Tran, Mark H Meissner - University of Washington, Seattle, WA
7:24 am – 7:36 am	26 Microembolic Risk of Carotid Artery Plaque Composition By MRI at the Time of Elective Revascularization Jennifer R. Li ¹ , Chiara Giannarelli ¹ , Venkatesh Mani ¹ , Errol Gordon ¹ , Prakash Krishnan ¹ , Jason Kovacic ¹ , George Dangas ¹ , Ziad Ali ² , Zahi Fayad ¹ , Juan Badimon ¹ , Peter Faries ¹ , Jose Wiley ¹ - ¹ Icahn School of Medicine at Mount Sinai, New York, NY; ² Columbia University Medical Center, New York, NY
7:36 am – 7:48 am	27 Natural History of Iatrogenic Pediatric Femoral Artery Injury Elizabeth A. Andraska, Huiting Chen, Tatum O. Jackson, Katherine A. Gallagher, Jonathan L. Eliason, Dawn M. Coleman - University of Michigan, Ann Arbor, MI
7:48 am – 7:56 am	28 (CR) Bullet Embolism To the Peripheral Vasculature, Two Cases Nicholas B. Johnson, Katherine A. Rodby, Amir Vafa, Daniel Katz, Samantha Minc - Mount Sinai Hospital, Chicago, IL
7:56 am – 8:04 am	29 (CR) Axillary-Femoral Bypass May Provide Inadequate Distal Perfusion Compared To In-Line Large Diameter Aortic Reconstruction Loren L. Masterson, Patrick Vaccaro, Michael R. Go - Ohio State University, Columbus, OH
8:04 am – 8:12 am	30 (RF) Peak Ankle Velocities and Average Ankle Velocities Utilized For Identifying Critical Limb Ischemia Justin Brown, Shannon Rosati, Daniel Newton, Jill Peysha, Michael Amendola, Luke Wolfe, Mark Levy - Virginia Commonwealth University, Richmond, VA

Schedule-At-A-Glance

8:12 am – 8:24 am	31 Applicability of the Society for Vascular Surgery's Objective Performance Goals for Critical Limb Ischemia To Current Practice of Lower Extremity Bypass Julia T. Saraidaridis, Virendra Patel, Robert T. Lancaster, Richard P. Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA
8:24 am – 8:32 am	32 (CR) Resection of A Large Innominate Vein Aneurysm In A Patient With Neurofibromatosis Type 1 Peter B. Bartline, Stephen H. McKellar, Daniel V. Kinikini - University of Utah, Salt Lake City, UT
	33 Paper #33 is being presented at 6:48 am (instead of 8:32 am) to accommodate additional programming. See page 10.
8:32 am – 8:37 am	Introduction of Honorary Members
8:37 am - 8:42 am	Gore Travel Award Winner Announcement
8:44 am – 9:00 am	INTRODUCTION OF THE PRESIDENT
9:00 am – 9:45 am	PRESIDENTIAL ADDRESS Music, Evolution and Progress Vikram Kashyap, MD
10:00 am - 1:00 pm	SVM VASCULAR LAB REVIEW COURSE - PART 2 (Separate Subscription)
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks
4:00 pm – 6:00 pm	SCIENTIFIC SESSION IV
4:00 pm – 4:12 pm	34 Cost Analysis of Angioplasty Versus Stenting In the Treatment of Peripheral Arterial Disease Margarita Vinogradova, Jessica Paz, Jacob Loeffler, Misty Humphries - University of California, Davis Medical Center, Sacramento, CA
4:12 pm – 4:24 pm	35 Mortality and Cost of Chronic and Acute Kidney Disease After Vascular Surgery Azra Bihorac, Matthew Huber, Tezcan Ozrazgat-Baslanti, Paul Thottakkara, Robert Feezor, Charles Hobson - University of Florida, Gainesville, FL

Schedule-At-A-Glance

4:24 pm – 4:36 pm	36 Comparison of Non-Penetrating Titanium Clips Versus Continuous Polypropylene Suture In Dialysis Fistula Creation Khanh Nguyen ¹ , Olamide Alabi ² , Theodore Teruya ² , Neha Sheng ² , Christian Bianchi ² , Jason Chiriano ² , Sheela Patel ² , Ahmed Abou-Zamzam, Jr. ² - ¹ Oregon Health Sciences University, Portland, OR; ² Loma Linda University Medical Center, Loma Linda, CA
4:36 pm – 4:48 pm	37 Ten Year Experience of Vascular Surgeon Management of Iatrogenic Pseudoaneurysms: Do Anticoagulant/Antiplatelet Medications Matter? Patrick Stone ¹ , James Campbell ¹ , John E Campbell ¹ , Maria Martinez ¹ , David Masinter ² , Stephanie N. Thompson ² , Ali F. AbuRahma ¹ - ¹ WVU Charleston, Charleston, WV; ² CAMC Health Education and Research Institute, Charleston, WV
4:48 pm – 4:56 pm	38 (RF) A Novel Anesthetic Technique For PEVAR Stuart A. Harlin, Christopher J. LeCroy, Ruth A. Grissom, Susan M. Pouliot - Coastal Vascular and Interventional, Pensacola, FL
4:56 pm – 5:04 pm	39 (CR) External Carotid Artery Branch Embolization As An Adjunctive Palliative Therapy For Unresectable Head and Neck Malignancy Reshma Brahmabhatt, Shipra Arya, Ravi Veeraswamy - Emory University School of Medicine, Atlanta, GA
5:04 pm – 5:12 pm	40 (CR) Delayed Hybrid Repair of Major Vascular Injuries Following A Gunshot Wound To the Abdomen Clayton Brinster, Elizabeth A. Blazick, Virendra Patel, Richard P. Cambria, Mark F. Conrad, Glenn M. LaMuraglia - Massachusetts General Hospital, Boston, MA
5:12 pm – 5:24 pm	41 Indication For Lower Extremity Arterial Bypass and Hospital Profiling Andrew A. Gonzalez ¹ , Justin B. Dimick ² , Nicholas H. Osborne ² - ¹ University of Illinois at Chicago, Chicago, IL; ² University of Michigan, Ann Arbor, MI

Schedule-At-A-Glance

5:24 pm – 5:36 pm	42 Perceptions of 0+5 Trained Surgeon By Community Vascular Surgeons Laura A. Peterson, Jennifer Avise, Jeanette Stafford, Matthew Godlman, Christopher J. Godshall, Justin Hurie, Matthew Edwards, Matthew Corriere - Wake Forest University, Winston Salem, NC
5:36 pm – 5:48 pm	43 A Prospective Observational Study Comparing Early Clinical Outcomes of 810nm and 1470nm Endovenous Laser Ablation In the Treatment of Superficial Venous Insufficiency Joseph El-Sheikha, Dan Carradice, Clement Leung, Ian Chetter - Academic Vascular Unit of Hull York Medical School and Hull Royal Infirmary, Hull, United Kingdom
5:48 pm – 5:56 pm	44 (CR) Popliteal Artery Pseudoaneurysm Secondary To Osteochondroma: A Case Report and Literature Review Katherine E. Brown, Samer Naffouje - University of Illinois Medical Center at Chicago, Chicago, IL
5:56 pm – 6:04 pm	45 (RF) Numerous Applications of 3D Printing In Vascular Surgery Khurram Rasheed, Doran Mix, Ankur Chandra - University of Rochester, Rochester, NY
7:00 pm – 10:00 pm	PRESIDENT'S DINNER All registered attendees are welcome to attend. The President's Dinner is by separate subscription - tickets are required.

Sunday, February 1, 2015

6:30 am – 7:00 am	Continental Breakfast
6:30 am – 9:00 am	Registration
7:00 am – 9:00 am	SCIENTIFIC SESSION V
7:00 am – 7:12 am	46 Mortality Rate Discrepancies Among Patients Undergoing Amputation - A Comparison of Source Data John P. Davis, Amani D. Politano, Christopher A. Guidry, Scott R. Ellis, Wendy M. Novicoff, Kenneth J. Cherry, John A. Kern, Gilbert R. Upchurch, Margaret C. Tracci - University of Virginia, Charlottesville, VA

Schedule-At-A-Glance

7:12 am – 7:24 am	47 Safety and Effectiveness of Adjunctive Intraarterial Abciximab In the Management of Acute Limb Ischemia Gregory G. Salzler, Peter H. Connolly, Darren B. Schneider, Andrew J. Meltzer - New York Presbyterian Hospital-Weill Cornell Medical College, New York, NY
7:24 am – 7:36 am	48 Heparin Bonded PTFE Does Not Improve Hemodialysis Arteriovenous Graft Function Nicolas Zea, Grayson Menard, Linda Le, Hernan Bazan, W.C. Sternbergh, Taylor Smith - Ochsner Clinic Foundation, New Orleans, LA
7:36 am – 7:48 am	49 Gender Differences In Aortic Neck Morphology In Patients With Abdominal Aortic Aneurysms Undergoing EVAR Diego Ayo, Sheila N Blumberg, Byron Gaing, Andrew Baxter, Caron Rockman, Firas Mussa, Thomas Maldonado - New York University School of Medicine, New York, NY
7:48 am – 7:56 am	50 (CR) Loeys-Dietz Syndrome, Pregnancy and Aortic Degeneration Jeffrey D. Crawford, Matthew S. Slater, Timothy K. Liem, Gregory J. Landry, Amir F. Azarbal, Gregory L. Moneta, Erica L. Mitchell - Oregon Health and Sciences University, Portland, OR
7:56 am – 8:04 am	51 (RF) Observation May Be Safe In Selected Cases of Blunt Traumatic Abdominal Aortic Injury Joseph J. DuBose, Samuel S. Leake, Harleen K. Sandhu, Miguel Sanchez-Perez, John B. Holcomb, Ali Azizzadeh, Hazim J. Safi, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX
8:04 am – 8:16 am	52 Outcomes of Women Treated For Popliteal Artery Aneurysms Randall R. DeMartino, Syed M. Peeran, Ying Huang, Mark Fleming, Manju Kalra, Oderich Gustavo, Audra Duncan, Thomas C. Bower, Peter Gloviczki - Mayo Clinic, Rochester, MN
8:16 am – 8:28 am	53 Abdominal Wall Grafts: A Viable Addition To Arteriovenous Access Strategies Mathew Wooster ¹ , Alexis Powell ¹ , Jay Denisco ² , Victor Bowers ³ - ¹ University of South Florida, Tampa, FL; ² Florida State University, Tampa, FL; ³ Tampa General Medical Group, Tampa, FL

Schedule-At-A-Glance

8:28 am – 8:40 am	54 A Diversity Survey of VESS and the Recent Vascular Trainees Within WVS Nathan K. Itoga ¹ , Karen Woo ² , Jean Bismuth ³ , Carlos Bechara ⁴ , Marlene Grenon ⁵ , Erica Mitchell ⁶ , Wei Zhou ¹ - ¹ Stanford University, Stanford, CA; ² University of Southern California, Los Angeles, CA; ³ Houston Methodist Hospital, Houston, TX; ⁴ Baylor College of Medicine, Houston, TX; ⁵ University of California San Francisco, San Francisco, CA; ⁶ Oregon Health and Science University, Stanford, CA
8:40 am – 8:52 am	55 Outcomes of Common Femoral and Profunda Femoris Endovascular Interventions Jonathan Bath ¹ , Efthymios Avgerinos ² - ¹ University of Cincinnati, Cincinnati, OH; ² University of Pittsburgh Medical Center, Pittsburgh, PA
8:52 am – 9:04 am	56 Description and Outcomes of A Simple Surgical Procedure To Treat the Failing Forearm Arteriovenous Fistula Joshua Washer, William Gordon, Adam Weltler - Medical University of South Carolina, Charleston, SC
9:15 am	Meeting Adjourns



Notes

Full Program & Abstracts

Thursday, January 29, 2015

7:00 am – 9:00 am	Executive Council Meeting
7:00 am – 5:00 pm	Registration
9:00 am – 12:15 pm	COOK FELLOW LUMINARIES (By Invitation)
10:30 am – 11:00 am	Coffee Break
12:15 pm – 1:15 pm	Fellows Lunch
1:30 pm – 3:30 pm	TECHNOLOGY FORUM Podium Presentations
3:30 pm – 6:30 pm	TECHNOLOGY FORUM Hands-On
6:30 pm – 8:00 pm	WELCOME RECEPTION All registered attendees, guests & exhibitors are welcome.

Friday, January 30, 2015

6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration
7:00 am – 9:15 am	SCIENTIFIC SESSION I
7:00 am – 7:12 am	1 Translational Therapy Targeting Epigenetic Enzymes May Improve Wound Healing In Patients With Type 2 Diabetes Huiting Chen, Amrita Joshi, Danielle C. Horne, Anna M. Eliassen, Scott T. Robinson, Dawn M. Coleman, John E. Rectenwald, Steve Kunkel, Katherine A. Gallagher - University of Michigan, Ann Arbor, MI

Introduction and Objectives: Diabetic wounds are characterized by a chronic inflammatory state that is maintained by overexpression of pro-inflammatory cytokines generated by macrophages. Based on our previous data, post-translational epigenetic changes to the genome in bone marrow stem cells may influence macrophages and other immune cells towards a pro-inflammatory phenotype. We have previously found in a murine model that under diabetic conditions, changes in histone methylation (decreased H3K27 methylation) promote pro-inflammatory cytokine production and are driven by an epigenetic enzyme known as Jmjd3. We hypothesized that bone marrow from patients with Type 2 Diabetes (T2D) would exhibit increased levels of this enzymes, Jmjd3, and that this could serve as a future therapeutic target for stem cell therapy in diabetic wounds.

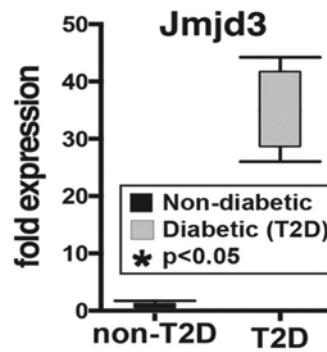
Full Program & Abstracts

Methods: Human bone marrow was obtained from 6 patients (N=3 with T2D; N=3 non-T2D) following amputation under our IRB-approved protocol. Immune cell isolations were performed immediately following surgery. qPCR was performed to quantify enzyme transcript production in the samples. S.E.M. was used to determine significance.

Results: Human bone marrow isolated from T2D patients demonstrated a significant increase in this key enzyme in the bone marrow stem cells compared to bone marrow from non-T2D individuals $P < .05$ (Figure 1).

Conclusions: Findings in mouse models do not often replicate in human tissues. This finding that this epigenetic enzyme is increased in T2D patients compared to controls may indicate that functionally this enzyme plays a similar role in promoting inflammation in wound tissues. Manipulation of this enzyme may affect macrophage function/phenotypes could allow for development of new therapies to prevent chronic inflammation in diabetic wounds.

Figure 1.



Full Program & Abstracts

7:12 am – 7:24 am

2

Population Based Study of Amputations Due To Diabetes and Peripheral Arterial Disease Using Statewide Data

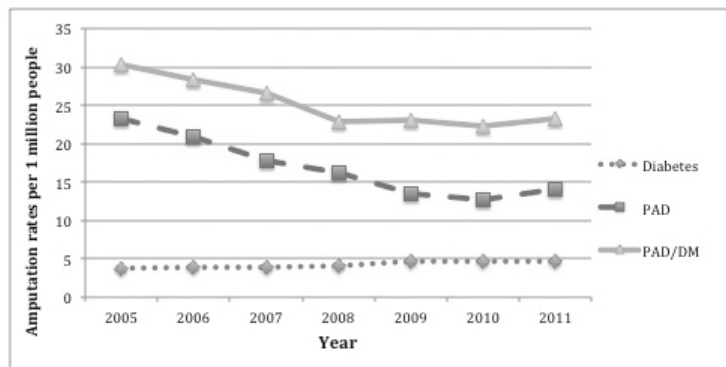
Misty Humphries, Ann Brunson, Patrick Romano, Nasim Hedayati, Joy Melnikow - University of California Davis Medical Center, Sacramento, CA

Introduction and Objectives: Conflicting data exists regarding if amputation rates continue to decrease in patients with diabetes mellitus (DM) and peripheral arterial disease (PAD). This study aims to determine amputation rates due to DM, PAD, or a combination of PAD/DM and identify treatment patterns prior to amputation using an all payer statewide database.

Methods: Using the California OSHPD database, all patients that underwent major amputation were identified. Population based amputation rates were determined, and attempts at limb salvage were identified using procedural ICD-9 and CPT codes.

Results: From 2005-2011 32,025 amputations were performed in California. 11,896 patients meet the diagnostic criteria for DM (n=1095), PAD (n=4335), or a combination of PAD/DM (n=6466). Yearly population based amputation rates showed from 2010-2011 rates have increased in patients with PAD and PAD/DM. (Figure) From 2008-2011 amputation rates have also been increasing in patients with DM. Forty-eight percent of patients with PAD/DM had no attempt at revascularization prior to amputation compared to 36% of patients with PAD alone. Women were less likely than men to have a revascularization procedure in both the PAD (49% vs. 52% p=0.004) and PAD/DM (32% vs. 68%, p<0.001) populations. In hospital mortality after amputation was highest in patients with PAD (26%) and PAD/DM (23%). For patients with PAD/DM having either an open (27%) or endovascular (25%) procedure prior to amputation was associated with increased mortality.

Conclusions: Amputation rates for all patients seem to be increasing despite advancements in revascularization techniques. Patients with PAD/DM represent a population that is at high risk for death, even with minimally invasive techniques aimed at limb salvage. Increased focus on preventive care is essential to further decrease amputation rates.



Full Program & Abstracts

7:24 am – 7:36 am

3

Snorkel/Chimney Stent Morphology Predicts Renal Dysfunction After Complex EVAR

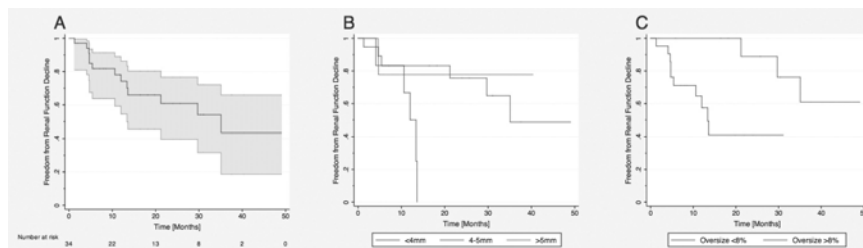
Kenneth Tran, Brant Ullery, Jason T. Lee - Stanford University, Stanford, CA

Introduction and Objectives: Despite high technical success and midterm patency of snorkel stents, concerns remain about structural durability and its effect on long-term renal function. We sought to evaluate the luminal stability of renal snorkel stents in order to investigate morphologic predictive factors of renal dysfunction following sn-EVAR.

Methods: Patients with high quality CT-A after sn-EVAR between 2009-2013 were included for analysis. Renal stent diameters and other morphology were measured on a 3D workstation at the proximal, main-body junction, and distal locations. Creatinine values and eGFR were recorded throughout the pre-, peri-, and post-operative course. Acute kidney injury and chronic renal decline were evaluated using the RIFLE criteria and CKD staging system, respectively.

Results: 43 patients underwent Sn-EVAR (31 double renal, 12 single renal) with a two year primary patency of 95% at a mean follow-up of 22 months, of which 34 had suitable imaging protocols. In this subset, snorkel stents had mean deformations of -0.11(2.8%), -0.22(4.6%) and +0.74mm(1.8%) at the proximal, junction, and distal locations. Seven (20.5%) and 13(38.2%) patients developed AKI and chronic renal decline, respectively. Multivariate regression identified less oversizing ($P=.001$) and smaller proximal luminal diameters at latest follow-up ($p=.037$) as independent risk factors for developing AKI and chronic renal decline, respectively. Twelve month freedom from renal decline for the cohort was 0.74 (Figure 1A). Larger renal luminal diameters (Figure 1B, $P=.010$) and increased stent-graft oversizing (Figure 1C, $p=.012$) were associated with improvement in renal decline.

Conclusions: Renal snorkel stent-grafts maintain a high degree of patency and luminal stability at two year follow-up. Careful consideration of selecting larger diameter and properly oversized renal stent-grafts may decrease the risk of developing renal dysfunction.



Full Program & Abstracts

7:36 am – 7:48 am

4

Outcomes of Bypass Support Use During Inferior Vena Cava Resection and Reconstruction

Natalia O. Glebova¹, Caitlin W. Hicks², Kristen M. Piazza², Kristine C. Orion², Ying Wei Lum², Christopher J. Abularrage², James H. Black, III² - ¹University of Colorado Denver, Aurora, CO; ²Johns Hopkins Hospital, Baltimore, MD

Introduction and Objectives: The safety and effectiveness of using veno-venous and cardiopulmonary bypass for resection of the inferior vena cava (IVC) for malignancy is not well studied. The goal of this study was to compare outcomes following IVC resection with and without bypass support.

Methods: We analyzed all patients undergoing IVC resection at our institution (9/1999-6/2014) and compared the use of bypass support with cross-clamp alone using univariable and Kaplan-Meier analyses. Outcomes included perioperative complications and survival.

Results: Sixty-three patients underwent IVC resection (mean age 57.8±2 years, mean follow-up 20.9±3.3 months). Bypass patients (32%) were similar to non-bypass patients (68%) in age, gender; tumor size, type, and grade (p=NS). Bypass patients were more likely to undergo complete IVC reconstruction (55% vs. 24%; p=0.01) at the suprarenal level (62% vs. 35%; p=0.05), and had higher intraoperative blood loss (9.6±2.1 vs. 3.2±1.4 L; p=0.01). Complete R0 resection was similar between groups (50% vs. 52%, p=NS). Perioperative complications were higher in bypass patients (p=0.005), including death (10% vs. 0%) and venous thromboembolic events (VTE; 40% vs. 21%). The incidence of acute kidney injury (10% vs. 9%) and renal failure requiring dialysis (10% vs. 2%) was similar (p=NS). There were no differences in overall mortality (15% vs. 14%, p=NS) or tumor recurrence (50% vs. 47%, p=NS). Bypass patients had a non-significant trend toward longer disease-free survival (20.7±5.2 vs. 10.4±3.8 months, p=0.12).

Conclusions: Use of bypass support for IVC resection is associated with more complex operations and higher rates of perioperative complications. However, the overall mortality and morbidity of bypass, including renal complications, is similar to cross-clamping alone. Thus, the need for bypass should not preclude attempts at complete tumor resection.

Full Program & Abstracts

7:48 am – 7:56 am

5 (RF)

Renal Injury After EVAR Portends Shortened Survival

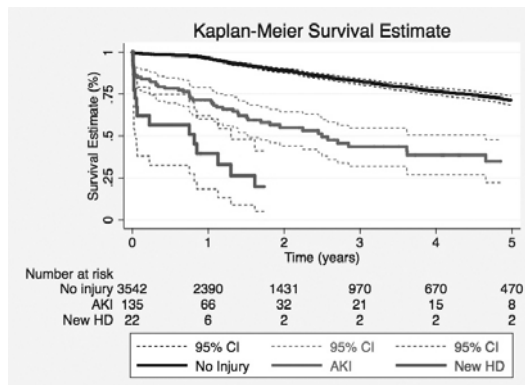
Devin S. Zarkowsky¹, Caitlin W. Hicks², David H. Stone¹, Daniel J. Bertges³, Jeffrey E. Indes⁴, Jeffrey A. Kalish⁵, Philip P. Goodney¹ - ¹Dartmouth-Hitchcock Medical Center, Lebanon, NH; ²Johns Hopkins Hospital, Baltimore, MD; ³University of Vermont College of Medicine, Burlington, VT; ⁴Yale University School of Medicine, New Haven, CT; ⁵Boston Medical Center, Boston, MA

Introduction and Objectives: Surgeons perceive supportive care to mitigate renal dysfunction identified in the peri-EVAR period, however the effect of kidney injury on long-term patient outcomes has not been well characterized.

Methods: De-identified EVAR patient data contained within the Vascular Study Group of New England database was queried for patients demonstrating post-operative acute kidney injury or new dialysis requirement. Univariate statistical comparisons of demographic and clinical outcome data were completed with appropriate tests. Life table analysis predicted mortality. Logistic regression and Cox hazard modeling extrapolated those parameters most influencing mortality.

Results: Between January, 2003 and August, 2013, 3,809 patients received EVAR in VSGNE hospitals. Those already receiving dialysis were excluded; four patients with renal transplants were not. Most, 3542, developed no post-operative renal injury. AKI occurred in 135 patients, while 22 required dialysis as a direct result of EVAR. Median follow-up is 18.0 months (0-121.6), 11.8 (0-115.1) and 2.2 (0.1-77.3) for each group respectively. Baseline creatinine values were different between the No Injury, AKI and NewHD groups, 1.1 vs. 1.5 vs. 1.4 mg/dL (p<0.001). Five-year survival by life table analysis was lower in patients who required HD (18.2%, 95%CI 5.2-40.0%) and patients with AKI (35.9%, 95%CI 23.8-48.2%) when compared to patients without renal injury (71.9%, 95%CI 69.3-74.4%). Figure1 demonstrates a differential in the survival estimate for each patient group. Cox hazard model shows renal injury - either AKI or New HD requirement - was associated with greater mortality risk at 5 years (HR=3.44, 95%CI=2.32-5.10).

Conclusions: Renal injury after EVAR is associated with a significant decrease in life expectancy, even when adjusting for patient-level comorbidities. Limiting AKI after EVAR represents a topic for QI initiatives in VSGNE.



Full Program & Abstracts

7:56 am – 8:04 am

6 (RF)

Urban Blunt Carotid and Vertebral Artery Injury: A 12 Year Comparison

Mark E. Lytle, James West, Jason N. Burkes, Tammy Fisher, Yahya Daoud, William P. Shutze, Sr. - Baylor University Medical Center in Dallas, Dallas, TX

Introduction and Objectives: Blunt Cerebrovascular Injury (BCVI) occurs in 0.5-1.7% of trauma patients. These injuries result in an intimal flap, dissection, pseudoaneurysm or transection which can lead to stroke and death. We sought to evaluate the differences between extra-cranial carotid and vertebral artery BCVI and to evaluate a novel injury grading scale in regards to outcome and therapy.

Methods: Utilizing a computerized trauma database from a single university-affiliated Level 1 trauma center, patients who were treated for BCVI from January 2003 to July 2014 were identified. Medical records and imaging were reviewed for patient demographics, injury characteristics, and therapeutic interventions, and outcomes. Radiographic imaging was reviewed by a blinded, experienced professional, and classified according to the established blunt carotid injury grading scale and into a modified BCVI Grading Scale.

Results: There were 103 patients with BCVI were identified (65 male, 38 female) with an average age of 45 years (15-92). The average Injury Severity Score (ISS) was 22 (4-75). Injuries were to the carotid artery (CA) in 37, vertebral artery (VA) in 60 and both in 6. There were no differences between the CA and VA groups in age, race, gender, injury mechanism, pulse at scene, or length of stay. The CA group had a higher incidence of TBI (68 vs. 43%), intracranial hemorrhage (59 vs. 23%) and ISS (31 vs. 16.5%) compared to the VA group. The mortality in the CA group was 27% compared to 5% in the VA group. The modified BCVI grading score better classified patient injuries and outcomes than the original grading score.

Conclusions: For BCVI the ISS, the incidence of TBI, ICH and mortality is higher for CA than VA injuries. This may reflect the increased forces necessary to produce injury to the CA compared to the VA with blunt force type mechanisms.

Full Program & Abstracts

8:04 am – 8:12 am

7 (CR)

Caval Reconstruction For Lower Extremity Sarcoma Metastasis Trapped Within An IVC Filter

Lidie Lajoie, Joseph Benevenia, Michael Curi - Rutgers/NJMS, Newark, NJ

Introduction and Objectives: This report describes the first case of a hematogenously spread metastasis from a lower extremity sarcoma found trapped within an IVC filter treated by caval resection and reconstruction. While endovascular techniques for treating thrombosed IVC filters are successful in a majority of cases, the malignant nature of this lesion required a novel approach.

Methods: An IVC filter was placed for thromboembolism prevention prior to surgical resection of a high-grade pleomorphic leiomyosarcoma encasing the superficial femoral artery and femoral vein in a 72 year old woman. A PET-CT performed 3 months postoperatively revealed a new area of uptake within the cava at the level of the filter. In this unique case, the segment of infrarenal IVC with the thrombosed filter was resected and reconstruction performed with an interposition prosthetic graft.

Results: There were no early or late complications and the patient remains clinically free of recurrence at ten months follow up.

Conclusions: The use of IVC filters for prevention of pulmonary embolism in patients undergoing resection for lower extremity sarcoma is controversial. In this case, the presence of an IVC filter halted hematogenous spread which could have resulted in distant pulmonary metastasis. This allowed for caval resection with an intent to cure. Caval reconstruction is a safe and effective treatment for malignancy involving the inferior vena cava, and should be the first considered approach in these cases.



Full Program & Abstracts



Full Program & Abstracts

8:12 am – 8:24 am

8

Thrombomodulin Demonstrates Critical Beneficial Direct Effects On Smooth Muscle Cell Physiology

Heather Bass, Richard Beard, Sarah Yuan, Peter R. Nelson - University of South Florida Morsani College of Medicine, Tampa, FL

Introduction and Objectives: Following vascular injury, critical endothelial cell (EC) function is lost. Thrombomodulin (TM), an endothelial anticoagulant, is one lost regulator. TM has known effects through inhibition of thrombin, but here we sought to examine direct, independent effects of TM on SMC physiology. We hypothesized that exogenous TM would induce a favorable SMC phenotype and would inhibit SMC migration.

Methods: Primary human saphenous vein SMC were explanted and used in early passage (1-4). SMC migration was measured using: (1) a 4-hour Boyden-chamber chemotaxis assay, and (2) a 24-hour Electric Cell-substrate Impedance Sensing (ECIS) wound assay. Migration experiments were conducted with serum-starved SMC exposed to increasing doses of soluble human TM and results quantified by cell counts. Thrombin served as positive control and serum-free media as negative control. Dose-dose comparisons were performed using a t-test ($\alpha < .05$). Multiphoton laser scanning microscopy was used to assess the effect of exogenous TM on SMC phenotype.

Results: SMC demonstrated low, baseline migration in serum-free conditions. Thrombin significantly stimulated SMC migration as expected. TM, independent of thrombin, significantly inhibited SMC migration in a dose-dependent fashion (Figure 1). 70% reduction was observed at 5 μ g/mL (56 ± 1.7 vs. 18 ± 3.5 cells/5hpf, $P = .0005$). SMC exposed to TM demonstrated a spindle-shaped morphology with organized stress fibers consistent with a differentiated, contractile phenotype, whereas, control thrombin stimulation lead to a dedifferentiated, synthetic phenotype (Figure 2).

Conclusions: Thrombomodulin demonstrated direct effects on SMC physiology, independent from thrombin, including maintenance of a differentiated, contractile phenotype and inhibition of migration. These findings provide new knowledge in understanding the biology of vascular injury, and supports a strategy focused on restoring key endothelial function to prevent intimal hyperplasia.

Figure 1: Thrombomodulin Dose-Response Migration

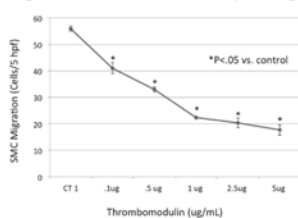
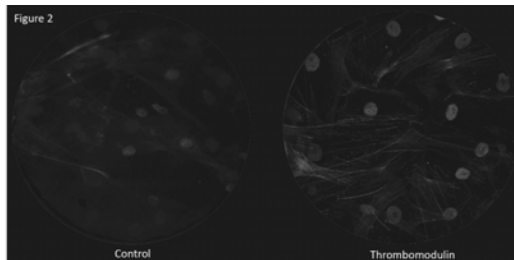


Figure 2



Full Program & Abstracts

8:24am – 8:35 am

9

The Incidence of Ischemic Colitis After Repair of Ruptured Abdominal Aneurysms Is Decreasing In the Endovascular Era

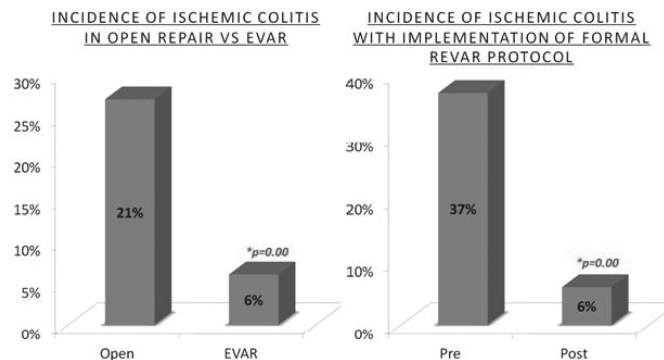
Sarasijhaa Desikan, Niten Singh, Nam Tran, Elina Quiroga, Ty Garland, Benjamin W. Starnes - University of Washington Medical Center, Seattle, WA

Objective: Ischemic colitis (IC) is a well-described complication of ruptured abdominal aortic aneurysms (rAAA). The purpose of this study was to compare the incidence of IC in patients with rAAA undergoing open (OR) vs. endovascular aneurysm repair (EVAR) at a single institution. In addition, we analyzed incidence of ischemic colitis pre- and post-implementation of a formal rupture AAA protocol.

Methods: A retrospective analysis of prospectively collected data on all patients presenting with rAAA to our institution between Jan 2002 and Oct 2013 was performed. Variables were analyzed for association with IC. Comparisons were made using Pearson's chi-squared test for categorical variables, Student t-test for continuous variables, and logistic regression for multivariate analysis. Significance was set at $p < 0.05$.

Results: 303 patients with rAAA presented over the 10 year study period. 191 patients underwent open repair and 89 patients underwent EVAR. 23 patients died either in the emergency department, en route to the operating room, or after choosing comfort care. Predictive factors of IC included EBL, corresponding need for resuscitation, and duration of procedure. Of the patients undergoing open repair, the rate of ischemic colitis was 21% (40/191). This was significantly higher than patients undergoing EVAR, 6.7% (6/89), $p=0.000$. Type of intervention did not influence 30 day mortality in patients with IC. However, only 17% (1/6) of patients who had IC following EVAR required colectomy vs. 48% (19/40) of patients with IC following OR ($p=0.21$). Implementation of our formal REVAR protocol decreased the incidence of IC significantly from 37.1% (36/97) to 6.4% (10/157), $p=0.000$.

Conclusions: Incidence of ischemic colitis has decreased significantly in the endovascular era, but continues to portend a poor prognosis. Implementation of a formal, multidisciplinary REVAR protocol decreases incidence of IC.



Full Program & Abstracts

8:35 am – 8:47 am

10

Series of Non-Contrast Time of Flight MRAs To Predict Problems With AVF Maturation

Aaron J. Gonzalez, Kevin Casey, Benjamin Drinkwine, Jeffrey Weiss - Naval Medical Center San Diego, San Diego, CA

Objectives: Achieving hemodialysis access maturation remains a challenging problem for vascular surgeons. We herein describe our experience using magnetic resonance angiography (MRA) to evaluate surgically constructed hemodialysis arteriovenous fistulas (AVFs) without the risk of radiation exposure, intravenous contrast, or reliance on the operator-dependent modality of duplex ultrasonography.

Methods: Consecutive patients with abnormal findings on ultrasonography following AVF creation underwent 3 dimensional (3-D) Time of Flight (TOF) MRA evaluation. Imaging was performed at 3 Tesla with a scan acquisition time of approximately 15 minutes. The technique is similar to head and neck MRA, except pre-saturation bands are not used thereby allowing for simultaneous visualization of both arterial and venous flow.

Results: Twenty studies were reviewed and aided in predicting AVF maturation issues. Eighteen studies were of diagnostic quality and yielded findings useable by the vascular surgeon to take corrective measures. These included inflow stenosis, anastomotic narrowing, venous outflow stenosis, and hemodynamically significant venous tributaries. The findings led to subsequent catheter directed treatment in many of the patients, which required significantly less contrast administration than typically used. Interpretation may be limited when flow is turbulent or when it travels parallel to the scan plane.

Conclusions: We have successfully implemented TOF MRA to assist in identifying AVF maturation problems. This unique modality provides 3-D images in a non-invasive fashion and provides the surgeon an anatomic map for planning corrective actions. Future studies will focus on the best algorithm using TOF to improve AVF maturation rates.



Full Program & Abstracts

8:47 am – 8:55 am

11 (CR)

Staged Approach To Repair of Large Femoral Pseudoaneurysm Caused By Infected Femoral Stents

Lindsay Bools, Joshua Arnold - University of Tennessee, Knoxville, TN

Introduction: Infection of endovascular stents is a rare complication but can cause significant morbidity and mortality to the patient. We present a case of infected superficial femoral artery stents which resulted in a femoral pseudoaneurysm and bacteremia.

Methods: A 61 year old male presented with left groin swelling and erythema and MRSA bacteremia. He had recently undergone several endovascular procedures including bilateral iliac stents and multiple stents (bare metal and covered) in the left superficial femoral artery. The patient was found to have infected femoral stents which caused a pseudoaneurysm.

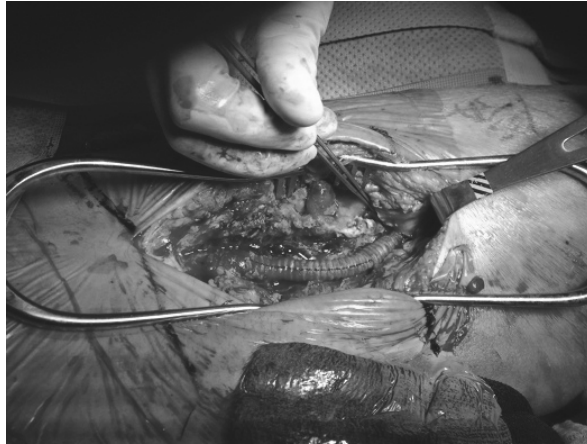
Results: The patient underwent a staged approach to repair this infected pseudoaneurysm. At the initial procedure, exploration and debridement of the femoral pseudoaneurysm was performed. A rifampin-soaked Dacron interposition graft was used for temporary revascularization of the common femoral to the patent Viabahn stent graft. One week later, the second stage was performed. The Dacron graft and stent grafts were removed. A femoral to below knee popliteal bypass was performed with saphenous vein. A sartorius flap was used for coverage of the bypass graft. At one month follow-up, the patient's wounds were healing well, and he had good distal perfusion.

Conclusion: The main keys for treatment of stent infection are removal of all infected stent material and revascularization either with an in situ or extra-anatomic bypass.



Pseudoaneurysm

Full Program & Abstracts



First stage repair



One month follow-up

Full Program & Abstracts

8:55 am – 9:03 am

12 (CR)

Osteosarcoma Masquerading As A Subclavian Artery Pseudoaneurysm

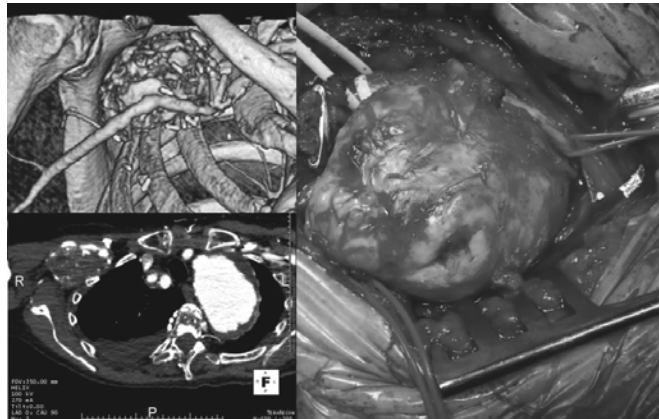
Max Wohlauer, Michael Park - Cleveland Clinic, Cleveland, OH

Introduction and Objectives: 68 year-old female with a thoracoabdominal aortic aneurysm recently status-post first stage elephant trunk procedure with right brachiocephalic artery endarterectomy and reimplantation of the innominate and left carotid using a 14 x 10 mm branch graft presented to clinic with increasing pain in her right arm and shoulder x 2 weeks. She also had a remote history of radiation to the right axilla for breast cancer. On physical exam she had a tender mass under her clavicle, numbness in shoulder and right hand weakness. CT scan revealed a 5.3 x 4.3 cm coarsely rim calcified lesion in the right axillary region thought to represent a pseudoaneurysm.

Methods: She was taken to the operating room for exploration. After obtaining proximal and distal control, the mass revealed to be a solid tumor which was resected using oncologic principles.

Results: Pathology revealed an extraskeletal osteosarcoma.

Conclusions: Extraskeletal osteosarcoma (ESOS) is an extremely rare primary bone cancer, making up < 1% of all osteosarcomas. Less than 350 cases are described in the literature. Of the cases described in the literature, less than 5% involve the upper extremity / thorax. They are aggressive tumors located in the soft tissue and not an extension of bone. ESOS does not respond well to chemotherapy and treatment involves multimodality therapy with surgical resection and adjuvant radiation.



Full Program & Abstracts

9:30 am - 12:00 pm	SVM VASCULAR LAB REVIEW COURSE - PART 1 (Separate Subscription)
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks – Visit Exhibitors
4:00 pm – 6:00 pm	SCIENTIFIC SESSION II
4:00 pm – 4:12 pm	13 Median Arcuate Ligament Syndrome Is Not A Vascular Disease John M. Weber, Mena Boules, Kathryn Fong, Kevin El-Hayek, Matthew Kroh, Woosup M. Park - Cleveland Clinic Foundation, Cleveland, OH

Introduction and Objectives: Median arcuate ligament syndrome is a rare disorder characterized by postprandial abdominal pain, weight loss, and celiac stenosis. Diagnosis can be challenging, leading to a delay in treatment. We report on our continued experience using a laparoscopic approach for this uncommon diagnosis.

Methods: This is an IRB-approved, prospectively collected retrospective analysis of patients treated with laparoscopic median arcuate ligament release at our institution. Data collected included patient demographics, preoperative symptoms, operative approach, and postoperative outcomes. Patients were then contacted to complete a postoperative survey designed to assess the improvement of symptoms and overall patient satisfaction.

Results: A total of 39 patients (33 women, 6 men) underwent laparoscopic median arcuate ligament release from March 2007 to July 2014. Mean age was 40.6 years (range 17 to 77 years). Twenty-seven of 39 patients had a postoperative celiac axis ultrasound. Twenty-two had a patent celiac axis on post-operative duplex. The remaining 5 with residual celiac axis stenosis reported complete resolution of their symptoms. Thirty-three of 39 (84.6%) reported symptom relief after surgery. Nine of 33 (27.3%) had cardiovascular risk factors versus 4 out of 6 (67%) non-responders. Five patients with atypical presentations underwent preoperative celiac plexus block, with 4 reporting relief of symptoms after block. These four also reported postoperative symptom relief. One patient of 39 received a postoperative stent and remained symptomatic. There were no deaths.

Conclusions: Laparoscopic median arcuate ligament release continues to be a safe and effective means of managing median arcuate ligament syndrome. Our data suggests that the symptoms associated with MALS are not related to vascular compromise, and atherosclerotic risk factors may predict poorer outcomes. Symptomatic relief is seen in the vast majority of patients undergoing this procedure. However, patient selection remains critically important in obtaining optimal results.

Full Program & Abstracts

4:12 pm – 4:24 pm

14

Clinical Outcomes Are More Sustainable In Men Than Women Following Femoropopliteal Stenting: 3 Year Results of the DURABILITY II Trial

Daniel K. Han, Christine Chung, Marvin V. Weaver, Rami O. Tadros, Peter L. Faries, Ageliki G. Vouyouka - Mount Sinai, New York, NY

Introduction: This study investigated the effects of gender on the three year outcomes of the DURABILITY II trial.

Methods: Two hundred eighty seven patients enrolled in the Study for Evaluating Endovascular Treatments of Lesions in the Superficial Femoral Artery and Proximal Popliteal by using the Protege EverFlex Nitinol Stent System II (DURABILITY II) trial (prospective, non-randomized trial) were stratified by gender and evaluated for primary, primary assisted, and secondary patency at 3 years. Clinical scores including changes in ankle-brachial index (ABI) and Walking Impairment Questionnaire (WIQ) scores were evaluated.

Results: 190 male and 97 female patients were included for analysis. The 3 year primary, assisted primary and secondary patency rates for women versus men were 62.5 vs. 58.8%, 68.5 vs. 64.9%, and 72.1 vs. 67.2%, respectively (p=NS). While ABIs at presentation were similar between women versus men (0.64 vs 0.65, p=NS), women achieved lower ABI scores at 3 years compared to men (0.85 vs 0.92, p<0.05). Women versus men had inferior walking distance scores at presentation (13.6 vs 25.7, p<0.05), scores were equalized by 2 years (51.6 vs 60.8, p=NS), however 3 year follow up demonstrated less durable results for women versus men (37.3 vs 58.8, p<0.05). In addition, women had worse WIQ scores for pain, walking speed, and stair climbing. However, the relative change in scores between men and women were comparable, with both groups seeing similar improvements from baseline for these parameters.

Conclusions: Women continue to see clinical improvement following intervention, achieving comparable ABIs and walking distance to men at 2 years. These benefits are diminished at 3 year follow-up with women achieving lower absolute ABI and WIQ parameters compared to men, but improved overall compared to scores at presentation.

Full Program & Abstracts

4:24 pm – 4:36 pm

15

Mesenteric Ischemia With Limb Malperfusion Requiring Peripheral Bypass Portends A Poor Outcome In Patients With Acute Aortic Dissection

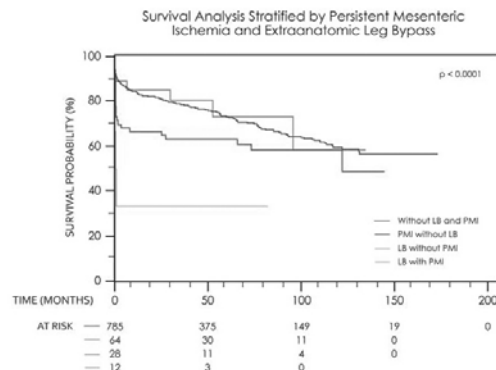
Samuel S. Leake, Katie Jeffress, Harleen K. Sandhu, Charles C. Miller, III, Tom C. Nguyen, Ali Azzizadeh, Anthony L. Estrera, Hazim J. Safi, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

Introduction and Objectives: Acute aortic dissection (AAD) can cause limb ischemia due to branch vessel occlusion. A minority of patients have persistent ischemia after aortic stabilization and require peripheral arterial bypass. We investigated whether the need for limb bypass is associated with adverse outcomes.

Methods: We reviewed our cases of AAD from 1999 to 2013 and identified patients with malperfusion syndromes. Patients with type A dissection had urgent repair of the ascending aorta. Patients with type B dissection had blood pressure control and, since 2004, we increasingly placed thoracic endografts for patients with malperfusion syndromes. Those patients with persistent limb ischemia after aortic repair had bypass grafting. We performed univariate and multivariate analysis to determine the effect of need for bypass surgery and clinical outcomes.

Results: We treated 894 AAD patients with a mean age of 59.4 ± 14.5 years. Of 148 (17%) patients who presented with limb ischemia, 40 (4.5%) required limb bypass. Patients requiring limb bypass were more likely to have mesenteric ischemia compared to the rest of the cohort (30% vs. 8%, OR 5.2, $P < .0001$) and was associated with worse survival. Limb bypass performed in the absence of mesenteric ischemia is unrelated to long-term mortality ($P = .863$). Mesenteric ischemia is independently associated with lower long term survival ($P = .038$), and interacts with limb bypass ($P = .037$) to produce further excess mortality (Figure) over median follow-up of 3.8 years. Among survivors, the bypass patency rate was 71%.

Conclusions: Acute aortic dissection patients requiring limb bypass surgery have similar survival to those without limb malperfusion after adjusting for mesenteric ischemia. The need for lower limb bypass is a marker for more extensive dissection and should prompt evaluation for mesenteric malperfusion.



Full Program & Abstracts

4:36 pm – 4:48 pm

16

Pneumatic Compression Improves Quality of Life In Patients With Lower Extremity Lymphedema

Sheila Nafula Blumberg, Todd Berland, Caron Rockman, Firas F. Mussa, Allison Brooks, Neal Cayne, Thomas Maldonado - NYU Langone Medical Center, New York, NY

Introduction and Objectives: Lymphedema is an incurable and disfiguring disease secondary to excessive fluid and protein in the interstitium as a result of lymphatic obstruction. Pneumatic compression (PC) offers a novel modality for treatment of lymphatic obstruction through targeting lymphatic beds and mimicking a functional drainage system. The objective of this study is to demonstrate improved quality of life in patients with lower extremity lymphedema.

Methods: Consecutive patients presenting to a single institution for treatment of lymphedema were all treated with PC for at least three months. All patients underwent a pre-and post-PC assessment of episodes of cellulitis, number of ulcers, and venous insufficiency. Post-PC symptom questionnaires were administered. Symptom improvement was the primary outcome for analysis.

Results: 100 patients met inclusion criteria. At presentation, 70 % were female with a mean age of 57.5 years. Secondary lymphedema was present in 78%. Mean length of PC use was 12.7 months with a mean of 5.3 treatments per week. The number of episodes of cellulitis and ulcers pre- and post-PC decreased from mean of 0.26 to 0.05 episodes ($p=0.002$) and 0.12 to 0.02 ulcers ($p=0.007$) respectively. 14 % had concomitant superficial venous insufficiency, all of whom underwent venous ablation. 100% of patients reported symptomatic improvement post-PC with 54% greatly improved. 90% would recommend the treatment to others.

Conclusions: PC improves symptom relief and reduces episodes of cellulitis and ulceration in lower extremity lymphedema. It is well tolerated by patients and should be recommended as an adjunct to standard lymphedema therapy. Screening for venous insufficiency is recommended.

Full Program & Abstracts

4:48 pm – 4:56 pm

17 (CR)

Endovascular Management of Aortic Stump Pseudoaneurysm

Inkyong K. Parrack¹, Hasan Aldailami², Heather L. Gill², Peter H. Connolly¹, Darren B. Schneider¹, Andrew J. Meltzer¹ - ¹NY Presbyterian-Cornell University, New York, NY; ²McGill University, Montreal, QC, Canada

Introduction and Objectives: 67 year old man presented with abdominal pain. PMH was significant for CMML, COPD requiring oxygen, and afib. Surgical history was notable for EVAR in the setting of ruptured AAA 4yr earlier with a subsequent graft infection requiring stent graft explantation, axillo-bifemoral bypass, with the aorta oversewn above the lower renal artery. Emergent CTA was performed that revealed a contained rupture of the aortic stump, measuring >7cm.

Methods: This high-risk patient was deemed unlikely to have a good outcome with an open surgical repair. He agreed to undergo endovascular repair via compassionate use of physician-modified endograft. A branched device was created using the Cook Zenith platform. The iliac limbs were constrained to 8mm and a third 8mm limb affixed to the bifurcation of the device. After removal of the suprarenal stents, the device was resheathed “upside down” in a 24Fr sheath using a customized loading capsule and delivery system with branch pre-cannulation.

10mm Dacron conduit was sewn to the axillary artery, and the device was introduced through the conduit and into the thoracic aorta. Following deployment of the main body, the visceral arteries were cannulated. Branches consisting of Viabahn lined with self-expanding nitinol stents were extended from the device into all target vessels.

Results: Completion angiography revealed exclusion of the aortic stump with no endoleak, with perfusion of all visceral targets. The patient did well and was discharged 3days later. Follow-up CTA at 1month demonstrated an excellent result.

Conclusions: Endovascular repair via physician-modified endograft is a viable option for patients with an urgent and complex aortic pathology who may not be amenable to an open operation.

Full Program & Abstracts

4:56 pm – 5:04 pm

18 (RF)

Surgical Revascularization of Iliac Occlusive Disease: A Contemporary Series

Rose An, Mohammed M. Moursi, Guillermo A. Escobar, Ahsan T. Ali, Matthew R. Smeds - University of Arkansas for Medical Sciences, Little Rock, AR

Objectives: Surgical management of iliac occlusive disease is performed less frequently with increasing endovascular revascularization options. In selected patients, ilio-femoral (IFB) or femoral-femoral bypass (FFB) can be a durable option for repair. The purpose of our study was to review the safety and patency of these procedures in the modern era.

Methods: Patients undergoing open revascularization by IFB or FFB at a single institution between January 2003 and January 2013 were reviewed (n=117). Patients treated for aneurysmal disease, those with aortic occlusive disease, and those with no follow-up were excluded from analysis. Demographics, intraoperative data, postoperative complications and follow up patency was evaluated.

Results: We identified 72 patients undergoing IFB and 30 undergoing FFB with average follow up of 36 months (Range: 1-136) and 41 months (Range: 1-109) respectively. Demographics were similar between the two groups. Polytetrafluoroethylene was used in all cases. There were no perioperative deaths. Secondary procedures to improve inflow/outflow were performed in 29% (21/72) of IFB cases and 47% (14/30) of the FFB cases ($p = 0.11$). ABI improved from 0.39 preoperatively to 0.79 postoperatively ($p=0.0001$) with no statistical difference between IFB and FFB groups. Kaplan-Meier life table analysis was used to analyze outcomes of survival, primary and secondary patency. Primary patency at 1 and 5 years was 94% and 66% respectively for the IFB group and 89% and 68% for the FFB group. 5 year secondary patency improved to 77% in the IFB group and 82% in the FFB group. 5 year survival was similar between the two groups (70% in the IFB group vs. 74% in the FFB group respectively).

Conclusions: Both femoral-femoral and ilio-femoral bypasses may be durable options in select patients with complex ilio-femoral occlusive disease with similar 5 year patency and survival.

Full Program & Abstracts

5:04 pm – 5:12 pm

19 (RF)

A Validated Method For Automatic Data Extraction From Electronic Medical Records To Increase the Ease and Accuracy of Retrospective Chart Review

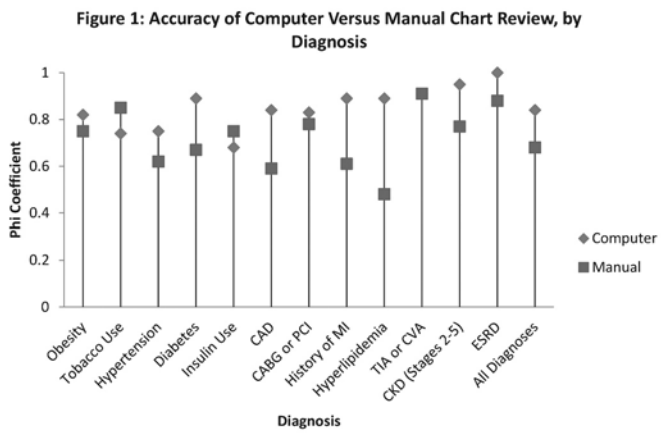
Matthew E. Bennett, Thomas M. Loh, Jean Bismuth - Houston Methodist Hospital, Houston, TX

Introduction and Objectives: Retrospective research studies require extensive searching of prior medical records to obtain relevant information about each patient. This process is time consuming, labor intensive, and error-prone. We validated a method whereby relevant past medical history is automatically extracted from structured text documents stored in the electronic medical record.

Methods: Subjects under an existing vascular research protocol were randomly selected for evaluation. Coding abstracts were collected, automatically parsed, and diagnoses identified and tabulated based on keyword identification. Output was compared with results obtained by research assistants manually reviewing patient charts. Discrepancies between computer and manual measurements were re-reviewed to determine the source of disagreement. The phi coefficient (ϕ) was calculated for each data gathering method versus the true presence of diagnoses.

Results: 40 patients were analyzed. The automated computer method's output correlated more strongly with true presence of diagnoses (mean $\phi=0.83$ computer versus 0.69 manual, $p=0.002$). Except for tobacco and insulin use, all other diagnoses were equally or more accurately classified by the computer (Figure 1). The computer versus manual error rate was significantly less (5.5% versus 13%, $p<0.001$), due primarily to missed diagnoses by manual reviewers. The computer analyzed a median of 3 documents per patient. 53% of computer errors occurred when only a single document was analyzed ($n=14$ patients).

Conclusions: Automated data extraction from text documents is a valid and useful tool for conducting large retrospective studies. It reduces errors in the data gathering and entry process as compared to manual chart review, especially when extracting data from multiple documents. It will substantially increase the speed and accuracy of retrospective chart reviews at our institution, and possibly elsewhere.



Full Program & Abstracts

5:12 pm – 5:24 pm

20

Assessing the Validity of the Procedure Based Assessment Tool During Vascular Cadaveric Simulation Training: Results From An Un-Blinded Observational Study

Lucy Green, Christina K. Moody, Rachel Barnes, Ian C. Chetter - Hull York Medical School, Hull, United Kingdom

Introduction and Objectives: Simulation training is becoming increasingly recognised as an important adjunct to training. In order to integrate such training into curricula a valid assessment method needs to be established. The aim of this study is to determine if Procedure Based Assessment (PBA) is a valid method of assessing trainees, as determined by previous operative experience, in simulated cadaveric vascular procedures.

Methods: General, vascular and orthopaedic trainees were recruited from cadaveric skills courses based at the Royal College of Surgeons of England and assessed using the procedural checklist and global summary score of the PBA tool. Trainees gave self reported numbers of operations previously observed and performed as a measure of previous operative experience. Validity was determined using Spearman's Correlation Coefficient.

Results: Ninety four assessments were performed for above and below knee amputations and arteriovenous fistula. PBA demonstrated construct validity for previous operative experience in number of procedures observed and performed. The strongest correlations were seen for number of procedures previously performed ($r = .373$ $p = .000$) for the procedural checklist and ($r = .453$ $p = .000$) for the global summary score. The level of assessor had a non significant effect on scores.

Conclusions: Previous experience as primary operator correlates to a higher degree with PBA scores in simulated cadaveric procedures suggesting that trainees derive greater benefit from doing rather than just observing. Surgical training should incorporate focused skills training in the future. The level of assessor had a non significant impact which may indicate that PBA could be used by assessors other than consultants.

Full Program & Abstracts

5:24 pm – 5:36 pm

21

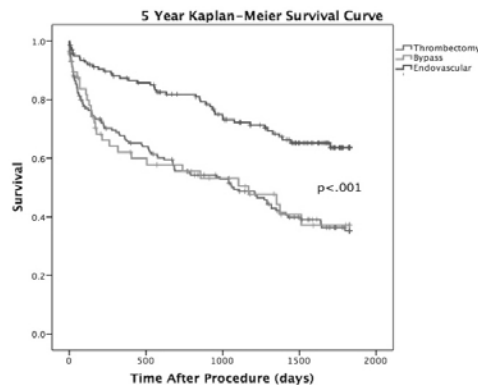
Risk Factors For Long-Term Mortality and Amputation After Open and Endovascular Treatment of Acute Limb Ischemia

Elizabeth A. Genovese, Rabih A. Chaer, Ashraf G. Taha, Luke K. Marone, Efthymios Avgerinos, Michel S. Makaroun, Donald T. Baril - University of Pittsburgh Medical Center, Pittsburgh, PA

Introduction and Objectives: To determine predictors of long-term mortality and amputation following open and endovascular treatment of acute limb ischemia(ALI).

Methods: A retrospective review of ALI patients at a single institution from 2005-2011 was performed. Data on demographics, presentation, treatment, perioperative adverse events, limb salvage and survival were analyzed using Kaplan-Meier and Cox proportional hazards models.

Results: 445 limbs in 411 patients were treated for ALI. Interventions included thrombectomy(49%), bypass(19%), and endovascular revascularization (32%). Mean age was 68 ± 14.8 , 54% were male, and 23% had cancer. The majority of patients presented with Rutherford Class IIa(54%) or IIb(39%). Etiology of ALI included emboli(27%), in-situ thrombosis(28%), failed bypasses(32%), and thrombosed stents(13%). Patients treated with open procedures had significantly more advanced ischemia and higher rates of perioperative respiratory failure; rates of post-procedure bleeding and cardiac events were similar between treatments. Excluding Rutherford III patients ($n=12$), overall 5-year survival was 53%, stratified by treatment was 43% for thrombectomy, 49% for bypass, 67% for endovascular ($p<.001$)(see Graph); 5-year limb salvage was 81%, stratified by treatment was 82% for thrombectomy, 73% for bypass, and 83% for endovascular ($p=0.042$). Adjusting for comorbidities, patient presentation, adverse events and treatment method, the risk of mortality increased with age ($HR=1.03, p<.001$), female gender ($HR=1.48, p=.028$), cancer ($HR 2.19, p<.001$), in-situ thrombosis ($HR=1.91, p=.005$), cardiac adverse events ($HR=2.93, p<.001$), respiratory failure ($HR=2.75, p<.001$), hemodialysis ($HR=4.45, p<.001$) and bleeding events ($HR=2.04, p=.005$). Risk of amputation increased with advanced ischemia (IIa $HR=2.4, p=.001$) bypass thrombosis ($HR=3.87, p=.001$), technical failure of primary intervention ($HR=5.5, p<.001$), and open revascularization ($HR=1.77, p=.043$).



Full Program & Abstracts

Conclusions: Following treatment for ALI, long-term mortality and amputation rates were higher in patients treated with open techniques. Additionally, overall mortality rates were high and most strongly associated with patient comorbidities, presentation, and perioperative adverse events. Comparatively, amputation risk was increased with advanced ischemia, thrombosed bypass, and failure of the initial procedure.

Full Program & Abstracts

5:36 pm – 5:48 pm

22

The Prevalence of Bovine Aortic Arch Configuration In Adult Patients With and Without Thoracic Aortic Pathology




Pamela A. Moorehead, Ann Kim, Tejas V. Kashyap, Daniel E. Kendrick, Vikram S. Kashyap - University Hospitals Case Medical Center, Cleveland, OH

Introduction and Objectives: Bovine aortic arch occurs in approximately 15% of the US population (35% in African Americans and 13% in Caucasians), and is regarded as a clinically insignificant, normal variant. The aim of this study is to assess the prevalence of types I (T1BA, common origin of innominate/left CCA) and II (T2BA, left CCA originates from innominate) bovine arch in patients with and without thoracic aortic pathology.

Methods: We retrospectively reviewed all serial CT images (n=817) performed at our institution over four months to determine overall prevalence of BA. Thoracic aorta/arch vessels were visualized, with images read by certified radiologists. A separate analysis compared a series of 157 consecutive patients with thoracic pathology (dissection (TAD; n=26) or aneurysm \geq 4.0cm (TAA; n=130)) from a 25 month period, to 757 control patients without pathology from the original sample. Statistical analysis included a chi-square contingency table.

Results: Analysis revealed a prevalence of 31.1% BA (n=254), including 14.9% T1BA and 16.1% T2BA. There was increased prevalence of T2BA in the pathology group (23.7%) compared with controls (15.9%; p=0.03). T1BA was not significantly different between groups (11.5% v. 14.9%; p=0.59). When thoracic disease was stratified by pathology type, T2BA occurred more frequently in patients with TAA (24.6% v. 15.9%; p=0.04). A general, but non-significant trend toward increased T2BA occurred in patients with TAD (19.2% v. 14.9%; p=0.56).

Conclusions: Our analyses revealed a prevalence of bovine arch of 31%, consistent with the demographics of our patient population. T2BA occurred more frequently in patients with thoracic aortic pathology than those without pathology. Therefore, patients with BA may be associated with higher levels of thoracic aortic pathology and require increased vigilance.

	 Standard Arch	 T1BA	 T2BA
Control	524 (69.2%)	113 (14.9%)	120 (15.9%)
Aortic Pathology	101 (64.7%)	18 (11.5%) (p = 0.59)	37 (23.7%) (p = 0.03)
Dissection	15 (57.7%)	6 (23.1%) (p = 0.24)	5 (19.2%) (p = 0.56)
Dilation (\geq 4 cm)	86 (66.2%)	12 (9.2%) (p = 0.20)	32 (24.6%) (p = 0.04)

Full Program & Abstracts

5:48 pm – 6:00 pm

23

Preoperative Frailty Increases Risk of Non-Home Discharge After Elective Vascular Surgery In Home-Dwelling Patients

Shipra Arya¹, Chandler Long¹, Reshma Brahmabhatt¹, Susan Shafii¹, Luke P. Brewster¹, Ravi Veeraswamy¹, Theodore M. Johnson, II¹, Jason M. Johanning² - ¹Emory University, Atlanta, GA; ²University of Nebraska Medical Center, Omaha, NE

Introduction and Objectives: Patient-centered quality outcomes such as disposition after surgery are increasingly being scrutinized. Preoperative factors predictive of non-home discharge (DC) may identify at risk patients for targeted interventions. This study examines the association between preoperative risk factors, frailty, and non-home DC after elective vascular surgery procedures.

Methods: The 2011-2012 NSQIP database was queried to identify all home-dwelling patients who underwent elective vascular procedures. Preoperative frailty was measured using the modified frailty index (mFI; derived from Canadian Study of Health and Aging). Univariate and multivariate analysis was performed to examine association of frailty and non-home DC.

Results: Of 16,035 home-dwelling patients, 1,369 patients (8.5%) did not return home postoperatively. Female gender, open procedures, age, body mass index (BMI), non-smoking status, dyspnea, occurrence of any postoperative complication were associated with increased risk of non-home DC in univariate analysis. Frailty [mFI>0.25] conferred a significantly increased risk of non-home DC disposition for each procedure type (Table 1). On multivariate logistic regression analysis, frailty increased the odds of non-home DC 1.7 times [Odds Ratio 1.7; 95% CI (1.4-1.9)] after adjusting for other covariates including complications. In the presence of complications, the risk of non-home DC was 30% in frail vs 19% non-frail patients (p<0.001). In the absence of complications although absolute risk was lower, frail patients were twice as likely to not return home (Frail 6% vs non-frail 3.3%, p<0.001).

Conclusions: Frail home-dwelling patients undergoing elective vascular procedures are at high risk of not returning home after surgery. Preoperative frailty assessment appears to hold potential for counseling regarding post surgery disposition and DC planning.

Full Program & Abstracts

Table 1. Procedure type and risk of non-home discharge (DC) by frailty (mFI>0.25).

Procedure	N	Prevalence Frailty	Non-home discharge (%)	
		n (% of total)	Frail patients	Non-frail
Endovascular aneurysm repair	2431	555 (22.8%)	56 (10.1%)	118 (6.3%)
Open aortic aneurysm repair	756	160 (21.2%)	58 (36.3%)	108 (18.1%)
Infra-inguinal bypass	3158	1559 (49.4%)	358 (22.9%)	187 (11.7%)
Supra-inguinal bypass	1360	510 (37.5%)	105 (20.6%)	87 (10.2%)
Peripheral vascular interventions	2231	966 (43.3%)	49 (5.1%)	33 (2.6%)
Carotid stenting	118	47 (39.8%)	2 (4.3%)	0 (0%)
Carotid endarterectomy	5981	2201 (36.8%)	115 (5.2%)	93 (2.5%)
Total	16035	5998 (37.4%)	743 (12.4%)	626 (6.2%)

p<0.01 for each procedure type comparing non-home DC risk in frail patients to non-frail

6:00 pm – 7:00 pm

VESS MEMBER BUSINESS MEETING

7:15 pm

Free Evening

Full Program & Abstracts

Saturday, January 31, 2015

6:00 am – 7:00 am Continental Breakfast

6:00 am – 9:30 am Registration

6:48 am – 9:00 am SCIENTIFIC SESSION III

6:48 am - 7:00 am

33*

Maximizing the Versatility of Endovascular Robotics Using Dynact Image Fusion Guidance To Facilitate Navigation

Cassidy Duran¹, Alan B. Lumsden¹, Ponraj Chinnadurai², Jean Bismuth¹- ¹The Methodist DeBakey Heart & Vascular Center, Houston, TX; ²Seimen, Hoffman Estates, IL

Objective: To report our initial experience of using intra-operative C-arm Cone beam CT (DynaCT®) image fusion guidance along with steerable robotic endovascular catheter navigation to facilitate visceral vessel cannulation procedures.

Methods: Between October 2012 and August 2014, 11 patients underwent endovascular procedures using DynaCT image fusion technique along with Hansen Magellan vascular robotic catheter. All patients had pre-operative contrast enhanced multi-slice CT imaging (MSCT). For case planning, relevant landmarks and centerlines were electronically marked and stored. At the beginning of each procedure, a non-contrast DynaCT® was acquired in the hybrid operating room equipped with a flat-panel robotic C-arm angiographic system. Pre-operative images were co-registered to intra-operative DynaCT images using bony structures. Stored landmarks were overlaid on 2D fluoroscopic images as virtual markers. Vascular access and the robotic catheter were setup and performed per standard. Vessel cannulation was attempted based on virtual markers using robotic catheter. The impact of these virtual markers from image fusion on vessel cannulation was evaluated retrospectively.

Results: All 14 vessels were cannulated successfully in 11 patients' attempted using image fusion guidance. Median vessel diameter at origin was 5.1 mm (2.3 to 13mm), while 10/14 vessels had either calcified/stenosed origin from parent vessel, accounting for the range of vessel diameters. 8/14 vessels (57.1%) were cannulated without any contrast injection. Median number of angiograms required before cannulation was 0 (0 - 2). On qualitative assessment, 11/12 vessels (91.7%) had grade=1 accuracy (guide-wire inside virtual ostial marker). 11/11 vessels had grade=1 accuracy (virtual centerlines that matched with the actual vessel trajectory during cannulation).

Conclusion: Our initial experience with using DynaCT image fusion guidance along with steerable endovascular robotic navigation indicates that such strategies enhance intra-operative 2D fluoroscopy and could play a role in reducing contrast agent use thereby maximizing the versatility of endovascular robotic technology.

*Please Note: This paper is being presented earlier and out of sequence to accommodate additional programming.

Full Program & Abstracts

7:00 am – 7:12 am

24

Contemporary Outcomes For Autogenous Infrainguinal Bypass In the Endovascular Era

Mahmoud B. Malas, Isibor J. Arhuidese, Tammam Obeid, Alaa Khaled, Karren Massada, Caitlin Hicks, Umair Qazi, Thomas Reifsnnyder - Johns Hopkins Medical Institutions, Baltimore, MD

Introduction and Objectives: We aim to evaluate the current long-term outcome of lower extremity open revascularization in this era of increasing use of endovascular alternatives.

Methods: We evaluated all patients who had infrainguinal bypass conduits placed for peripheral arterial disease in our institution from January 2007 to July 2014. Univariate methods (Chi Square, ANOVA) were employed to compare patients' characteristics. Kaplan-Meier and Cox regression analyses were employed to evaluate graft failure and identify its predictors. Outcomes were defined per the Society for Vascular Surgery standards.

Results: There were 436 autogenous grafts (Femoral-Popliteal: 32%, Femoral-Tibial: 39%, Popliteal-Tibial : 27%, Tibial-Tibial : 2%) placed in 372 patients with a mean age of 67 (S.D:11.6) years. Most of our patients were male (59%) and white (73%). The majority of our patients (85%) presented with critical limb ischemia (CLI). Sixty-nine cases (16%) were redo bypasses from outside institutions. Arm veins and spliced conduits were utilized in 15% and 14% of cases, respectively. Primary patency at 1, 3 and 5 years was 68%, 61% and 57% respectively. Primary assisted patency was at 90%, 82% and 78% at 1, 3 and 5 years respectively. Patency was significantly higher for grafts harvested from the lower versus upper extremities and for proximal vs. distal bypass (table 1). Limb salvage rate was 87%. Significant predictors of graft failure were older age, hypertension, hyperlipidemia, current smoking and prior bypass (P<0.05).

Conclusions: In this current cohort of patients, we have demonstrated that infrainguinal bypass remains the gold standard for lower extremity revascularization. Patency and limb salvage rates are optimized with exclusive selection of autogenous conduits, careful follow up and intervention and proper management of comorbidities.

Table 1: One, three and five year primary assisted patency rates (all p<0.05).

Bypass	1 Year % (95% CI)	3 years % (95% CI)	5 years % (95% CI)
Femoral-Popliteal	88.0 (80.1-93.0)	84.5 (74.9-90.7)	81.4 (69.5-89.0)
Femoral-Tibial	91.0 (84.9-94.7)	80.7 (71.1-87.4)	77.1 (64.6-85.6)
Popliteal-Tibial	89.5 (81.2-94.3)	82.2 (69.7-89.9)	75.9 (56.9-87.4)

Full Program & Abstracts

7:12 am – 7:24 am

25

Influence of Gender On Abdominal Aortic Aneurysm Repair In the Community

Daiva Nevidomskyte, Sherene Shalhub, Singh Niten, Nam Tran, Mark H Meissner - University of Washington, Seattle, WA

Introduction and Objectives: Women have been shown to experience inferior outcomes following intact and ruptured abdominal aortic aneurysm (AAA) treatment in endovascular (EVAR) and open surgical repair (OSR) groups. The goal of our study was to compare gender-specific presentation, management and early outcomes after AAA repair using a statewide registry.

Methods: We utilized the Washington State Surgical Care and Outcomes Assessment Program (VI-SCOAP) registry data collected in 19 hospitals from July 2010 to September 2013. Demographics, presentation, procedural data and outcomes in elective and emergent AAA repair groups were analyzed.

Results: We identified 1231 patients (19.6% women) who underwent intact (86.4%) or ruptured AAA (13.6%) repairs. 972 (79%) had EVAR and 259 (21%) had OSR. Men and women were of equivalent age and there were no differences in comorbidities or AAA family history. Women had smaller aneurysm diameters (6.2 ± 1.8 vs. 5.8 ± 1.1 cm, $p < .01$) at the time of presentation and men had slightly higher incidence of rupture at larger aneurysm size. Men were more likely to undergo EVAR, with the difference originating from elective treatment category (82.1% vs. 74.1%, $p=.01$). Overall, women had higher 30-day mortality (6.6% vs. 3.5%, $p=.03$) and significantly higher mortality rates in elective EVAR (3.1% vs. 0.6%, $p=.01$), but not ruptured or elective OSR groups. Following elective EVAR women were less likely to be discharged to home after longer hospital stays (3 days vs. 2 days, $p<.01$).

Conclusions: Despite presentation at a similar age, with a smaller aneurysm diameter, and lower incidence of rupture, women experience substantially worse hospital outcomes driven by elective endovascular procedures. Utilization of endovascular techniques in women still remains lower compared to men. Improvement of elective outcomes in women will likely depend on technical advancements in repair techniques and management strategies that may differ between genders.

Full Program & Abstracts

7:24 am – 7:36 am

26

Microembolic Risk of Carotid Artery Plaque Composition By MRI at the Time of Elective Revascularization

Jennifer R Li¹, Chiara Giannarelli¹, Venkatesh Mani¹, Errol Gordon¹, Prakash Krishnan¹, Jason Kovacic¹, George Dangas¹, Ziad Ali², Zahi Fayad¹, Juan Badimon¹, Peter Faries¹, Jose Wiley¹ - ¹Icahn School of Medicine at Mount Sinai, New York, NY; ²Columbia University Medical Center, New York, NY

Introduction and Objectives: Current guidelines for management of carotid atherosclerosis, the predisposing factor for ischemic stroke, are based on degree of stenosis and presence of symptoms. Both carotid endarterectomy (CEA) and minimally invasive (CAS) procedures pose risks to the patient, including peri/post-operative stroke. Intracerebral microembolization is a major factor leading to stroke after surgical or percutaneous revascularization. The ability of transcranial Doppler (TCD) to detect intraoperative microembolization, diffusion-weighted brain MRI to detect microinfarct lesions, and carotid MRI to provide detailed information on plaque morphology make these powerful tools in determining embolic potential. The study objective is to correlate high-risk plaque features as defined on carotid MRI and tissue histology with rates of intraoperative microembolism as detected by TCD and DW-MRI, with peri-operative changes in neurocognitive function, in a cohort of 150 patients undergoing elective CEA or CAS.

Methods: 150 patients undergoing either CAS or CEA are enrolled. A pre-procedural Mini-mental Status Exam, carotid MRI, and cerebral diffusion-weighted MRI are obtained within the week prior to procedure. All MRI are performed with 3T MR system. Transcranial Doppler intraoperatively monitor for microembolic signals (MES), detected as high-intensity unidirectional transient signals. Plaque specimen and filter debris are analyzed histologically. A post-procedure DW-MRI and MMSE are performed within 72 hours to examine for microinfarcts and changes in neurocognitive function.

Results: Ipsilateral MES have been detected in CEA primarily during the dissection phase and subsequent to release of carotid clamping, and in CAS during stent deployment and post-dilation. Pre- vs. post-procedural MMSEs demonstrate no significant neurological function change subsequent to MES. Carotid MRI images will be analyzed for presence of lipid-necrotic core, calcification, ulceration, and intra-plaque hemorrhage and correlated with plaque histology.

Conclusions: Preliminary results suggest that high-risk carotid atherosclerotic lesions identified by MRI criteria are associated with increased MES in patients undergoing carotid revascularization.

Full Program & Abstracts

7:36 am – 7:48 am

27

Natural History of Iatrogenic Pediatric Femoral Artery Injury

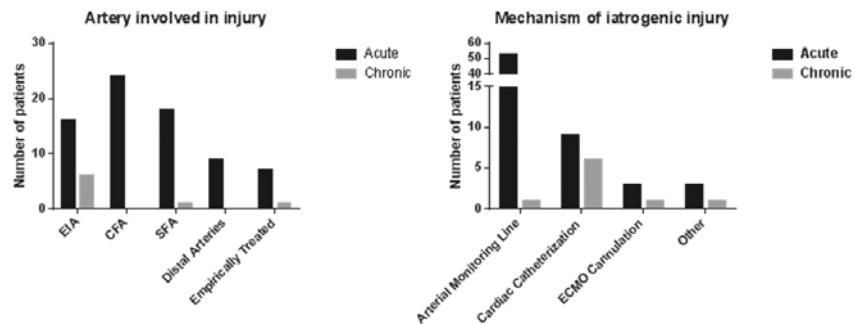
Elizabeth A. Andraska, Huiting Chen, Tatum O. Jackson, Katherine A. Gallagher, Jonathan L. Eliason, Dawn M. Coleman - University of Michigan, Ann Arbor, MI

Introduction: Iatrogenic femoral artery trauma complicates the course of critically-ill neonates and children. Complications from persistent arterial occlusion include claudication and limb length discrepancies. Data supporting risk factors for such and need for revascularization are lacking.

Methods: Review of a prospectively maintained database at a tertiary institution of iatrogenic pediatric femoral artery injuries incurred between 2013-2014 was performed. Additional injuries were identified by review of pediatric arterial duplex performed between 2008-2013. Demographics, risk factors and outcomes were queried. Data analysis utilized Fischer's exact t-test and logistic regression.

Results: Seventy-six patients were identified of which 68 presented with ALI and 8 with chronic arterial occlusion resulting in claudication (N=6) or limb length discrepancy (N=2). Figure 1 demonstrates anatomic pattern and mechanism of injury. Mean weight at injury was 6.3kg; mean age at injury was 49 weeks (50% aged <3 months). Mean follow-up was 14 months (out to 11 years). Six patients required surgery for ALI and 6 required delayed surgery for limb length discrepancy (N=4) or for persistent external iliac artery (EIA) occlusion. Mean age at delayed revascularization was 6 years (range 2-13y). Vasopressor use, mechanism/location of injury and concomitant venous thrombosis were not significantly correlated with need for surgery; trends suggested cardiac catheterization and EIA thrombosis may correlate with chronic disease. Increased age at injury was associated with need for surgery.

Conclusions: While a majority of children with ALI may be successfully treated medically, 9% will require surgery for ALI and 16% ultimately required surgery during follow-up. Persistent EIA thrombosis is a likely risk factor for limb length discrepancy with growth; identifying risk factors for this and improved methods for surveillance require ongoing investigation.



Full Program & Abstracts

7:48 am – 7:56 am

28 (CR)

Bullet Embolism To the Peripheral Vasculature, Two Cases

Nicholas B. Johnson, Katherine A. Rodby, Amir Vafa, Daniel Katz, Samantha Minc - Mount Sinai Hospital, Chicago, IL

Objective: Bullet embolism is a rare occurrence which unrecognized may result in loss of limb or life. We present two cases of bullet penetration into the aorta with embolization into the right common iliac and popliteal arteries respectively.

Methods: Two case reports and brief review of the literature.

Results: Over the period from 2007 to 2014, two cases of bullet embolism presented to a busy trauma center. Case #1, a 19 year-old male experienced no lasting adverse sequelae of the embolism, while Case#2, a 24 year-old male required fasciotomy secondary to limb ischemia with residual disability. Each patient presented with penetration of the aorta and embolism of a bullet into the periphery. In each case, the entry site at the thoracic (Figure 1A) and abdominal aorta respectively was controlled and repaired primarily. The retained missiles in the right common iliac (Figures 1B/C) and right distal popliteal arteries respectively were extracted through simple arteriotomies with primary closure.

Conclusions: A projectile which retains enough energy to pierce a vessel of larger caliber than itself, but not exit the other side may embolize. It is a rare finding. Review of 7,500 casualties of the Vietnam War by Rich et al. revealed 22 cases of projectile embolism (0.3%). The diagnosis, when missed or delayed may result in morbidity, amputation, and mortality. Bullet embolus should be considered when retained missiles, and entry and exit wound counts or sites are incompatible. The cases presented demonstrate successfully diagnosed and simply treated bullet embolism to the peripheral vasculature.

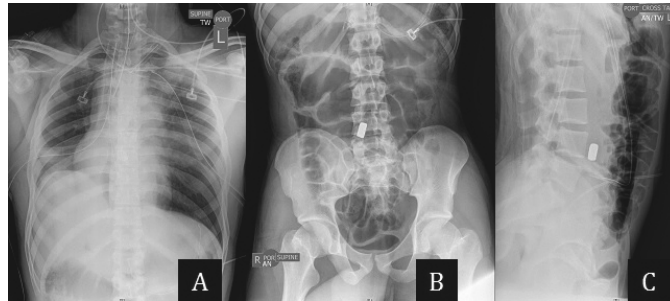


Figure 1: Case #1. A, Chest x-ray with thoracic hematoma. B, Large-caliber bullet embolus in right common iliac artery. C, Lateral demonstration of embolus.

Full Program & Abstracts

7:56 am – 8:04 am

29 (CR)

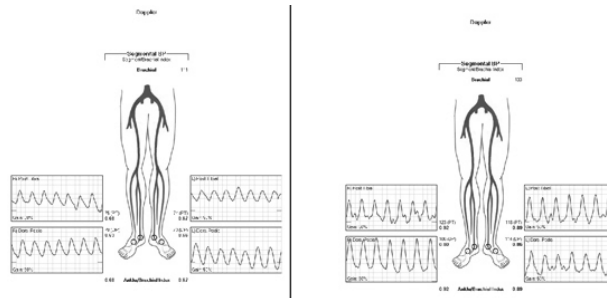
Axillary-Femoral Bypass May Provide Inadequate Distal Perfusion Compared To In-Line Large Diameter Aortic Reconstruction

Loren L. Masterson, Patrick Vaccaro, Michael R. Go - Ohio State University, Columbus, OH

Introduction: Standard treatment of aortic infection includes aortic excision and axillaryfemoral bypass, usually providing sufficient distal perfusion. However, we reported visceral and cord ischemia after thoracic aortic ligation and axillaryfemoral bypass corrected by ascending to abdominal aortic bypass, and here describe a case of claudication by ascending infrarenal aortic ligation and axillaryfemoral bypass. We theorize in select cases, even widely patent axillaryfemoral bypass may not provide sufficient distal perfusion.

Case: A healthy 48-year-old man had a motor vehicle crash, sustaining injuries requiring several operations and a prolonged course complicated by MRSA pneumonia. He recovered but later had unexplained fevers, bacteremia and developed an MRSA infected abdominal aortic aneurysm requiring axillary-bifemoral bypass with an 8 mm graft and aortic excision. He recovered, but never regained his previously palpable pedal pulses and had diminished ABIs with severe claudication despite imaging demonstrating no stenoses. He had thoracobifemoral bypass with 10 mm graft, regained palpable pulses and normal ABIs, and had complete resolution of symptoms.

Conclusion: Extra-anatomic bypass is commonly used in elderly, less active patients with infrarenal aortic occlusion and typically provides sufficient distal perfusion. However, in cases of supravisceral ligation or younger, active patients, it may not allow sufficient flow. During thoracoabdominal aneurysm repair, distal perfusion is objectively measured; effective left heart bypass should provide 60% of baseline flow and maintain distal pressures of 60-70 mmHg. Typically, flow rates of 25-40 ml/Kg/min are enough to maintain renal and cord perfusion. We suggest that intraoperative measurement of distal pressure after extra-anatomic bypass may help assure adequate perfusion in large, active patients or supravisceral aortic ligation.



Full Program & Abstracts

8:04 am – 8:12 am

30 (RF)

Peak Ankle Velocities and Average Ankle Velocities Utilized For Identifying Critical Limb Ischemia

Justin Brown, Shannon Rosati, Daniel Newton, Jill Peysha, Michael Amendola, Luke Wolfe, Mark Levy - Virginia Commonwealth University, Richmond, VA

Introduction: The arterial-brachial index (ABI) is an accepted measure to identify critical limb ischemia. In certain patient populations, i.e. diabetics, ABI does not accurately estimate lower extremity (LE) arterial perfusion. We therefore aim to investigate other reliable indicators of critical limb ischemia in patients in whom ABI measurements are unreliable.

Methods: A retrospective review of all (LE) arterial duplexes and ABI measurements simultaneously performed between January 2010 and June 2014 was conducted. An ABI of < 0.5 was chosen to represent critical limb ischemia. Peak Ankle Velocity (PAV) was defined as the higher psv measured at the ankle AT and PT. Average Ankle Velocity (AAV) is the mean psv of the AT and PT. Previous ROC analysis observed $PAV < 40$ and $AAV < 30$ as appropriate threshold for evaluation.

Results: A total of 761 studies were initially evaluated with 202 excluded for bypasses or supraphysiologic ABIs. Diabetics represented 256 (46%) of studies. Analysis of the studies demonstrated 316 (57%) had a $PAV < 40$. Similarly 306 studies (55%) had an $AAV < 30$. When combining the variables we observed that 277 (50%) studies had neither $PAV < 40$ nor $AAV < 30$, 68 (12%) had either $PAV < 30$, and 214 (38%) had both a $PAV < 30$. In patients with an $AAV < 30$ or a $PAV < 40$ we observed 89% sensitivity and 96% negative predictive value for an ABI is < 0.50 .

Conclusion: Determining critical limb ischemia in patients with unreliable ABIs remains difficult. A $PAV < 40$ or an $AAV < 30$ has a high sensitivity and negative predictive value in detecting critical limb ischemia. This can be used as a valuable tool for all patients with potential limb ischemia.

Full Program & Abstracts

8:12 am – 8:24 am

31

Applicability of the Society for Vascular Surgery's Objective Performance Goals for Critical Limb Ischemia To Current Practice of Lower Extremity Bypass

Julia T. Saraidaridis, Virendra Patel, Robert T. Lancaster, Richard P. Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

Objectives: In 2009, the SVS established objective performance goals (OPG) for critical limb ischemia based on data from previous, randomized, controlled trials of lower extremity bypass (LEB). These OPG sought to establish a benchmark from which to compare future endovascular therapy against established lower extremity bypass outcomes. However, the cohort used to develop the OPG excluded all patients who required prosthetic conduit and those with end stage renal disease (ESRD), possibly limiting the generalizability of these recommendations. The goal of this study was to determine if the SVS OPG are applicable to the current population of patients undergoing LEB.

Methods: All patients who underwent infrainguinal LEB for critical limb ischemia from January, 2010 to June, 2014 were identified in a prospectively maintained database. Patients were stratified into OPG eligible and ineligible (nonOPG) groups based on their demographic and operative characteristics. Outcomes included 30 day major adverse limb events (MALE), major adverse cardiac events (MACE), 1-year survival, and 1-year limb salvage.

Results: There were 93 individual patients identified. Only 47 (49%) patients met OPG inclusion criteria. The 30-day MALE was 11% (14.9%nonOPG vs. 6.5%OPG; p=.19) and the MACE was 10.8% with no difference between the cohorts (12.7%nonOPG vs. 8.7%OPG, p=0.53). 1-year survival was 80%+/-4% (70.7%nonOPG vs. 88.5%OPG; p=.26) and 1-year limb salvage was 73%+/-5% (60%nonOPG vs. 85%OPG; p=.03)

Conclusions: The SVS OPG for LEB are likely not generalizable to current practice as 51% of patients would have been excluded from the SVS cohort due to ESRD and prosthetic conduit. SVS OPG were attainable in patients who met SVS OPG inclusion criteria; but for the patients who are not OPG eligible, new benchmarks are needed.

Full Program & Abstracts

8:24 am – 8:32 am

32 (CR)

Resection of A Large Innominate Vein Aneurysm In A Patient With Neurofibromatosis Type 1

Peter B. Bartline, Stephen H. McKellar, Daniel V. Kinikini - University of Utah, Salt Lake City, UT

Introduction: Venous aneurysms are exceedingly rare manifestations of Neurofibromatosis Type 1 (NF1). There are only a handful of cases reported, and no prior cases describing treatment of mediastinal venous aneurysms in this patient population exist.

Report: A 58 year-old female with NF1 presented with a right neck mass. The mass had recently doubled in size and was associated with cough, hoarseness of voice, and pain. Her pertinent past medical history included untreated obstructive sleep apnea, severe pulmonary hypertension, and a recent hospital admission for pneumonia. On physical exam, numerous cutaneous neurofibromas were noted. The mass encompassed her right neck and supraclavicular area with marked respiratory variation. CT showed a complex 7 cm venous aneurysm including her right innominate, internal jugular, and subclavian veins. Her symptoms, rapid aneurysm growth, and risk of rupture compelled us to offer repair. The surgical approach involved median sternotomy with right cervical extension and a right infraclavicular counter-incision. Extracorporeal circulation was established through the left groin. Ligation of the right internal jugular vein was required. The aneurysm was completely excised and venous reconstruction consisted of cryovein anastomosed to right innominate vein and infraclavicular subclavian vein. Intraoperatively, her preexisting pulmonary hypertension resulted in acute right heart failure requiring placement of a right ventricular assist device (RVAD). She subsequently returned to the operating room for RVAD weaning and sternal closure. Her post-operative course was lengthy, however her aneurysm-related symptoms resolved.

Conclusions: This case represents management of the only innominate vein aneurysm in the setting of NF1 described in the literature. Vascular reconstruction is possible, however difficult. Careful pre-operative planning and use of extracorporeal circulation was necessary in this case.

Full Program & Abstracts

33

Paper #33 is being presented at 6:48 am (instead of 8:32 am) to accommodate additional programming. See page 48.

8:32 am – 8:37 am	Introduction of Honorary Members
8:37 am - 8:42 am	Gore Travel Award Winner Announcement
8:44 am – 9:00 am	INTRODUCTION OF THE PRESIDENT
9:00 am – 9:45 am	PRESIDENTIAL ADDRESS Music, Evolution and Progress Vikram Kashyap, MD
10:00 am - 1:00 pm	SVM VASCULAR LAB REVIEW COURSE - PART 2 (Separate Subscription)
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks

Full Program & Abstracts

4:00 pm – 6:00 pm

SCIENTIFIC SESSION IV

4:00 pm – 4:12 pm

34

Cost Analysis of Angioplasty Versus Stenting in the Treatment of Peripheral Arterial Disease

Margarita Vinogradova, Jessica Paz, Jacob Loeffler, Misty Humphries - University of California, Davis Medical Center, Sacramento, CA

Introduction and Objectives: Endovascular techniques are now first line treatment for patients with peripheral arterial disease (PAD). Debate continues over the use of primary stenting (PS) vs. balloon angioplasty (BA) of the femoropopliteal vessels. This study aims to compare costs associated with angioplasty and stenting during infrainguinal endovascular interventions.

Methods: A retrospective analysis of all patients that underwent infrainguinal treatment of PAD (n=106) between 2006 and 2014 was performed. Demographic, procedural, and cost data associated with the initial procedures, surveillance, follow-up, and reintervention was collected. Only patients with complete cost data were included in the analysis (PS=15 vs. BA=9).

Results: There was no significant difference in gender, age, smoking status, or TASC classification between patients that underwent only BA compared to those that had stent placement. Patients treated by BA had longer vessel treatment lengths (10mm vs. 7.5mm) and were more likely to have a tibial vessel treated (4) than patients with PS (2), although these values did not reach statistical significance. On average PS cost \$14,019 more than BA (Figure 1). There was no significant difference in clinical follow-up, radiographic surveillance, or secondary procedure costs. Patients in the PS group were more likely to have a secondary procedure and revenue from BA procedures did not recover the cost of the procedure in 63% of patients, although this too was not statistically significant.

Conclusions: Although PS placement has been advocated in the treatment of femoropopliteal disease, the increased costs of stents and costs of secondary procedures in patients after PS may not be cost effective. Further research is needed to evaluate cost of angioplasty vs. stent placement with long term outcomes that include secondary procedures.

Cost \$USD Median (\$ IQR)	Angioplasty Group	Stent Group	p-value
Total Costs	9622 (8447, 15436)	23641 (15623, 28402)	0.03
Initial Procedural Costs	8458 (6946, 12979)	13956 (10917, 19008)	0.03
Clinical Follow-up Costs	977 (170, 1330)	841 (388, 1202)	1.00
Radiology Follow-up Costs	519 (436, 1346)	568 (211, 935)	0.79
Secondary Procedure Costs	0 (0, 0)	0 (0, 12644)	0.30
Patients with Negative Cost Margin n (%)	5 (63%)	6 (38%)	0.47

Full Program & Abstracts

4:12 pm – 4:24 pm

35

Mortality and Cost of Chronic and Acute Kidney Disease After Vascular Surgery

Azra Bihorac, Matthew Huber, Tezcan Ozrazgat-Baslanti, Paul Thottakkara, Robert Feezor, Charles Hobson - University of Florida, Gainesville, FL

Introduction: Both chronic (CKD) and acute kidney disease (AKI) are common yet underappreciated risk factors for adverse perioperative outcomes. We hypothesize that AKI and CKD are associated with similar increases in hospital mortality and cost in patients undergoing major vascular surgery.

Methods: We used multivariable regression analyses to evaluate the associations between acute and chronic kidney disease and incremental hospital mortality and cost in a single-center cohort of 3,646 adult patients undergoing major vascular surgery. We defined AKI using KDIGO (Kidney Disease: Improving Global Outcomes) criteria as change in creatinine ≥ 0.3 mg/dl or $\geq 50\%$ increase from the reference value. CKD was determined from medical history. Regression models were adjusted for demographic and socio-economic characteristics, comorbid conditions, surgery type, and postoperative complications.

Results: The prevalence of kidney disease among vascular surgery patients is high with 49% of patients developing AKI. In risk-adjusted logistic regression analysis, postoperative AKI without CKD (OR 3.6, 95% CI 1.9-6.8) or with underlying CKD (OR 2.5, 95% CI 1.2-5.5) was the most significant predictor of hospital mortality, even higher than end stage renal disease. The risk-adjusted average cost was significantly higher for patients with any type of kidney disease. The incremental cost of having any type of kidney disease ranged from \$4,300 to \$19,800, even after adjustment for underlying comorbidities and other postoperative complications (Table).

Conclusions: Kidney disease after major vascular surgery is associated with significant increase in hospital mortality and cost with the highest risk observed among patients with AKI regardless of previous CKD.

Full Program & Abstracts

	Hospital mortality		Hospital Cost		
	Risk-adjusted odds ratio (95% CI)	Risk-adjusted mean% (95% CI)	Risk-adjusted Relative Cost Ratio (95% CI)	Risk-Adjusted Incremental Cost per Patient (\$1000) Mean (95% CI)	Risk-Adjusted Average Cost per Patient (\$1000) Mean (95% CI)
Patients with no kidney disease (n=1557, 43%)	1 (Reference)	2.9 (1.4, 4.3)	1 (Reference)	0 (Reference)	39.0 (37.6, 40.4)
AKI without CKD (n=1465, 40%)	3.58 (1.88, 6.8) ^a	7.3 (6.3, 8.3) ^a	1.25 (1.2, 1.31) ^a	9.8 (7.9, 11.7) ^a	48.8 (47.4, 50.2) ^a
AKI with CKD (n=336, 9%)	2.53 (1.17, 5.45) ^a	5.7 (4.2, 7.3) ^a	1.51 (1.4, 1.63) ^a	19.8 (15.7, 23.9) ^a	58.9 (55.3, 62.4) ^a
CKD without AKI (n=160, 4%)	1.07 (0.31, 3.72)	3.0 (0.5, 5.6)	1.11 (1.01, 1.22) ^a	4.3 (0.3, 8.2) ^a	43.3 (39.7, 46.9) ^a
End stage renal disease (n=128, 4%)	2.73 (0.96, 7.79)	6.1 (2.8, 9.4)	1.44 (1.28, 1.62) ^a	17.0 (10.7, 23.3) ^a	56.0 (50.1, 61.9) ^a

CI, confidence interval; ^a P<0.05 compared to patients with no kidney disease.

Full Program & Abstracts

4:24 pm – 4:36 pm

36

Comparison of Non-Penetrating Titanium Clips Versus Continuous Polypropylene Suture In Dialysis Fistula Creation

Khanh Nguyen¹, Olamide Alabi², Theodore Teruya², Neha Sheng², Christian Bianchi², Jason Chiriano², Sheela Patel², Ahmed Abou-Zamzam, Jr.² - ¹Oregon Health Sciences University, Portland, OR; ²Loma Linda University Medical Center, Loma Linda, CA

Introduction and Objectives: Non-penetrating titanium clips (clips) offer a theoretical advantage of inducing less intimal hyperplasia at an anastomosis due to less endothelial injury. Whether this translates into improved outcomes when used in creating arteriovenous fistulas (AVF) remains unclear. We sought to compare the maturation, patency and failure rates of anastomoses created using traditional continuous polypropylene suture (suture) and clips.

Methods: All primary AVF created at a single Veterans Administration medical center were reviewed over a 5-year period. Anastomoses were created with either clips or suture based on surgeon preference. Patient characteristics and surgical outcomes were collected. Comparisons were made between the two groups.

Results: Over a five-year period, 484 fistulas were created (71% clips and 29% suture) in 484 patients. The mean age was 65±11 years with 96% males. Comorbidities included diabetes (73%), hypertension (97%), and tobacco use (50% previous or current). Fifty-four percent of patients were pre-dialysis. Comparison of patient characteristics showed no differences between the clip and suture groups. There was no significant difference in maturation rate (72 vs. 80%, p=0.17), median time to maturation (71±13 vs. 62±35 days, p=0.07), 1-year functional primary patency rate (39.3 vs. 33.9%, p=0.29) or 1-year assisted patency rate (78.1 vs. 78.6, p=0.95). Functional patency rates were not significantly different at 2 or 5 years. Median time to first failure or reintervention was significantly longer in the clip group (944±92 vs. 777±254 days, p=0.01).

Conclusions: Compared to traditional polypropylene suture creation of upper extremity arteriovenous fistulas, non-penetrating clips had equivalent maturation, 1, 2 and 5-year functional patency rates. The use of clips was associated with a longer time to first failure or reintervention. Neither clips nor suture offer any clear advantage in the creation of arteriovenous fistulas.

Full Program & Abstracts

4:36 pm – 4:48 pm

37

Ten Year Experience of Vascular Surgeon Management of Iatrogenic Pseudoaneurysms: Do Anticoagulant/Antiplatelet Medications Matter?

Patrick Stone¹, James Campbell¹, John E Campbell¹, Maria Martinez¹, David Masinter², Stephanie N. Thompson², Ali F. AbuRahma¹ - ¹WVU Charleston, Charleston, WV; ²CAMC Health Education and Research Institute, Charleston, WV

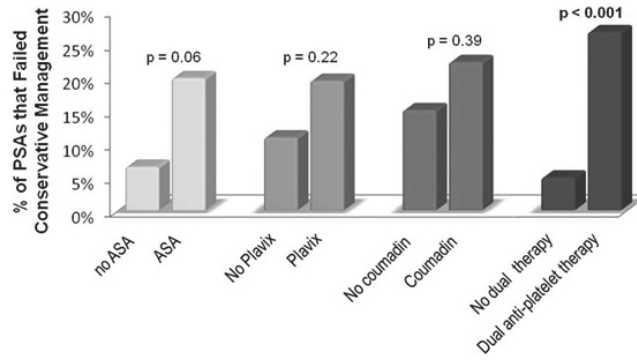
Introduction and Objectives: Previous studies examining the natural history of femoral pseudoaneurysms were performed prior to the current era of anticoagulant/antiplatelet therapy. The purpose of the study was to elucidate in a vascular surgeon directed approach to pseudoaneurysms, the association between medication use and the failure of conservative, observation-only management.

Methods: We retrospectively examined 308 femoral iatrogenic pseudoaneurysms diagnosed via duplex imaging at our institution during a 10 year time period (2004-2013). Information on pseudoaneurysm characteristics, treatment, and antiplatelet/anticoagulant medication usage was obtained. We identified patients who failed observation only conservation management, with failure defined as the need for delayed treatment due to pseudoaneurysms expansion (≥ 1 cm increase or size enlarging to ≥ 3 cm) and/or persistence (≥ 15 days).

Results: Immediate/acute treatments of pseudoaneurysms included 1 ultrasound-guided compression, 14 surgical repairs and 126 thrombin injections. Of the 167 pseudoaneurysms initially managed by observation only, 70(42%) were found by ultrasound imaging to thrombose spontaneously. The use of antiplatelet/anticoagulant medication during time of observation did not affect the length of time to achieve spontaneous resolution ($p=0.44$). Twenty-seven pseudoaneurysms (16%) originally managed conservatively required additional treatment due to expansion and/or persistence. Patients receiving dual antiplatelet therapy had higher rates of failed conservative management (27%) than patients not on dual therapy (5%, $p<0.01$). The number of antiplatelet/anticoagulant medications utilized during observation was larger in patients failing conservative management (2.0 ± 0.7) versus patients not requiring additional intervention (1.5 ± 0.7 , $p<0.01$).

Conclusions: The majority of the pseudoaneurysms were managed successfully. However, anticoagulant/antiplatelet agents associated with pseudoaneurysms requiring further intervention after failing observation-only management. When observation is the chosen strategy for pseudoaneurysm management, especially in the setting of aggressive antithrombotic and dual antiplatelet therapy, surveillance is required to ensure proper resolution.

Full Program & Abstracts



Full Program & Abstracts

4:48 pm – 4:56 pm

38 (RF)

A Novel Anesthetic Technique For PEVAR

Stuart A. Harlin, Christopher J. LeCroy, Ruth A. Grissom,
Susan M. Pouliot - Coastal Vascular and Interventional,
Pensacola, FL

Introduction: Percutaneous Endovascular Aneurysm Repair (PEVAR) continues to evolve. Device profiles continue to decline, further reducing the physiological insult of the procedure. Anesthesia, however, has not evolved with a large proportion of patients continuing to receive general anesthesia for their increasingly less invasive procedures. We report on a novel anesthetic technique providing outstanding anesthesia in patients undergoing PEVAR in an outpatient setting. The total anesthesia used was remarkably cost effective.

Methods: 6 patients underwent PEVAR in an outpatient setting. The patients received moderate IV sedation using Versed and Fentanyl in combination with bilateral ilioinguinal nerve blocks. Patients received 25 mL bilaterally of 0.5% Bupivacaine with epinephrine. All patients were ASA class III. None received central venous access, arterial or urinary catheters. Standard non invasive monitoring was employed. A board certified anesthesiologist was present at all times during the procedures.

Results: All patients underwent successful repair. Average cost per case for anesthetic supplies averaged around \$7.00. The Fentanyl dose ranged from 100-200 mcg with an average dose of 130 mcg. Versed dose ranged from 2-3 mg with an average dose of 2.4 mg. No patient required conversion to general anesthesia. Post operative pain relief was excellent. 3 patients required pain medication prior to discharge. 2 patients required PO narcotic analgesic the night of discharge. No patients required narcotics after that time.

Conclusion: Bilateral ilioinguinal nerve block, when combined with moderate IV sedation allows outstanding anesthesia for patients undergoing PEVAR. This novel combination has not been reported previously. The technique provides safe, effective, care for of a subset of patients not requiring general anesthesia. It offers a greatly reduced cost when compared with general anesthesia. Additional benefits include prolonged pain relief peri-operatively as well as potentially decreasing the physiologic and cognitive effects seen with general anesthesia.

Full Program & Abstracts

4:56 pm – 5:04 pm

39 (CR)

External Carotid Artery Branch Embolization As An Adjunctive Palliative Therapy For Unresectable Head and Neck Malignancy

Reshma Brahmabhatt, Shipra Arya, Ravi Veeraswamy - Emory University School of Medicine, Atlanta, GA

Introduction and Objectives: Embolization of the external carotid artery (ECA) has been reported as a preoperative adjunct to reduce bleeding during resection of certain vascular head and neck tumors. Its role in non-surgical oncologic patients has not been well described.

Methods: We describe a 39 year old man with stage IV melanoma and a large fungating mass on his right lateral neck, causing dysphagia and pain. The mass did not respond to chemotherapy or radiation therapy. Initial arteriogram showed multiple branches of the right ECA feeding the large mass. These branches were embolized using bare detachable platinum coils. Completion arteriogram demonstrated successful embolization of the ECA branches (Figure 1).

Results: The patient had no periprocedural complications and was discharged home on postoperative day 1. At his initial follow up visit (10 days), he reported decreased pain, weight gain, and resolved dysphagia. CT imaging showed regression of the mass (Figure 2). While there was mixed growth of the tumor on imaging at 2 months, the patient symptoms remained resolved (continued weight gain, no dysphagia).

Conclusions: ECA embolization is safe as a palliative procedure in patients with non-resectable symptomatic malignancies in the neck. Re-growth on imaging studies may not correlate with the patient's symptoms. However, embolization may result in only a temporary benefit, and the patient's care should continue in a multidisciplinary fashion.

Full Program & Abstracts

Figure 1: Coil embolization of ECA branches feeding a malignant neck mass.

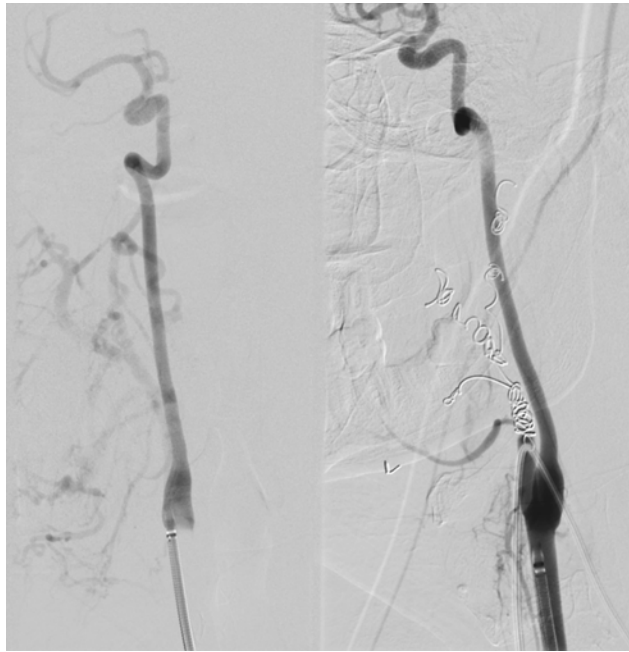
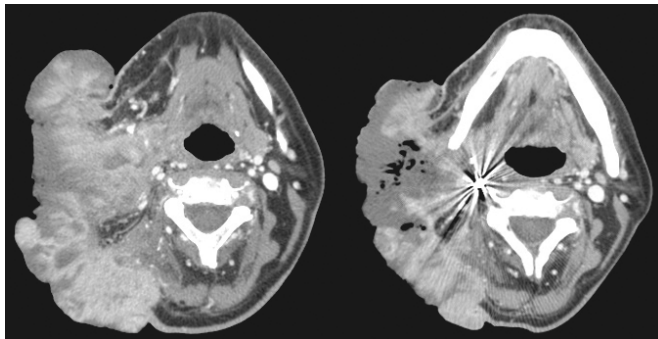


Figure 2: Preoperative and postoperative CT scans showing regression of the mass.



Full Program & Abstracts

5:04 pm – 5:12 pm

40 (CR)

Delayed Hybrid Repair of Major Vascular Injuries Following A Gunshot Wound To the Abdomen

Clayton Brinster, Elizabeth A. Blazick, Virendra Patel, Richard P. Cambria, Mark F. Conrad, Glenn M. LaMuraglia - Massachusetts General Hospital, Boston, MA

A 20-year-old man sustained a gunshot wound to the right upper quadrant and underwent exploratory laparotomy with repair of multiple injuries, including primary repair of a partial hepatic artery laceration.

He re-presented on postoperative day seven with abdominal pain. CTA revealed anterior and posterior visceral aortic pseudoaneurysms with associated periaortic hematoma. A pseudoaneurysm thought to arise from the hepatic artery was also visualized. Based on the suspected instability of the patient's visceral aorta, a three-stage, hybrid operation was planned to include treatment of the mesenteric pseudoaneurysm, revascularization of the mesenteric branches of the abdominal aorta, and endovascular exclusion of the visceral aortic pseudoaneurysms.

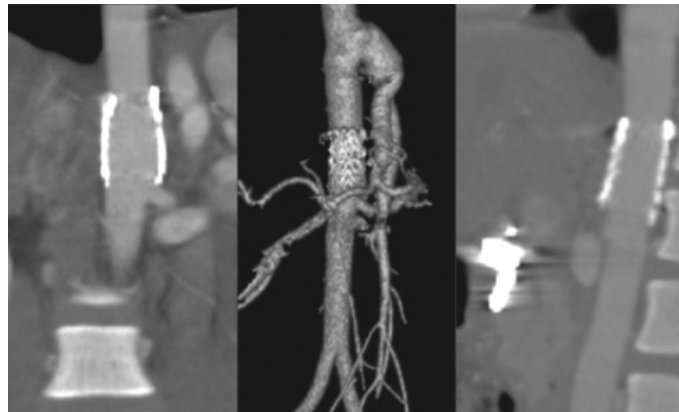
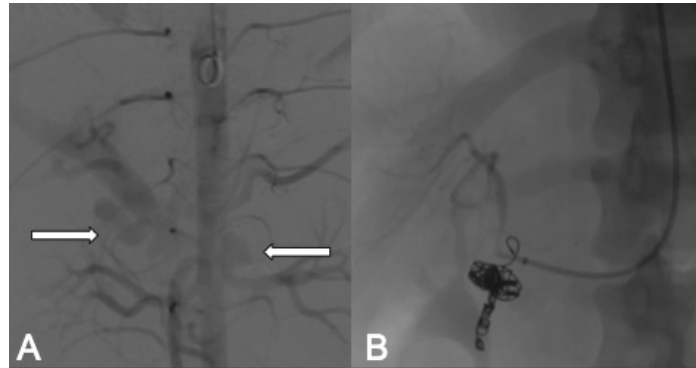
In the first stage, transbrachial angiogram confirmed visceral aortic pseudoaneurysms and revealed a gastroduodenal pseudoaneurysm (GDA) with associated portal venous fistulization (Figure 1A). Successful GDA coil embolization was performed with resolution of arteriovenous fistulization (Figure 1B).

The patient was repositioned and a thoracoabdominal exposure of the visceral aorta was performed. A bifurcated aorto-mesenteric bypass was completed with sequential ligation of the celiac and superior mesenteric arteries, respectively. Antegrade aortic and mesenteric perfusion were maintained throughout the procedure.

Stage three included the deployment of two aortic cuff stent grafts with resultant exclusion of the visceral aortic segment and associated pseudoaneurysms. Renal artery perfusion was maintained. Recovery was uneventful, and the patient was discharged home on postoperative day nine.

CT scans at one and 12 months demonstrated exclusion of the gastroduodenal and aortic pseudoaneurysms, a patent aorto-mesenteric bypass graft, and the absence of endoleak or stent graft migration (Figure 2).

Full Program & Abstracts



Full Program & Abstracts

5:12 pm – 5:24 pm

41

Indication For Lower Extremity Arterial Bypass and Hospital Profiling

Andrew A. Gonzalez¹, Justin B. Dimick², Nicholas H. Osborne² - ¹University of Illinois at Chicago, Chicago, IL; ²University of Michigan, Ann Arbor, MI

Introduction: Surgical readmissions are common, costly, and the focus of national quality improvement efforts. For example, Medicare's Hospital Readmissions Reduction Program has indicated hospitals will be penalized for excessive readmissions following vascular surgery in the near future. Yet, the extent to which institutional case-mix influences hospital profiling has not been explored. We sought to evaluate whether higher readmission rates in vascular surgery are a reflection of worse performance or of treating sicker patients.

Methods: This retrospective observational cohort study of the national Medicare population includes 479,551 beneficiaries undergoing lower extremity revascularization (LER) in 1,707 hospitals from 2005-2009. We used a hierarchical logistic regression model to account for age, gender, pre-existing comorbidities, and differences in hospital operative volume. We estimated 30-day readmission rates for each hospital when including (1) all LER patients; (2) low-risk patients (claudication or rest pain); or (3) high-risk patients (ulceration or tissue loss). We stratified hospitals into quintiles based upon their overall LER readmission rate. Next we examined differences in readmissions performance for low-risk and high-risk patients between hospitals with the highest and lowest readmission rates. We also compared the proportion of high-risk patients treated.

Results: Owing to the large sample size, all p-values were <0.001. Hospital 30-day readmission rates varied widely by indication - 8.7% (low-risk) vs 22.2% (high-risk) between the lowest and highest readmitting institutions (11.4% vs 17.6%). However, when stratified by indication, there was a sizable reduction in the performance differences between lowest and highest readmitting institutions for both low-risk patients (7.7% vs 9.6%) and high-risk patients (20.4% vs 24.5%). In contrast, the difference in the proportion of high-risk patients was large (22.8% vs. 31.7%).

Conclusions: Our findings suggest that the differences in readmission rates following vascular surgery are largely driven by case-mix rather than true differences in quality.

Full Program & Abstracts

5:24 pm – 5:36 pm

42

Perceptions of 0+5 Trained Surgeon By Community Vascular Surgeons

Laura A. Peterson, Jennifer Avise, Jeanette Stafford, Matthew Godlman, Christopher J. Godshall, Justin Hurie, Matthew Edwards, Matthew Corriere - Wake Forest University, Winston Salem, NC

Introduction: Vascular training includes both residency (“0+5”) and post-residency fellowship (“5+2”) programs. Training models potentially influence attitudes toward graduates as prospective hires, but previous survey studies have focused on academic surgeons. We surveyed community surgeons to explore their perceptions of 0+5 versus 5+2 graduates.

Methods: Private practice vascular were identified from membership rosters of one regional and one national society and recruited for an anonymous survey evaluating respondents’ training, practice distribution, general surgery responsibilities, hiring practices, and perceptions of 0+5 versus 5+2 trained vascular surgeons. Agreement among specific responses was evaluated using McNemar’s test.

Results: 406 surgeons were contacted and 71 (17.5%) responded; 42% of respondents indicated that half or more of their cases consisted of open procedures and 10% reported general surgery coverage as part of their practice. Respondents indicated that they believe 5+2 graduates have greater maturity (41% versus 7%, $p<0.0001$) and better preparation for open cases (89% versus 28%, $p<0.0001$), as well as endovascular cases (96% versus 87%, $p=0.0339$). 84% stated that they would interview a 0+5 surgeon, but 28% indicated reluctance to hire them. Ability to cover general surgery call was identified as very or somewhat important for a potential partner by 16.9% of respondents.

Conclusions: Community vascular surgeons still perform a significant amount of open surgical procedures but most do not consider general surgery coverage capability important for new partners. 5+2 graduates were perceived as more mature and better prepared to perform open surgical cases, which may influence hiring practices. Attitudes toward 0+5 versus 5+2 trained surgeons may differ between academic and community surgeons, and further studies are needed to determine whether these perceptions reflect valid differences skills, familiarity with 0+5 graduates, or other biases.

Full Program & Abstracts

5:36 pm – 5:48 pm

43

A Prospective Observational Study Comparing Early Clinical Outcomes of 810nm and 1470nm Endovenous Laser Ablation In the Treatment of Superficial Venous Insufficiency

Joseph El-Sheikha, Dan Carradice, Clement Leung, Ian Chetter - Academic Vascular Unit of Hull York Medical School and Hull Royal Infirmary, Hull, United Kingdom

Introduction and Objectives: The use of longer wavelengths in endovenous laser ablation (EVLA) has been proposed to reduce procedural morbidity by allowing a decrease in the energy requirement through “selective absorptive targeting”. This study compares the outcomes of EVLA using 810nm and 1470nm wavelengths in the treatment of superficial venous insufficiency (SVI).

Methods: A prospective observational study was conducted on patients undergoing treatment for primary, symptomatic, unilateral, isolated great saphenous vein incompetence with EVLA. Two sequential cohorts were treated with laser wavelengths 810nm or 1470nm. All patients were treated using the same Never-Touch fibre design and received concomitant phlebectomy of symptomatic tributaries. Patient follow-up was at 1, 6 and 12 weeks post-EVLA. Outcomes included linear endovenous energy delivery (LEED), technical success, post-procedural pain (10cm visual analogue score), analgesia requirement, complications, recovery time, quality of life (AVVQ, EQ-5D and SF-36) and patient satisfaction.

Results: Total of 97 patients were included (810nm, n=50; 1470nm, n=47) with similar baseline characteristics. Despite a significantly lower LEED in the 1470nm group compared to the 810nm group (59 (S.D. 15) J/cm vs 107 (S.D. 20) J/cm, $p < 0.001$), the technical success was equivalent (97% vs 100%, $p = 0.295$). Pain was similar on days 0-5, but on day 6 post-EVLA there was a statistically significant difference, with slightly higher pain response in the 810nm group (0.7 (S.D. 0-2.5) vs 0 (S.D. 0-1.4), $p = 0.010$). This particular finding was not robust to perform multivariable analysis. There were no differences demonstrated in analgesia requirement, complications, recovery time, quality of life improvement or patient satisfaction.

Conclusions: EVLA using either 810nm or 1470nm wavelengths produce excellent clinical results, with no clear benefit to recommend one over the other when used in conjunction with a Never-Touch fibre.

Full Program & Abstracts

5:48 pm – 5:56 pm

44 (CR)

Popliteal Artery Pseudoaneurysm Secondary To Osteochondroma: A Case Report and Literature Review

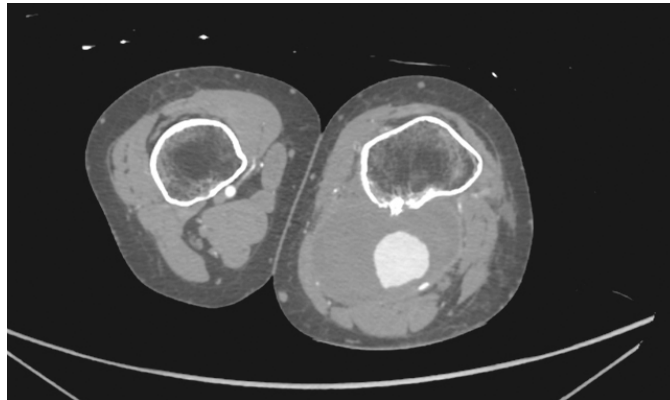
Katherine E. Brown, Samer Naffouje - University of Illinois Medical Center at Chicago, Chicago, IL

Introduction: Osteochondromas are the most common benign tumor of the bone which present in male patients within the first two decades of life. These tumors are rarely associated with vascular complications. We report a case of an 8 cm symptomatic popliteal artery pseudoaneurysm (PAP) secondary to an osteochondroma (OC) in a 57 year old female patient.

Methods: A literature review using PubMed/Medline of the English literature of PAP associated with OC was performed. All reports between 1966 and 2013 describing surgical repair for popliteal artery pseudoaneurysm were reviewed.

Results: A 57 year old female with multiple osteochondromas presented with a painful pulsatile mass in the left thigh after reporting a history of minor trauma to the leg approximately six months prior. Imaging revealed a popliteal artery pseudoaneurysm associated with an osteochondroma of the left femur. The pseudoaneurysm was resected via a medial approach and the artery was repaired with an interposition saphenous vein graft. The literature search performed identified forty articles in the English literature reporting forty -six similar cases. The majority of patients were males (39 cases, 84.78%) with the mean age of 20.50 ± 10.17 years. Open surgical repair of the arterial defect with primary repair or bypass with resection of the bone deformity is effective and the preferred treatment.

Conclusion: PAPs secondary to OC is a described entity that is uncommon and presents in the young population. They are typically always symptomatic and require a vascular surgical repair along with an orthopedic intervention. Primary resection and repair of these aneurysms appears to be the definitive treatment.



Full Program & Abstracts

5:56 pm – 6:04 pm

45 (RF)

Numerous Applications of 3D Printing In Vascular Surgery

Khurram Rasheed, Doran Mix, Ankur Chandra - University of Rochester, Rochester, NY

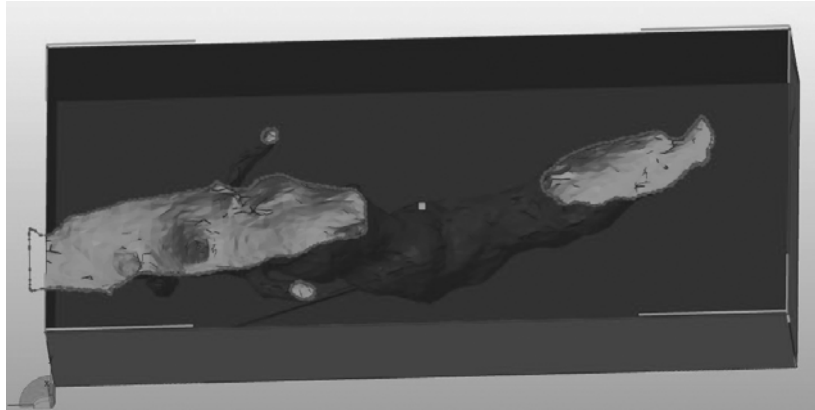
Introduction: 3-Dimensional printing has an increasing role within vascular surgery, with a wide array of possible applications. 3D printing has been successfully employed in cardiac surgery for surgical planning and education. A similar advance needs to be made within vascular surgery.

Methods: 3D models of vascular structures can be created from 2D DICOM data sets obtained from either CTA or MRA, utilizing Mimics® software. With user defined thresholding and segmentation parameters based on pixel intensity, vascular structures are isolated from surrounding tissue. Segmentation of the distal thoracic aorta to the bifurcation of the common iliac arteries, for example, can be performed in 30 minutes. 3D virtual models are subsequently printed with timings varying based on size, complexity and level of detail.

Results: We have utilized aortic aneurysm models to serve as molds, recreating patient-specific aortas applying materials with tissue mimicking properties, subject to hemodynamic and strain analysis. Additionally, 3D reconstructions of complex thoracoabdominal aneurysms, we have found to have comparable measurements to CT-scans while also offering greater insight to possible technical challenges encountered during surgery. Through 3D printing, construction of patient specific translucent flow lumen models of aortic aneurysms (Figure 1) and internal carotid arteries, allows the opportunity to practice deployment of stent-grafts, useful in surgical education and pre-procedural simulation.

Conclusions: 3D printed vascular models can be constructed reliably, accurately and efficiently serving as an adjunctive tool in patient evaluation. It's applications are broad; varying from investigating the natural history of disease processes to surgical planning to surgical education. 3D models will ultimately be an integral component of our assessment and practice enabling us to provide more sophisticated and patient oriented care.

Full Program & Abstracts



7:00 pm – 10:00 pm

PRESIDENT'S DINNER

All registered attendees are welcome to attend. The President's Dinner is by separate subscription - **tickets are required.**

Full Program & Abstracts

Sunday, February 1, 2015

6:30 am – 7:00 am Continental Breakfast

6:30 am – 9:00 am Registration

7:00 am – 9:00 am SCIENTIFIC SESSION V

7:00 am – 7:12 am 46

Mortality Rate Discrepancies Among Patients Undergoing Amputation - A Comparison of Source Data
John P. Davis, Amani D. Politano, Christopher A. Guidry, Scott R. Ellis, Wendy M. Novicoff, Kenneth J. Cherry, John A. Kern, Gilbert R. Upchurch, Margaret C. Tracci - University of Virginia, Charlottesville, VA

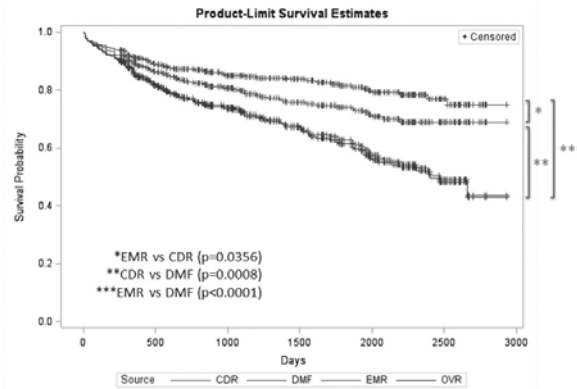
Introduction and Objectives: Postprocedure mortality remains a key outcome measure in clinical research assessing the safety and efficacy of intervention and is also frequently incorporated in quality metrics utilized by providers, institutions, and payers. Data sources used for these purposes vary; we hypothesize that reported mortality rates for patients undergoing vascular procedures vary based on the source of mortality data.

Methods: The institutional operative log was queried for vascular procedures including open and endovascular aneurysm repair, lower extremity bypass, and amputation performed between August 2007 and December 2013. Patient mortality was queried from the Electronic Medical Record (EMR), the institutional Clinical Data Repository (CDR), and the Social Security Death Master File (DMF). Kaplan-Meier curves compared associated death rates by data source, and McNemar's test was used to compare means between groups.

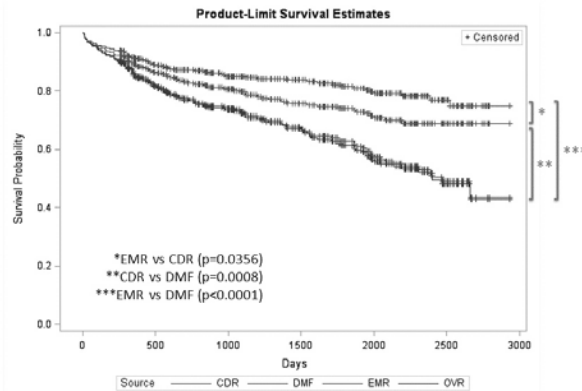
Results: A total of 1,265 patients were identified. Mortality rates according to EMR, CDR, and DMF were 15.9%, 21.1%, and 29.8%, respectively, with an overall mortality (OVR) of 31.6% with all sources combined. Kaplan-Meier survival curves showed significant differences in mortality rates between the EMR vs. OVR ($p < 0.0001$) and CDR vs. OVR ($p < 0.0001$). No difference was seen between the DMF vs. OVR ($p = 0.339$). All comparisons between groups were significant (EMR vs. CDR vs. DMF: $p \leq 0.0005$).

Conclusions: Postprocedure mortality is a widely utilized clinical endpoint. However, reported mortality rates vary significantly based on data source. Access to accurate, comprehensive mortality data is critical for the reliability and generalizability of outcomes utilized in research, quality activities, and benchmarking of clinical outcomes.

Full Program & Abstracts



Survival Probability by Mortality Source: Endovascular Aortic Aneurysm Repair



Survival Probability by Mortality Source: Endovascular Aortic Aneurysm Repair

Full Program & Abstracts

7:12 am – 7:24 am

47

Safety and Effectiveness of Adjunctive Intraarterial Abciximab In the Management of Acute Limb Ischemia

Gregory G. Salzler, Peter H. Connolly, Darren B. Schneider, Andrew J. Meltzer - New York Presbyterian Hospital-Weill Cornell Medical College, New York, NY

Introduction and Objectives: Contemporary endovascular management of acute limb ischemia (ALI) generally consists of tissue plasminogen activator (tPA) based catheter-directed thrombolysis (CDT) with or without percutaneous mechanical thrombectomy (PMT). Although abciximab (Reopro), a GPIIb/IIIa receptor antagonist, is widely utilized in coronary revascularization, its safety and effectiveness in the treatment of ALI is unknown. Here we review our contemporary experience with the endovascular management of ALI and assess the safety and effectiveness of abciximab.

Methods: All patients with Rutherford class II (RII) ALI undergoing CDT for ALI from 2011-2014 were identified. Demographics, procedural details, and outcomes were assessed and are reported.

Results: 40 patients with RII ALI underwent tPA-based CDT in 44 discrete interventions. In 6 patients adjunctive abciximab infusion was also utilized. The majority (70%) of patients treated with TPA ± PMT required overnight infusion and at least one subsequent procedure. Single-stage (on-table) thrombolysis was achieved in all cases of adjunctive abciximab use vs. 23% with tPA alone (p<0.001). There was no need for ICU monitoring nor were there bleeding complications associated with adjunctive abciximab use. Overall length of stay and total OR time favored the abciximab group but did not reach statistical significance. 30-day major adverse limb events occurred in 12.5% of patients. Overall primary patency, secondary-patency, and amputation-free survival were 51 ± 11%, 73 ± 8.7%, and 85 ± 7.6% at one year.

Conclusions: Early results suggest adjunctive abciximab safely facilitates on-table thrombolysis for RII ALI. This approach is associated with reduced resource utilization including fewer procedures, shorter OR time, and less ICU admissions. One-year outcomes compare favorably to a similar cohort of ALI patients treated with tPA-based therapy alone.

	Overall (n=44)	Abciximab (n=6)	tPA alone (n=38)	p-value
Average # of Procedures	1.95	1.00	2.11	<0.001
Average Total OR Time	223 min	160 min	233 min	0.20
30-day Mortality	1	0	1	0.86
Bleeding Complications	4	0	4	0.54
Average ICU Length of Stay	1.2 days	0 days	1.39 days	0.03
Average Overall Length of Stay	10.6 days	2.5 days	11.4 days	0.18
30-day Major Adverse Limb Events	12.5%	0%	13%	0.46
1-Year Primary Patency	51 ± 11%	100%	44%	0.11
1-Year Secondary Patency	73 ± 8.7%	100%	69%	0.20
1-Year Amputation-Free Survival	85 ± 7.6%	100%	83%	0.43

Full Program & Abstracts

7:24 am – 7:36 am

48

Heparin Bonded PTFE Does Not Improve Hemodialysis Arteriovenous Graft Function

Nicolas Zea, Grayson Menard, Linda Le, Hernan Bazan, W.C. Sternbergh, Taylor Smith - Ochsner Clinic Foundation, New Orleans, LA

Introduction and Objectives: While heparin-bonded polytetrafluoroethylene (PTFE), when compared to standard PTFE, has been shown to be beneficial in distal extremity bypass grafts, the data supporting its usage for dialysis access is less clear. We compared the patency rates, number of interventions, and complications between heparin-bonded (HEP) and non-heparin-bonded (NonHEP) PTFE grafts placed for dialysis access.

Methods: A retrospective review of all dialysis access procedures entered into a prospectively maintained vascular surgery database was performed. Primary end points included functional graft patency, time to graft abandonment, and number of procedures required to re-establish graft patency following thrombosis. The number of interventions required to maintain graft patency and graft related complications were also reviewed. Kaplan-Meier curves were used to compare the two groups.

Results: Between January 2013 and March 2014, 301 dialysis access procedures were performed which included 72 AV grafts (AVG) comprised of 32 HEP and 39 NonHEP. At a mean follow-up of 7.35 ± 5.15 months, 22/32 HEP grafts were functional compared to 31/39 NonHEP grafts (67% vs. 79%, $p=0.22$). Primary, primary-assisted, and secondary patency at 1, 3, 6 and 12 month follow-up was not significantly different between the HEP and NonHEP grafts. The incidence of grafts abandoned due to thrombosis ($p=0.51$) and time to graft abandonment were also not different ($p=0.13$). The number of HEP grafts undergoing an open or percutaneous thrombectomy was significantly higher than the NonHEP grafts ($p=0.03$), as was the incidence of any intervention performed to maintain graft patency ($p=0.002$). Kaplan-Meier survival curve failed to show a benefit in functional patency with HEP vs. NonHEP PTFE.

Conclusions: We did not demonstrate a benefit to the routine use of heparin-bonded PTFE for AVG creation. Functional patency rates were not improved and the rates of re-intervention were higher with heparin bonded PTFE AV grafts.

Full Program & Abstracts

7:36 am – 7:48 am

49

Gender Differences In Aortic Neck Morphology In Patients With Abdominal Aortic Aneurysms Undergoing EVAR

Diego Ayo, Sheila N Blumberg, Byron Gaing, Andrew Baxter, Caron Rockman, Firas Mussa, Thomas Maldonado - New York University School of Medicine, New York, NY

Introduction and Objectives: Prior studies have alluded to gender differences in aortic neck morphology resulting in anatomic exclusion of some women from EVAR. The objective of this study is to correlate gender differences in aortic neck morphology and changes in the neck and aneurysm sac after EVAR.

Methods: A retrospective review of consecutive EVARs performed for infrarenal AAA was conducted from 2004 to 2013 at a single institution. Pre- and post-operative imaging studies were utilized to measure aortic neck length and diameter, shape, and angulation, aneurysm sac diameter. Volumetric analysis of neck thrombus burden was performed using TeraRecon®.

Results: 146 patients met inclusion criteria 21% were women with a mean age of 75.5 (p=0.724) with comparable baseline comorbidities to men. Neck angulation was greater in women 23.9° vs 13.5° (P<0.028). The percent thrombus of the aortic neck was greater in female patients at 35.7% vs 30%(P=0.02). Preoperative AAA diameter was 5.8 in female and 5.5 in males (p=0.348). Abdominal aneurysm sacs were smaller in women at 1 year follow up (4.2cm vs. 5.1cm, P<0.002). In addition, although not statistically significant, reintervention rates post-EVAR for type 1 leaks were higher in men (3.5% vs. 0% P=0.27). Neck shape, changes in neck diameter, neck length, percent oversizing of graft were not significantly different between gender (table 1).

Conclusions: Although female patients have more hostile aortic neck morphology compared to males, AAAs post-EVAR have acceptable sac regression and reintervention rates. Long term follow up is necessary to further validate findings.

Full Program & Abstracts

Neck Morphology	Men	Women	
s	mean +/- SD	mean +/- SD	P (<0.05)
Neck length (cm)	3.2+/-1.5	2.98+/-1.3	0.431
Infra-renal neck angle (deg)	13.5+/-16.9	23.9+/-23.8	0.028*
% thrombus volume at 5mm	30+/-9.3	35.7+/-12.1	0.02*
Change in AAA on CT Scan (cm)	ff	ff	ff
Most recent Pre Op	5.5+/- 1.2	5.7+/- 1.1	0.396
Post Op at 30 days	5.4+/-1.2	5.6+/-1.2	0.486
post op at 1 year	5.1 +/-1	4.2+/-0.6	0.002*
Neck diameter (dm)			
Pre Op at 5mm	2.4+/-0.3	2.3+/-0.4	0.326
Post Op at 5mm	2.4+/-0.5	2.4+/-0.6	0.853
Δ(>5mm) in Pre op/post op dm of neck at 5mm			0.16
Growth	13 (11.3%)	16 (51.6%)	
Shrinkage	8 (7.0%)	3 (9.7%)	
No change	81 (70.4%)	16 (51.6%)	
Neck Shape			0.421
Funnel	13/115(11.3)	3/31 (9.7%)	
Conical	37/115 (32.2%)	14/31 (45.2%)	
Cylindrical	64/115 (55.7%)	14/31 (45.2%)	
Complication of Type 1 Endoleak	4/115 (3.5%)	0/31 (0%)	0.27
Intervention			
extension cuff	4/115 (3.5%)	0/31 (0%)	0.27

Full Program & Abstracts

7:48 am – 7:56 am

50 (CR)

Loeys-Dietz Syndrome, Pregnancy and Aortic Degeneration

Jeffrey D. Crawford, Matthew S. Slater, Timothy K. Liem, Gregory J. Landry, Amir F. Azarbal, Gregory L. Moneta, Erica L. Mitchell - Oregon Health and Sciences University, Portland, OR

Loeys-Dietz Syndrome (LDS) is a rare autosomal dominant connective tissue disorder (CTD) caused by heterozygous mutations in the genes encoding transforming growth factor beta receptors (TGFB_R) 1 and 2. The syndrome, characterized by vascular, skeletal, craniofacial and cutaneous manifestations, predisposes patients to aggressive and widespread vascular disease including aortic root dilation and arterial dissection. Women with LDS are prone to aortic dissection and uterine rupture during pregnancy and the postpartum period. Additionally, aortic disease is believed more aggressive during pregnancy as a result of estrogen-induced changes in the aortic media. We describe the case of a 29 year-old G2P1 woman at 28 weeks gestation presenting with abdominal pain. Work-up revealed a 7cm ascending aortic aneurysm and a DeBakey type 1 aortic dissection extending to the aortic bifurcation. Surgical management included concomitant Cesarean-section delivery of a live born premature infant, tubal ligation, ascending aortic replacement with reconstruction of the arch vessels and aortic valve replacement. This is the first reported case of aortic dissection with visceral involvement occurring in a patient with both LDS and pregnancy. This case highlights key concepts regarding etiology and management of acute aortic pathology in the setting of pregnancy and/or LDS including: the effects of pregnancy on aortic pathology, management of aortic pathology during pregnancy, diagnostic criteria for LDS and management of aortic pathology in patients with LDS and CTD.

Full Program & Abstracts

7:56 am – 8:04 am

51 (RF)

Observation May Be Safe In Selected Cases of Blunt Traumatic Abdominal Aortic Injury

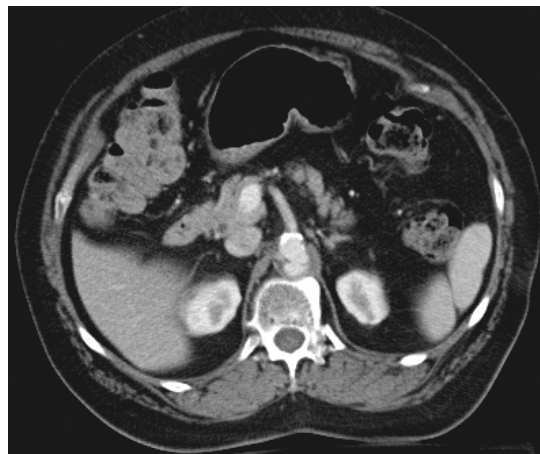
Joseph J. DuBose, Samuel S. Leake, Harleen K. Sandhu, Miguel Sanchez-Perez, John B. Holcomb, Ali Azizzadeh, Hazim J. Safi, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

Introduction and Objectives: Blunt traumatic abdominal aortic injury (BTAAI) is an uncommon injury and is associated with extensive intraperitoneal injuries. Optimal management remains unclear, including the role of prosthetic aortic graft replacement with concomitant bowel injury and the management of small pseudoaneurysms.

Methods: We reviewed BTAAI cases occurring 2001-2014. Thoracic and isolated iliac artery injuries were excluded. We included patient demographics, mechanism of injury, admission physiology, and reviewed available imaging to characterize aortic injury type and severity.

Results: BTAAI was noted in 16 of 55,876 (< 0.01%) trauma patients admitted during the study period. Of these, 56% were males and the median age was 47 years (range 5-80). 75% involved high-speed motor vehicle crashes. Aortic repair was performed in six patients, including 3 prosthetic aortobiliac bypass grafts, 1 endovascular repair, and 2 primary repairs. The remainder were medically managed for their aortic injury including 3 with pseudoaneurysm (Figure) and 3 with large intimal flaps. There were five in-hospital deaths (31%) but only one attributed to aortic injury. Among patients surviving to discharge, there were no re-admissions or delayed deaths. All nonoperative and surgically repaired patients seen in follow up had stable aortas. No patient with graft or endograft repair had evidence of graft infection on follow up (median 31 months, range 5-80).

Conclusions: BTAAI is a rare entity and is associated with high in-hospital mortality primarily due to associated injuries. Observation of selected small pseudoaneurysms and intimal flaps appears safe. Survival after hospital discharge is excellent and aortic-related complications are rare. The indications for repair and the role of revascularization with in situ prosthetic graft in the setting of concomitant bowel injuries are not well defined.



Full Program & Abstracts

8:04 am – 8:16 am

52

Outcomes of Women Treated For Popliteal Artery Aneurysms

Randall R. DeMartino, Syed M. Peeran, Ying Huang, Mark Fleming, Manju Kalra, Oderich Gustavo, Audra Duncan, Thomas C. Bower, Peter Glaviczki - Mayo Clinic, Rochester, MN

Objective: Popliteal artery aneurysms (PAA) in women are rare and their outcomes compared to men with PAA are unknown. The purpose of the present study was to compare the outcomes of PAA of women compared to men.

Methods: All patients who underwent PAA repair at a single institution from 1985 to 2013 were reviewed. All women with degenerative PAA treated during that time frame were matched on year of repair to men (5:1). Presentation, mode of repair and outcomes were reviewed. Survival and amputation free survival were evaluated by life table analysis.

Results: During the study interval, 8 women with degenerative PAA underwent surgical treatment (1.6% of 485 total PAA repairs). Median follow up was 5 years overall (range 1mo-19 years), but was shorter for females 1.6 vs. 6 years ($p=0.04$). At time of repair, women were of similar age compared to men (73.5 vs. 71.7 years), had similar aneurysm size (2.7 vs. 2.9cm) for women and men respectively. Women had similar urgency (25 vs 17.5% emergent) and symptomatic status (50 vs 55% acute) even though 7 of the 8 women had a thrombosed PAA at the time of repair. Operative time, approach, graft type and inflow and outflow sources were similar between genders. No women received endovascular repair (0 vs 10%). One patient of each gender underwent amputation (one woman on POD 158 and one man on POD 3). Overall, women had lower survival and amputation free survival at 2 years (51% vs. 100% and 20% vs. 94% ($p<0.01$ for both, SE 0.2) respectively).

Conclusions: PAA requiring intervention in females is a rare clinical occurrence. Although our series is limited, females requiring PAA repair had higher long-term mortality compared to men with a similar pathology and treatment strategy.

Full Program & Abstracts

8:16 am – 8:28 am

53

Abdominal Wall Grafts: A Viable Addition To Arteriovenous Access Strategies

Mathew Wooster¹, Alexis Powell¹, Jay Denisco², Victor Bowers³ - ¹University of South Florida, Tampa, FL; ²Florida State University, Tampa, FL; ³Tampa General Medical Group, Tampa, FL

Objective: We seek to present our experience with innovative abdominal wall arteriovenous access grafts for patients who have run out of traditional dialysis access options.

Methods: We retrospectively reviewed our cohort of patients who have undergone creation of abdominal wall grafts. In all patients, an iliac artery was used for inflow and either an iliac vein or the distal IVC was used for the outflow. Ringed PTFE, non-ringed PTFE, and bovine carotid artery were used as access conduits.

Results: Our 12 patient cohort had a mean primary patency of 17.4 months with mean secondary patency of 33 months. There were no operative deaths noted and four total graft infections.

Conclusion: Abdominal wall grafts with iliac vessel inflow/outflow represent viable alternatives for patients who have exhausted more traditional dialysis access options.

Full Program & Abstracts

8:28 am – 8:40 am

54

A Diversity Survey of VESS and the Recent Vascular Trainees Within WVS

Nathan K. Itoga¹, Karen Woo², Jean Bismuth³, Carlos Bechara⁴, Marlene Grenon⁵, Erica Mitchell⁶, Wei Zhou¹ -
¹Stanford University, Stanford, CA; ²University of Southern California, Los Angeles, CA; ³Houston Methodist Hospital, Houston, TX; ⁴Baylor College of Medicine, Houston, TX; ⁵University of California San Francisco, San Francisco, CA; ⁶Oregon Health and Science University, Stanford, CA

Objectives: Recent reports of a lack of diversity within the Society of Vascular Surgery (SVS) underlined the need to increase its effort to recruit a more diverse generation of leaders and trainees to address ethnic and cultural health care disparities. This studies aims to evaluate the diversity of the Vascular and Endovascular Surgery Society (VESS), as well as the trainees within the Western Vascular Society (WVS)

Methods: VESS members were surveyed using Survey Monkey regarding gender, age, practice setting, and ethnicity. Training programs within the boundaries of the WVS were surveyed regarding gender, ethnicity, and practice setting after training completion of their residents and fellows for the past seven years.

Results: Of the 72 people who responded to the VESS survey, 13 were female (18%) and 15 were non-Caucasian (21%). Female members were more likely to be affiliated with an academic institution ($P=0.067$) or work with residents ($P=0.09$) compared to their male counterpart. Minority members were younger and had fewer years in practice (8 vs. 14 years, $P=0.015$). All minority vascular surgeons were male with an age <50 years among the responders. Of the 30 vascular residents in the 0+5 vascular surgery programs, 13 were female (43%) and 17 were non-Caucasians (57%). Of the 63 vascular surgery fellows, 19 were female (30%) and 36 were non-Caucasians (57%). Fifteen of the 29 fellows (52%) have gone or will go into private practice with two entering the military practice.

Conclusions: This survey demonstrates that although the leaderships and members of the VESS, like the SVS, are comprised largely of Caucasian males, the younger generation of VESS members brings increased diversity and participation in academic training. The current and recent WVS trainees also show a trend towards increased diversity and higher percentage of female surgeons, particularly among 0+5 vascular residents.

Full Program & Abstracts

8:40 am – 8:52 am

55

Outcomes of Common Femoral and Profunda Femoris Endovascular Interventions

Jonathan Bath¹, Efthymios Avgerinos² - ¹University of Cincinnati, Cincinnati, OH; ²University of Pittsburgh Medical Center, Pittsburgh, PA

Introduction and Objectives: Atherosclerotic disease of common femoral and profunda femoris arteries (CFA/PFA) has been historically treated with surgical endarterectomy. Endovascular treatment of CFA and PFA disease has been reported in the recent literature. This review describes current endovascular treatments to the CFA and PFA.

Methods: An electronic PubMed database search of all reports of CFA and PFA endovascular treatments in the English language was performed. Relevant studies were retrieved and analyzed.

Results: Analysis of 19 studies was performed totaling 721 patients with a mean age of 70.5 years. Indications for treatment include claudication in 51.8%, critical limb ischemia in 45.5% and other in 2.8%. Technical success occurred in 96% of procedures with CFA treatment in 44% and PFA in 56% of cases. Angioplasty alone occurred in 69.4% of cases, stenting in 26% and thrombolysis or atherectomy in 4.6%. Mean ankle-brachial index increased by 0.23 following intervention. Access complications and groin hematomas occurred in 3.1% of cases; distal embolization in 1.3%. Mean peri-operative mortality was 0.27% with all-cause mortality of 15% over a mean follow-up period of 21 months. Mean primary patency was 79% at a mean follow-up of 12 months with secondary patency of 87.5% at a mean follow-up of 33 months. Routine stenting of the CFA or PFA led to a mean primary patency of 85.9% at a mean follow-up of 18 months. Endarterectomy or surgical bypass was undertaken in 8.8% of patients during the follow-up period, endovascular re-intervention occurred in 5.9% and major amputation in 2.7%.

Conclusions: Endovascular interventions to the CFA and PFA can be performed safely and with high technical success. Mid-term patency when routine stenting is applied is comparable to surgical endarterectomy. Primary endovascular therapy may be a favored approach for high surgical risk patients given the low rate of procedural-related mortality and morbidity.

Full Program & Abstracts

8:52 am – 9:04 am

56

Description and Outcomes of A Simple Surgical Procedure To Treat the Failing Forearm Arteriovenous Fistula

Joshua Washer, William Gordon, Adam Weltler - Medical University of South Carolina, Charleston, SC

Introduction and Objectives: National efforts to increase arteriovenous (AV) fistula utilization have led to liberalization of selection criteria for AV fistula creation, and, consequently, a non-maturation rate reported to be as high as 60%. Endovascular techniques to salvage the failing fistula can be effective but have limitations. We describe a simple surgical procedure to salvage the failing forearm AV fistula. The “reverse J graft” procedure involves tunneling PTFE graft subcutaneously in a “J” configuration, creating the venous anastomosis end-to-end to the failing fistula, and creating the arterial anastomosis end-to-side to the more proximal artery. This report details the outcomes of a series of failing forearm AV fistulas treated with this procedure.

Methods: A total of 37 reverse J graft procedures were performed in 37 patients over a 10 year period. Mean follow up time was 64 months. Vascular access clinic, hospital, and dialysis unit records were reviewed to identify patient demographics and determine functional patency rates. Kaplan-Meier survival analysis was used to estimate primary and secondary functional patency rates.

Results: Technical success was achieved in 36 of 37 procedures (97%). The one failure occurred for an unknown cause. An average of .85 surgical or endovascular procedures (0-7) were performed on the failing fistulas prior to the reverse J graft procedure. Nine fistulas were eventually converted to forearm loop AV grafts. The estimated primary and secondary functional patency rates were 24% and 80% at 6 months and 10% and 67% at 12 months.

Conclusions: The reverse J graft procedure described in this report is effective in salvaging the failing forearm AV fistula, maintaining the forearm as the access site, and preserving proximal vein for future access.

Full Program & Abstracts

Table 1 Patient Demographics	
Characteristic	Mean \pm SD or No. (%) (N=37)
Follow-up, months	64.1 \pm 32.8
Age, years	55 \pm 14.3
Sex	
Female	22 (59.5)
Male	15 (40.5)
Race	
Black	23 (62.2)
Caucasian	12 (32.4)
Asian	2 (5.4)
Diabetes	26 (70.3)
HTN	34 (91.9)
CAD	7 (18.9)
CHF	11 (29.7)
PAD	7 (18.9)
On Dialysis	31 (83.8)
Insurance	
Medicare	28 (75.7)
Medicaid	13 (35.1)
Private	20 (54.1)
SD, standard deviation	

9:15 am

Meeting Adjourns



Notes



Notes



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Notes

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Jason Alexander	Minneapolis Heart Institute
Marvin Atkins	Scott & White Hospital and Clinic
Leo Daab	Madigan Army Medical Center
Jodi Gerdes	Louisiana State University
London Guidry	Vascular Clinic
Jade Hiramoto	University of California San Francisco
Joe Huang	Rutgers - New Jersey Medical School
Russell lam	Advanced Vascular & Vein Center of Texas
Brian Knipp	Naval Medical Center, Portsmouth
Brian Matteson	St. Luke's Cardiothoracic and Vascular Associates
Marvin Morris	Mercy St. Vincent's Medical Center
Omar Mubarak	Vascular Institute of the Rockies
Tapash Palit	LSU Health Sciences Center - New Orleans
Mun Jye Poi	Baylor College Of Medicine
Brandon Propper	San Antonio Military Medical Center
Reagan Quan	Madigan Army Medical Center
Susan Shafii	Emory University School of Medicine
Malachi Sheahan	LSU School of Medicine
Claudie Sheahan	LSU School of Medicine
Matthew Smeds	University of Arkansas for Medical Sciences
Gale Tang	VA Puget Sound Health Care System/Univ. of Washington
Brandi Upton	Mercy Clinic

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Baltimore, MD 21229
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Cincinnati, OH 45209-1974
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ZHOU, WEI

Stanford University
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Stanford, CA 94305
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ZIPORIN, SCOTT J.

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ZUNIGA, CARLOS

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Lima, L-32
Peru
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czl28@hotmail.com

Notes

Geographical Listing of Active Members

ALABAMA

Alabaster

Taylor, Steven M.

Birmingham

Jordan, Jr., William D.

Matthews, Thomas C.

Passman, Marc A.

Patterson, Mark A.

Pearce, Benjamin J.

Quinney, Brent E.

Whitley, W. David

Dothan

Pfeiffer, III, Ralph B.

Huntsville

Roberts, Rick M.

Mobile

Esses, Glenn E.

McPhillips, Frank

Winfield

Manord, Jeffrey D.

ARIZONA

Flagstaff

Caparelli, David J.

Phoenix

Erickson, Curtis A.

Scottsdale

Fowl, Richard .

Money, Samuel R.

Sun City West

Carlton, Douglas J.

Tucson

Berman, Scott S.

Hughes, John D.

Leon, Jr., Luis R.

Lucas, Layla C.

Mills, Joseph L.

Quick, Rhonda C.

Trinidad, Magdiel

Twena, Mordechai F.

Westerband, Alex

ARKANSAS

Little Rock

Ali, Ahsan T.

Escobar, Guillermo A.

Smeds, Matthew Russell.

CALIFORNIA

Arcadia

Kronson, Jeffrey W.

Belmont

Chandra, Venita

Burlingame

Lin, Stephanie C.

Daly City

Scribner, Robert G.

Davis

Noll, Jr., Robert E.

Sampson, James Buchanan

Williams, Timothy K.

Fresno

Hadcock, Jr., William

Glendale

Acosta, Ignacio

La Jolla

Lane, III, John S.

Rayan, Sunil S.

Sedwitz, Marc M.

Laguna Hills

Duensing, Robert A.

Lancaster

Petrik, Pavel

Loma Linda

Abou-Zamzam, Jr., Ahmed M.

Chiriano, Jason T.

Teruya, Theodore H.

Los Angeles

Gelabert, Hugh A.

Jimenez, Juan Carlos

Keushkerian, Simon

Ochoa, Christian J.

O'Connell, Jessica B.

Quinones-Baldrich, William J.

Rowe, Vincent L.

Geographical Listing of Active Members

Wagner, Willis H.
Woo, Karen
Montebello
Torres, Gustavo A.

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

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

Rancho Palos Verdes
Donayre, Carlos E.

Riverside
Kim, Sung K.
Roseville
Gelfand, Dmitri

Sacramento
Carson, John G.
Dawson, David L.
Hedayati, Nasim
Humphries, Misty Dawn
Lee, Eugene S.
Pevac, William C.

Salinas
Rudo, Neil D.

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

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

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

Santa Monica
Mueller, Mark P.
Rigberg, David A.
Wagmeister, Robert

Sherman Oaks
DeRubertis, Brian G.

Stanford
Harris, Jr., E. John
Lee, Jason T.
Mell, Matthew
Zhou, Wei

Torrance
Marrocco, Christopher J.
Victorville
Chauvapun, Joe

Woodland
Al-Khatib, Weesam Kassim

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

Denver
Annest, Stephen J.
Fox, Charles J.
Johnnides, Christopher G.
Mubarak, Omar
Rehring, Thomas F.

CONNECTICUT
Bloomfield
Greenwald, Lori L.

Danbury
Dietzek, Alan M.

Darien
Gagne, Paul J.

Easton
Goldstein, Lee J.

Glastonbury
Bulger, Christopher M.

Hartford
Gallagher, James J.
Ruby, Steven T.

Manchester
Maru, Sandip T.

Geographical Listing of Active Members

New Haven

Dardik, Alan
Indes, Jeffrey
Ochoa Charar, Cassius Iyad

DELEWARE

Newark
Ierardi, Ralph P.

DISTRICT OF COLUMBIA

Washington
Beavers, Frederick P.
Hughes, Kakra
Shin, Susanna

FLORIDA

Aventura
Johr, Bernardo
Coral Springs
Rosa, Patricio

Ft. Lauderdale
O'Donnell, Sean D.

Gainesville
Feezor, Robert J.

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

Jupiter
Cires, Giancarlo

Lutz
Gonzalez, Alberto Jose

Maitland
Adcock, G. Kendrix
Winter, Robert P.

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

Ocoee
Horowitz, John D.

Orange Park
Rifkin, Kerry V.

Orlando

Thompson, Charles S.
Varnagy, David

Pensacola
Harlin, Stuart A.

Sarasota
Lepore, Jr., Michael R.

South Miami
Pereda, Juan Carlos

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

Tallahassee
Brumberg, Robert S.
Hoynes, Robert F.

Tampa
Back, Martin
Illig, Karl A.
Johnson, Brad L.
Kerr, Thomas M.
Nelson, Peter R.
Shafii, Susan Marian
Shames, Murray L.
Valentin, Marlene D.
Wilson, Jeffrey S.

Weston
Grove, Mark K.
King, Terry A.

GEORGIA

Albany
Morgan, III, Joe H.

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

Atlanta
Austin, Joseph Patrick
Best, Irwin M.
Corso, J. Eduardo
Duwayri, Yazan
H'Doubler, Jr., Peter B.
Methodius-Rayford, Walaya Chiyem

Geographical Listing of Active Members

Miller, Jay S.
Poindexter, Jr., James M.
Rajani, Ravi
Rheudasil, J. Mark
Ricotta, II, Joseph J.
Veeraswamy, Ravi K.

Augusta

Kauvar, David
Riesenman, Paul J.

Decatur

Brewster, Luke P.

Gainesville

Procter, Sr., Charles D.
Reeves, James G.

Lawrenceville

Moomey, Jr., Charles B.

Macon

Schroder, William B.

Marietta

Wyble, Jr., Charles W.

Newnan

Wellons, Eric

Savannah

Cohn, Jr., Edward J.

Tucker

Adeduntan, Azeez P.

IDAHO

Boise

Matteson, Brian
Tullis, Michael J.

ILLINOIS

Abbott Park

Schwartz, Lewis B.

Arlington Heights

Painter, Thomas A.

Buffalo Grove

Clark, Elizabeth T.

Chicago

Desai, Tina R.
Durham, Joseph R.
Eskandari, Mark K.
Keldahl, Mark L.
Rodriguez, Heron E.

Decatur

Trachtenberg, Jeffrey D.

Downers Grove

Wright, J. Gordon

Glenview

Morcos, Omar C.

Hinsdale

Ziporin, Scott J.

Maywood

Aulivola, Bernadette
Halandras, Pegge
Milner, Ross

Northfield

Golan, John F.

Rockford

Klazura, Paul J.

Skokie

Gupta, Navyash

Springfield

Lambert, Andrew D.

Winfield

Verta, Jr., Michael J.

INDIANA

Carmel

Motaganahalli, Raghunandan L.

Evansville

Patterson, Donald Edward

Indianapolis

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

Geographical Listing of Active Members

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.

KANSAS

Wichita

Hutchinson, Steven A.

KENTUCKY

Lexington

Endean, Eric D.

Minion, David J.

Newton, Wm. Dennis

Sorial, Ehab E.

Stewart, II, John D.

Xenos, Eleftherios

Louisville

Bergamini, Thomas M.

George, Jr., Salem M.

Jung, Matthew T.

Klamer, Thomas W.

Lambert, Jr., Glenn E.

Rachel, Elizabeth S.

Thomas, Bradley G.

Yancey, Andrea E.

Pikeville

Collins, David E.

LOUISIANA

Baton Rouge

Connors, III, Michael S.

Guidry, London Cade

McNeil, James W.

Olinde, Andrew J.

Perkowski, Paul E.

Schellack, Jon V.

Covington

Mena, Jose

Lafayette

Ingram, Jr., James C.

Marrero

Batson, Robert

Palit, Tapash

New Iberia

Dauterive, Jr., Edward

New Orleans

Adinolfi, Michael F.

Bazan, Hernan A.

Sheahan, Claudie

Sheahan, III, Malachi

Smith, Taylor A.

Sternbergh, III, W. Charles

MAINE

Bangor

Cambria, Robert A.

Hart, Joseph P.

Sherwood, Andrew J.

MARYLAND

Annapolis

Stanziale, Stephen F.

Baltimore

Black, III, James H.

Buchbinder, Dale

Freischlag, Julie A.

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

Bethesda

Rasmussen, Todd E.

Cockeysville

Parra, Jose R.

Columbia

Feinberg, Richard L.

Crownsville

Deaton, David H.

Geographical Listing of Active Members

Fredrick

McNeill, Paul M.

Glen Burnie

Neschis, David G.

Owings

Pietropaoli, John A.

Rockville

Salander, James M.

Sparks

Coll, David

MASSACHUSETTS

Boston

Chaikof, Elliot L.
Clouse, W. Darrin
Conrad, Mark F.
Hamdan, Allen D.
Kansal, Nikhil
Kwolek, Christopher J.
Nguyen, Louis L.
Pomposelli, Frank B.
Schermerhorn, Marc L.

Boylston

Aiello, Francesco A.

Brookline

Gupta, Naren
Dartmouth
Pin, Richard

Framingham

Simosa, Hector F.

Lawrence

Muto, Paula M.

North Chelmsford

Burke, Jr., Paul M.

South Weymouth

Kwasnik, Edward M.

Springfield

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

Wellesley

Iafrati, Mark D.

Winchester

Breckwoldt, William L.

Worcester

Robinson, III, William P.

MICHIGAN

Ada

Mansour, M. Ashraf.

Ann Arbor

Criado, Enrique
Eliason, Jonathan L.
Rectenwald, John E.

Bingham Farms

Brown, O. William

Detroit

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

E. Grand Rapids

Greenberg, Joshua I.

Flint

Wilson, David B.

Flushing

Shuster, Thomas A.

Grand Rapids

Chambers, Christopher M.
Cuff, Robert F.

Kalamazoo

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

Northville

Gallagher, Katherine

Norton Shores

Smith, Vance H.

Petoskey

Kazmers, Andris

Geographical Listing of Active Members

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

Alexander, Jason
Rizvi, Adnan Z.
Santilli, Steven M.
Sullivan, Timothy M.

Rochester

Ballinger, Beth Ann
Bjellum, Karl E.
Bower, Thomas C.
Duncan, Audra A.
Fleming, Mark D.
Mensink, Karen
Oderich, Gustavo S.

MISSISSIPPI

Biloxi

Hogan, Michael B.

Hattiesburg

Thompson, J. Keith

Jackson

Baldwin, Zachary K.
O'Mara, Charles S.
Rushton, Jr., Fred W.
Smith, Sumona

Vicksburg

Ferris, Eugene B.

MISSOURI

Liberty

Deiparine, Michael K.

Springfield

Schmittling, Zachary C.
Upton, Brandi

St. Louis

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

MONTANA

Billings

Morasch, Mark D.

Clinton

O'Brien, Patrick Joshua.

NEBRASKA

Omaha

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

NEVADA

Las Vegas

Luh, Eddy H.

Nellis AFB

Jones, III, Wilmer T.

NEW HAMPSHIRE

Lebanon

Goodney, Philip P.
Nolan, Brian W.

Nashua

Rodriguez, Christian C.

Geographical Listing of Active Members

NEW JERSEY

Bridgewater

Drascher, Gary A.

Camden

Caputo, Francis John

Gradell

Geuder, James W.

Hackensack

Simonian, Gregory T.

Monroe Township

Franco, Charles D.

Montclair

Weiswasser, Jonathan M.

Morristown

Ombrellino, Michael

New Brunswick

Graham, Alan M.

Rao, Niranjan V.

Vogel, Todd R.

Newark

Curi, Michael A.

Huang, Joe

Padberg, Jr., Frank T.

Plainsboro

Goldman, Kenneth A.

Short Hills

Sales, Clifford M.

Somers Point

Gosin, Jeffrey S.

Herrington, James W.

Tenafly

Wilderman, Michael J.

Toms River

Haque, Shahid N.

Trenton

O'Neill, Alissa Brotman

Westfield

Levison, Jonathan A.

NEW MEXICO

Albuquerque

Goff, Jr., James M.

Ketteler, Erika

Langsfeld, Mark

Marek, John M.

NEW YORK

Albany

Chang, Benjamin B.

Darling, III, R. Clement

Kreienberg, Paul B.

Mehta, Manish

Ozsvath, Kathleen J.

Paty, Philip S.K.

Roddy, Sean P.

Sternbach, Yaron

Taggart, John B.

Bronx

Greenstein, Stuart

Lipsitz, Evan C.

Brooklyn

D'Ayala, Marcus

Haser, Paul B.

Hingorani, Anil

Rao, Atul S.

Yang, Paul M.

Buffalo

Cherr, Gregory S.

Dosluoglu, Hasan H.

Cooperstown

Cooper, Shelby

Fayetteville

Surowiec, Scott M.

Great Neck

Panetta, Thomas

Patetsios, Peter

Purtill, William A.

Greenlawn

Gennaro, Mark

Hawthorne

Laskowski, Igor A.

Hudson

Shah, Melissa

Geographical Listing of Active Members

Kingston

Hnath, Jeffrey C.
Saltzberg, Stephanie

Lake Success

Doscher, William
Frankini, Larry A.
Schwartz, Mark A.

Mineolo

Wain, Reese A.

New Hyde Park

Landis, Gregg S.

New Rochelle

Karanfillian, Richard

New York

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

Old Bethpage

Gargiulo, III, Nicholas J.

Pittsford

Rhodes, Jeffrey M.

Rochester

Chandra, Ankur
Ellis, Jennifer

Fanciullo, Dustin John
Geary, Kevin J.
Riggs, Patrick N.
Stoner, Michael C.

Roslyn

Rosca, Mihai

Setayjet

Kvilekval, Kara H.V.

Staten Island

Deitch, Jonathan S.
Schor, Jonathan A.

Stony Brook

Loh, Shang A.
Tassiopoulos, Apostolos K.

Syracuse

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

Utica

Lauterbach, Stephen R.

White Plains

Suggs, William D.

NORTH CAROLINA

Asheville

Douglas, Michael G.

Chapel Hill

Farber, Mark A.

Charlotte

Arko, III, Frank R.
Roush, Timothy S.

Durham

Cox, Mitchell Wayne
Mureebe, Leila
Shortell, Cynthia K.

Fayetteville

Roulhac, Maurice R.

Gastonia

Eze, Augustine R.

Geographical Listing of Active Members

Granite Falls

Piercy, Kenneth Todd

Greensboro

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

Greenville

Bogey, Jr., William M.

Lenoir

Purcell, Peter N.

New Bern

Bell, III, William H.

Pinehurst

Atkinson, Clinton K.

Raleigh

Kim, Jason K.

Winston-Salem

Garg, Nitin
Corriere, Matthew A.
Edwards, Matthew S.
Hansen, Kimberley J.
Hurie, Justin
Moore, Phillip S.
Thomason, III, Robert Bradley

NORTH DAKOTA

Fargo

Bakken, Andrew

OHIO

Chagrin Falls

Poliquin, James R.

Chillicothe

Jepsen, Stephen J.

Cincinnati

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.

Park, Woosup Michael.

Srivastava, Sunita D.

Columbus

Franz, Randall W.

Go, Michael R.

Haurani, Mounir J.

Litzendorf, Maria E.

Dublin

Kulwicki, Aaron D.

Duncan Falls

Katz, Sherman A.

Garfield Heights

Alvarez-Tostado, Javier A.

Holland

Paolini, David J.

Lancaster

Mannava, Krishna

Marietta

Parmer, Shane S.

Mayfield Heights

Rizzo, Anthony

Solon

Moise, Mireille A.

Springfield

Matsuura, John H.

Toledo

Comerota, Anthony J.

Nazzal, Munier

Pigott, John P.

Russell, Todd E.

Seiwert, Andrew J.

Willoughby

Rollins, David L.

Geographical Listing of Active Members

Youngstown

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

Zanesville

Campbell, Jessica B.

OKLAHOMA

Tulsa

Yearly, II, Edwin C.

OREGON

Happy Valley

Crutchley, Teresa A.

Portland

Mitchell, Erica L.

Silverton

Waters, Harris J.

PENNSYLVANIA

Abington

Sullivan, Theodore R.

Allentown

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

Bellefonte

Simoni, Eugene J.

Bethlehem

Ivarsson, Bengt
Rosenfeld, Joel C.

Camphill

Razzino, Richard A.

Coopersburg

Guzzo, James L.

Danville

Elmore, James R.
Franklin, David P.

Easton

Fisher, Jay B.
Lipscomb, Amy L.

Gibsonia

Singh, Michael J.

Hershey

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

New Hope

Eisenberg, Joshua A.

Philadelphia

DiMuzio, Paul J.
Weingarten, Michael S.

Pittsburgh

Baril, Donald T.
Chaer, Rabih A.
Healy, Dean A.
Jeyabalan, Geetha
Muluk, Satish C.
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.

Wexford

Rhee, Robert Y.

Wilkes-Barre

Obmann, Melissa A.

Williamsport

Adams, Eric D.
Wynnewood
Bigatel, David A.

York

Harthun, Nancy L.

Geographical Listing of Active Members

PUERTO RICO

Coto Laurel

Martinez, Jorge L.

San Juan

de Jesus, Gustavo Alberto
Joglar, Fernando L.

RHODE ISLAND

Bristol

Gillespie, David L.

East Greenwich

Garcia-Toca, Manuel

Providence

Carney, Jr., Wilfred I.
Marcaccio, Edward J.
Slaiby, Jeffrey M.

SOUTH CAROLINA

Charleston

Keefer, Adam James
Morrison, Edward C.
Tonnessen, Britt H.

Florence

Stonerock, Charles E.
Winkler, Gabor A.

Greenville

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

Greenwood

Hobson, John R.
Lanford, Jeffrey E.

Rock Hill

Taormina, Martin V.

Spartanburg

Calton, Jr., William Cuyler

SOUTH DAKOTA

Rapid City

Orecchia, Paul M.

TENNESSEE

Alcoa

Reisser, John

Chattanooga

Collins, Jr., John T.
Joels, Charles S.
Phade, Sachin V.
Sprouse, II, Larry R.

Columbia

Richardson, Jr., James W.

Franklin

Pulliam, Cary W.

Hendersonville

Gerdes, Jodi

Jellico

Wilkins, Todd H.

Knoxville

Akers, Jr., Donald L.

Nashville

Dattilo, Jeffery B.
Edwards, Jr., 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.
Poltz, John K.
Seidel, Scott A.
Stewart, Mark T.

Belton

Warren, II, Thomas R.

Boerne

Bowser, Andrew

Geographical Listing of Active Members

Dallas

Gable, Dennis R.
Grimsley, Bradley R.
Iliya, Charles A.
Kohn, James S.
Lam, Russell C.
Shutze, William P.
Sundaram, Shankar M.

Denton

Ortega, Raul E.

El Paso

Cook, Patrick

Fort Worth

Paladugu, Ramesh

Galveston

Choi, Lorraine

Garland

Stephanian, Edic

Houston

Bechara, Carlos F.
Bismuth, Jean
Charlton-Ouw, Kristofer M.
Coogan, Sheila M.
Coselli, Joseph S.
Davies, Mark G.
El-Sayed, Hosam F.
Gilani, Ramyar
Huynh, Tam Thi Thanh
Kougias, Panos
Lin, Peter H.
Lumsden, Alan B.
Moinuddeen, Khaja
Naoum, Joseph J.
Peden, Eric K.
Poi, Mun Jye Jye

Humble

Bhatia, Devinder S.
Pickett, Taylor K.

Irving

Sun, Lucy

Missouri City

Barshes, Neal R.

Nacogdoches

Brown, Lyle L.
Randel, Mark A.

Round Rock

Bush, Ruth L.

San Antonio

Arthurs, Zachary M.
Davenport, Phyllis
Macris, Demetrios N.
Peck, Michael A.
Propper, Brandon
Sheehan, Maureen K.
Sykes, Mellick T.
Tamez, Jr., Daniel D.
Toursarkissian, Boulos
Sugar Land
Foteh, Kousta I.

Temple

Atkins, Marvin D.
Bohannon, W. Todd

UTAH

Murray

Whitten, Matthew G.
Wirthlin, Douglas J.

Provo

Smilanich, Robert

Salt Lake City

Brooke, Benjamin S.
Goodman, Greg R.
Ihnat, Daniel M.
Kraiss, Larry W.

South Ogden

Erdoes, Luke S.

VIRGINIA

Charlottesville

Tracci, Margaret Clarke

Christiansburg

Downing, Lamiere J.

Fairfax

Busuttill, Steven J.

Geographical Listing of Active Members

Lynchburg

Widmeyer, Jeffrey H.

Mechanicsville

Brown, Jeff A.

Norfolk

Panneton, Jean M.

Richmond

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

Vienna

Laredo, James

Virginia Beach

Parent, III, F. Noel

Yorktown

Deshmukh, Deepak

WASHINGTON

Bellevue

Ferris, Brian L.

Bellingham

Sohn, Michelle E.

Gig Harbor

Daab, Leo Joseph

Milton

Andersen, Charles A.

Puyallup

Osborne, Jr., Robert

Renton

Kasirajan, Karthik

Seattle

Ciocca, Rocco G.
Meissner, Mark H.
Quigley, Terence M.
Quiroga, Elina
Shalhub, Sherene
Singh, Niten
Starnes, Benjamin W.

Spokane

LaSalle, Andre

Vancouver

Teso, Desarom

WEST VIRGINIA

Charleston

Stone, Patrick A.

WISCONSIN

Appleton

Vogt, Philip A.
Green Bay
Hutto, John D.

Madison

Hoch, John R.
Tefera, Girma

Milwaukee

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

Wauhesha

Schmitt, David D.

Geographical Listing of Active Members

AUSTRALIA

Bedford Park
Puckridge, Phillip J.

St. Leonards
Mohabbat, Walid

CANADA

New Brunswick (Port Elgin)
Cole, C. William

Ontario (London)
De Rose, Guy

Ontario (Newmarket)
Gupta, Deepak

Ontario (Niagra Falls)
Rammohan, Surianarayanan

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

Ontario (Thornhill)
Lossing, Alan G.

Ontario (Toronto)
Huseynova, Khumar

COLOMBIA

Bogota
Molina-Hernandez, Alejandro

EGYPT

October City
Bassiouny, Hisham

FRANCE

Paris
Koskas, Fabien F.

IRELAND

Galway
Sultan, Sherif

ISRAEL

Jerusalem
Rubinstein, Chen

NETHERLANDS

Utrecht
Moll, Frans L.

PERU

Lima
Zuniga, Carlos

SWEDEN

Stockholm
Hultgren, Rebecka
Wahlgren, Carl-Magnus

TRINIDAD AND TOBAGO

St. Clair
Maharaj, Dale A.

TURKEY

Istanbul
Calik, Mustafa K.

Mugla

Yolyapan, Aykut

UNITED KINGDOM

Hull
Chetter, Ian C.



Notes



Notes

VESS Bylaws

ARTICLE I – NAME

The name of this organization shall be the "Vascular and Endovascular Surgery Society" (hereinafter the "Society"). Formerly Peripheral Vascular Surgery Society, Established in 1976.

ARTICLE II – OBJECTIVES

The objectives of this Society shall be:

1. To improve the science and art of vascular surgery and endovascular therapies and the interchange of medical knowledge and information thereon;
2. To promote basic and clinical research for improving the quality and safety of vascular surgical and endovascular procedures and vascular care in general;
3. To engage in scientific or educational purposes, and to promote important issues, as the Executive Council, from time to time, may determine to be beneficial to the membership as a whole or to society in general;
4. To provide a forum for the young vascular surgeon, to promote the field of vascular and endovascular surgery through education, scholarship, advocacy, and leadership.
5. To do any and all things which may be necessary or incidental to these Bylaws.

The Society shall carry on activities:

1. As 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;
2. As 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 – MEMBERSHIP

There shall be six types of membership:

- A. Active
 - B. Active Senior
 - C. Inactive Senior
 - D. Honorary
 - E. Candidate
 - F. Associate
- A. Active membership of this Society shall be limited to physicians of good professional standing who 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. Active members shall be required to pay annual dues. Active members have voting privileges, can serve on committees, sponsor new member applications as well as submit and sponsor papers for presentation at the annual meeting.

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- B. Active senior membership shall be granted to members who have been in practice for greater than 15 years. Active senior members may complete terms of elected office, and are required to pay dues. Active senior members can 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 re-election as Society officers.
- C. Inactive senior membership shall be granted to senior members upon receipt of written request. Inactive senior members will no longer receive a subscription to the Journal. Inactive senior members are not required to pay annual dues nor are they allowed to sponsor new member applications or papers and presentations submitted to the Annual Meeting. 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.
- D. Honorary membership shall be granted to individuals at the discretion of the Executive Council. Honorary members pay no dues and are not eligible for election as VESS officers.
- E. Candidate membership shall be granted to participants who are in good professional standing in an RRC accredited general surgery, vascular surgery residency, or other vascular residency recognized by the Society. Also students in accredited osteopathic and allopathic medical schools can participate in this membership group. Candidate members must be sponsored by an active or senior active VESS member. Candidate members shall have no voting rights. Candidate members can present papers at the Annual Meeting if sponsored by an active member. Candidate members may 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.
- F. Associate membership 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.

ARTICLE IV – ELECTION OF MEMBERS

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

- 1. Membership enrollment in the Society shall be completed via electronic application through the website.
- 2. Completed applications shall be submitted three months prior to any scheduled business 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 applicants recommended for membership by the Executive Council shall be submitted to the members at the business meeting.
- 4. Election to membership shall be by secret ballot, by a three-fourths (3/4) affirmative vote of the membership present.
- 5. An applicant who fails to be elected at one meeting may be reconsidered at the next two business meetings of the Society.

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ARTICLE V – DUES AND FEES

Dues and fees shall be levied by the Executive Council and approved by the membership at the Annual Meeting. Any member whose dues remain unpaid for a period of three 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 Council following payment of the dues in arrears.

ARTICLE VI – RESIGNATIONS, EXPULSIONS

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

ARTICLE VII – 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 Council meetings and the Annual Meeting. Successors to vacated offices of the 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 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 Council as are present.
6. The Secretary shall keep minutes at the meetings of the Society and the Executive Council, update the Executive Council on membership database and new applicant files and conduct correspondence of the 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 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 VIII – EXECUTIVE COUNCIL

1. There shall be an Executive Council 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

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Fundraising Committee chairman, Membership Committee chairman, Bylaws Committee chairman, the Women and Diversity chairman and the Communications Committee chairman shall be non-voting members of the Executive Council.

3. The Executive Council 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 Council meetings shall be held at the call of the President of the Society.
5. A majority of the members of the Executive Council shall constitute a quorum for the transaction of business.

ARTICLE IX – COMMITTEES AND REPRESENTATIVES

Standing committees of the Society shall consist of a Nominating Committee, a Program Committee, a Scholarship Committee, a Fundraising Committee, a Bylaws Committee, a Membership Committee, a Women and Diversity Committee and a Communications Committee.

The Nominating Committee shall consist of the current President in office, the President-Elect and the two most recent Past Presidents. Its functions shall be to make up a slate of officers for the Society, and to nominate representatives to affiliated societies to be presented to the Executive Council at the Annual Meeting. The proposed slate shall then be presented for vote during the Annual Member Business Meeting. Representatives shall be appointed by the Nominating Committee in concert with the Executive Council 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 Council at its Annual Meeting. From time to time, other organizations may seek representation from the Society. Additional representatives shall be appointed in the same manner outlined above.

The Program Committees (winter & spring) shall solicit papers and other presentations from members and other individuals and make up the programs for upcoming meetings. The Program Chairs shall be named by the Executive Council and serve a term of two years. Each Committee will consist of six additional society members serving a term of two years each, with three members alternating years to allow for overlap. Program Chairs will be responsible for filling the three empty positions for any given year.

The Scholarship Committee shall consist of six members, a chairman, selected by the Executive Council, three Councilors-At-Large and two 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 Council at the Annual Meeting.

The Fundraising 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 Executive Council at the Annual Meeting to serve a three-year term. The chairman will

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also serve on the Executive Council 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 four additional Society members to assist with this task. In addition, the current Society President shall be an ex-officio member.

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 Executive Council. The most senior member of the Bylaws Committee shall serve as chair. The Bylaws Committee shall review bylaws from time to time as directed by the Council and when appropriate, make recommendations regarding amendments.

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 Executive Council. The most senior member of the Membership Committee shall serve as chair. The committee shall review all applications and present their nominations for membership to the Executive Council for review and ratification at the Annual Business Meeting. The Committee shall also assist the Secretary with membership development and expansion campaigns.

The Women and Diversity Committee shall consist of four members to serve overlapping terms of four years each. The most senior member shall serve as chair for one year. Open positions shall be appointed by the Executive Council. The purpose of this committee is to identify and promote ways to address minority issues in vascular surgery, and encourage women and minorities to actively participate in the society and its committees.

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 membership and along with the Secretary will oversee subcommittee functions. The Communication Chair is appointed by the Executive Council for a maximum three year term renewed annually. The Committee shall consist of three subcommittees:

1. Website subcommittee consisting of one chair serving a two year term and two subcommittee members appointed for two year terms and is responsible for all web-based and electronic communication and maintenance of the Society website.
2. Newsletter subcommittee consisting of one chair serving a two year term and a minimum of two subcommittee members appointed for two year terms and is responsible for a membership newsletter at intervals defined by the Communication Chair.
3. Correspondence subcommittee consisting of one chair serving a two year term and two subcommittee members appointed for two year terms and is responsible for organizing, coordinating and implementing all membership correspondence. All communication subcommittee members shall be appointed by the Executive Council at appropriate intervals and renewed annually.

ARTICLE X – MEETINGS

1. The Society shall hold an Annual Meeting, customarily in winter, and held at a time and place selected by the Executive Council.

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2. The business meeting of the Society shall be conducted during the Annual 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 any other member category.
4. Special meetings may be called at any time by the president, or a simple majority of the Executive Council.

ARTICLE XI – QUORUM

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

ARTICLE XII – 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 XIII – PROCEDURE

Proceedings of the Society shall be conducted under Robert's Rules of Order.

Amended – August, 2012

Amended – February 1, 2013

Amended – January 31, 2014



Notes



Notes

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

W. L. Gore Travel Award

- 2015 **Matthew Mell, MD**
Stanford University, Stanford, CA

Young Faculty Research Award

- 2014 **Dawn M. Coleman, MD**
University of Michigan, Ann Arbor, MI
Efficacy of Apixiban In Anti-Inflammatory Induced Vein Wall Remodeling In A Murine Model of Deep Vein Thrombosis

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. M. 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. M. Wayne Causey, MD**
Madigan Army Medical Center, Tacoma, WA
Microarray 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
- 2013 **Cpt. M. Wayne Causey, MD**
Madigan Army Medical Center, Tacoma, WA
Pharmacologic Attenuation of the Hyperdynamic Response After Aortic Occlusion
- 2014 **Cpt. Daniel Scott, MD**
San Antonio Military Medical Center, San Antonio, TX
Use of the Short Musculoskeletal Function Assessment For Limb-Specific Outcomes Following Vascular Injuries

Member Update Form

Please help the VESS 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 VESS 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!

