Table of Contents

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2015 - 2016

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Past Meetings & Presidents

Date	Location	President
1976	Chicago, IL	Organizational Meeting
1977	Dallas, TX	Steven M. Dosick, MD
1978	San Francisco, CA	Robert G. Scribner, MD
1979	Chicago, IL	William S. Gross, MD
1980	Chicago, IL	Charles A. Andersen, MD
1981	Dallas, TX	Larry H. Hollier, MD
1982	Boston, MA	G. Edward Bone, MD
1983	San Francisco, CA	Robert C. Batson, MD
1984	Atlanta, GA	Lee C. Bloemendal, MD
1985	Baltimore, MD	George J. Collins, Jr.
1986	New Orleans, LA	Jonathan B. Towne, MD
1987	Toronto, Canada	Thomas S. Riles, MD
1988	Chicago, IL	Paul T. McDonald, MD
1989	New York, NY	Anthony J. Comerota, MD
1990	Los Angeles, CA	John W. Hallett, Jr., MD
1991	Boston, MA	Paul M. Orecchia, MD
1992	Chicago, IL	David L. Rollins, MD
1993	Washington, DC	Frank T. Padberg, Jr., MD
1994	Seattle, WA	Peter G. Kalman, MD
1995	New Orleans, LA	William J. Quinones-Baldrich, MD
1996	Chicago, IL	Joseph L. Mills, MD
1997	Boston, MA	Gary Giangola, MD
1998	San Diego, CA	J. Gordon Wright, MD
1999	Washington, DC	Jeffrey R. Rubin, MD
2000	Toronto, Canada	Donald L. Akers, Jr., MD
2001	Baltimore, MD	Thomas F. Lindsay, MD
2002	Boston, MA	R. Clement Darling, III, MD
2003	Chicago, IL	Jeffrey L. Ballard, MD
2004	Anaheim, CA	Samuel R. Money, MD
2005	Chicago, IL	Lewis B. Schwartz, MD
2006	Philadelphia, PA	Robert A. Cambria, MD
2007	Baltimore, MD	William D. Jordan, Jr., MD
2008	San Diego, CA	W. Charles Sternbergh, III, MD
2009	Denver, CO	Tina R. Desai, MD
2010	Boston, MA	Karl A. Illig, MD
2011	Chicago, IL	Marc A. Passman, MD
2012	Baltimore, MD	Martin R. Back, MD
2013	Park City, UT	Ruth L. Bush, MD, MPH
2014	Steamboat Springs, CO	W. Darrin Clouse, MD
2015	Vail, CO	Vikram S. Kashyap, MD

General Information

Registration

For security reasons, the scientific session hall and exhibit hall will be monitored for conference badges and/or hotel staff badges. Please wear your conference badge to all events. The VESS registration desk will be located in the **Ballroom Pre-Function** at the **Grand Summit Lodge**. Registration hours are as follows:

Thursday, February 4	7:00 am—5:00 pm
Friday, February 5	6:00 am—9:30 am
	3:00 pm—6:30 pm
Saturday, February 6	6:00 am—9:30 am
	3:00 pm—6:00 pm
Sunday, February 7	6:30 am—9:00 am

Scientific Sessions

All scientific sessions will be conducted in **Kokopelli II & III** at the **Grand Summit Lodge** unless otherwise noted.

Speaker Ready Area

The Speaker Ready Area will be located in the back of the **Kokopelli Ballroom** at the **Grand Summit Lodge**. Speakers are required to check-in to the Speaker Ready Area to upload their PowerPoint presentations (using USB flash drive) at least 2-hours prior to their scheduled talk. **No personal laptops will be permitted at the podium.** The hours of operation of the Speaker Ready Area are listed below:

Thursday, February 4	7:30 am—3:00 pm
Friday, February 5	6:30 am—9:30 am
	3:30 pm—7:00 pm
Saturday, February 6	6:30 am—9:30 am
	3:30 pm—6:00 pm
Sunday, February 7	6:30 am—9:30 am

Technology Forum

The Technology Forum—Venous Disease and Emerging Technologies—will be held on **Thursday, February 4, 2015** from **1:30 pm—5:00 pm** in **Kokopelli III** at the **Grand Summit Lodge**. There is no fee for this forum, but registration is required.

The field of venous disease has been an ever-growing field with increasing treatment options over a wide variety of platforms. This has given physicians a tremendous opportunity to treat patients more often in a less invasive way. With the rapidly expanding inventory, it is imperative that vascular surgeons – faculty and trainees alike – stay up-to-date with the latest technology. This information then impacts the required skills and decision-making process regarding the best available options in the treatment of superficial and deep venous disease, as well as dialysis access. The emphasis of this program is to bridge this information gap.

Continuing Medical Education Credit Information

Accreditation

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 (CME) for physicians.

AMA PRA Category 1 Credits™

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.

Learning Objectives

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) Discuss the ultrasound, CT, MR and angiographic findings associate with derangements of the normal vascular system; 4) Understand the indications for EVAR and complex EVAR for abdominal aortic aneurysms; 5) Describe changes in the perceptions of vascular training by vascular surgery residents and fellows; and 6) 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.

Acknowledgements

Educational Grants

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

Boston Scientific

Marketing Support

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

Abbott Vascular
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Schedule-At-A-Glance

Thursday, February 4, 2016

7:00 am – 5:00 pm	Registration
8:00 am – 9:00 am	Fellows' Breakfast
9:00 am – 12:30 pm	**2016 FELLOWS' PROGRAM**
10:30 am – 10:45 am	Coffee Break
12:30 pm – 1:30 pm	Fellows' Lunch
1:30 pm – 5:00 pm	**TECHNOLOGY FORUM – DIDACTIC & HANDS-ON** **Venous and Potpourri**
5:30 pm – 7:00 pm	**WELCOME RECEPTION** All attendees, guests & exhibitors are welcome.

Friday, February 5, 2016

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 **Developing Duplex Ultrasound Criteria For Diagnosis of Arteriovenous Fistula Stenosis** Kellie Wo, Russell N. Harada - Pali Momi Medical Center, Aiea, HI
7:12 am – 7:24 am	2 **Durability of A Brief Smoking Cessation Intervention For Patients With Vascular Disease: The Vascular Physician Offer and Report (VAPOR) Trial** Bjoern Suckow[1], Karina Newhall[2], Alik Farber[3], Adam Beck[4], Andrew Hoel[5], Andres Schanzer[6], Benjamin Brooke[7], Tze-Woei Tan[8], John Hallett[9], Philip P. Goodney[1] - [1]Dartmouth-Hitchcock Medical Center, Lebanon, NH; [2]The Dartmouth Institute, Lebanon, NH; [3]Boston Medical Center, Boston, MA; [4]University of Florida, Gainesville, FL; [5]Northwestern University, Chicago, IL; [6]University of Massachusetts, Worcester, MA; [7]University of Utah, Salt Lake City, UT; [8]Louisiana State University - Shreveport, Shreveport, LA; [9]Roper St. Francis, Charleston, SC
7:24 am – 7:36 am	3 **Fluoroscopy Time Is Not Accurate As A Surrogate For Radiation Exposure** Edvard Skripochnik, Shang A. Loh - Stony Brook University, Stony Brook, NY

Schedule-At-A-Glance

7:36 am – 7:48 am

4
Are They Listening To Us? The Impact of Brief Surgeon-Delivered Smoking Cessation Intervention On Vascular Patient Attitudes About Smoking In the Vascular Physician Offer and Report (VAPOR) Trial
Karina A. Newhall[1], Bjoern Suckow[2], Benjamin Brooke[3], Alik Farber[4], Adam W. Beck[5], Andrew W. Hoel[6], Andres Schanzer[7], Tze-Woei Tan[8], John J. Hallett[9], Philip Goodney[2], VAPOR Investigators - [1]White River Junction Veterans Administration, White River Junction, VT; [2]Dartmouth-Hitchcock Medical Center, Lebanon, NH; [3]University of Utah School of Medicine, Salt Lake City, UT; [4]Boston University School of Medicine, Boston, MA; [5]University of Florida College of Medicine, Gainesville, FL; [6]Northwestern University Feinberg School of Medicine, Chicago, IL; [7]University of Massachusetts School of Medicine, Worchester, MA; [8]Louisiana State University Shreveport Health Sciences Center, Shreveport, LA; [9]Roper St. Francis Vascular Center, Charleston, SC

7:48 am – 7:56 am

5 (CR)
Novel Bail-Out Technique For Renal Artery Shuttering During Endovascular Aneurysm Repair
Marcus R. Kret, Donald R. Lynch, Jr., E. John Harris, Jr., Jason T. Lee - Stanford University, Stanford, CA

7:56 am – 8:04 am

6 (RF)
Techniques For Internal Iliac Artery Preservation: Options and Outcomes
Yaron Sternbach, John Taggert, Sean Roddy, Benjamin Chang, Paul Kreienberg, Jeffrey Hnath, Kathleen Ozsvath, R. Clement Darling, III - Albany Medical College, Albany, NY

8:04 am – 8:12 am

7 (RF)
Patient-Reported Quality of Life After Endovascular Repair of Thoracoabdominal Aortic Aneurysms
Andrew J. Meltzer, Peter H. Connolly, Sharif Ellozy, Darren B. Schneider - Weill Cornell Medical College, New York, NY

8:12 am – 8:24 am

8
Abdominal Visceral Fat Correlates With Adverse Outcomes In Open But Not Endovascular Aortic Repair
Lauren E. Trakimas, Doran S. Mix, Claudia I. Aghaie, Khurram Rasheed, Jennifer L. Ellis, Roan J. Glocker, Adam A. Doyle, Michael C. Stoner - University of Rochester, Rochester, NY

8:24am – 8:36 am

9
Fellows' Assessment of the Future of Vascular Surgery
Anil Hingorani, Amrit Hingorani, Natalie Marks, Justin Eisenberg, Ali Rizvi, Enrico Ascher - NYU Lutheran Medical Center, Brooklyn, NY

Schedule-At-A-Glance

8:36 am – 8:48 am	10 **The Effect of SCIP Measures On Complications and Mortality In Vascular Surgery** Kenneth R. Nakazawa, Natalia N. Egorova, Peter L. Faries, Ageliki G. Vouyouka - Icahn School of Medicine at Mount Sinai, New York, NY
8:48 am – 8:56 am	11 (CR) **Resolution of Unilateral Blindness Following Complete Embolization of ECA For Debilitating AVM** Jason E. Davis, Massimo Napolitano, Greg Simonian, Michael Wilderman, Anjali Ratnathicam, David O'Connor - Hackensack University Medical Center, Hackensack, NJ
8:56 am – 9:04 am	12 (RF) **Surgical Management of Peripheral Vascular Manifestations of Loeys-Dietz Syndrome** Robert J. Beaulieu, Jennifer Lue, Bryan A. Ehlert, Caitlin W. Hicks, James H. Black, III - Johns Hopkins Hospital, Baltimore, MD
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks – Visit Exhibits
4:00 pm – 6:00 pm	**SCIENTIFIC SESSION II**
4:00 pm – 4:12 pm	13 **Involvement of Senior Surgical Residents Is Associated With Worse Outcomes After Infra-Inguinal Bypass Operations** Erin K. Greenleaf, Christopher S. Hollenbeak, Faisal Aziz - Penn State Hershey Medical Center, Hershey, PA
4:12 pm – 4:24 pm	14 **Change In Aortic Neck Diameter After Endovascular Aortic Aneurysm Repair** Marcus R. Kret, Kenneth Tran, Jason T. Lee - Stanford University, Stanford, CA
4:24 pm – 4:36 pm	15 **Cost Effectiveness of Endovascular Revascularization Compared To Open Surgical Treatment For Acutely Thrombosed Lower Extremity Arterial Bypass Grafts** Elizabeth A. Genovese[1], Kenneth J. Smith[1], Neal R. Barshes[2], Michel S. Makaroun[1], Donald T. Baril[1] - [1]University of Pittsburgh Medical Center, Pittsburgh, PA; [2]Baylor College of Medicine, Houston, TX
4:36 pm – 4:48 pm	16 **Natural History of Claudicants After Endovascular Therapy** Julia Saraidaridis, Emel Ergul, Virendra Patel, Richard Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

Schedule-At-A-Glance

4:48 pm – 4:56 pm	17 (RF) **Endovascular Salvage of Proximal Fixation Loss In the Paravisceral Aorta** Adam Tanious[1], Megan Carroll[1], Mathew Wooster[1], Andrew Jung[1], Marcelo Giarelli[2], Martin Back[1], Peter Nelson[1], Murray Shames[1] - [1]University of South Florida, Tampa, FL; [2]Tampa General Hospital, Tampa, FL
4:56 pm – 5:04 pm	18 (CR) **Supragenicular Approach To Release Popliteal Entrapment Without Distal Bypass Despite Preoperative Runoff Thrombosis** Christopher R. Ramos, Natalia Glebova - University of Colorado, Aurora, CO
5:04 pm – 5:12 pm	19 (RF) **The Impact of Biochemical Markers On Major Adverse Cardiovascular Events and Contralateral Carotid Artery Stenosis Progression Following Carotid Interventions** Patrick Stone, Stephanie Thompson - WVU Charleston, Charleston, WV
5:12 pm – 5:24 pm	20 **Superior Lower Extremity Vein Graft Bypass Patency Among Married Patients With Peripheral Arterial Disease** Emily Lagergren, Kelly Kempe, Timothy E. Craven, Susan T. Kornegay, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez, Matthew S. Edwards, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC
5:24 pm – 5:36 pm	21 **Cumulative Number of Treatment Interventions Predicts Health-Related Quality of Life In Patients With Critical Limb Ischemia** Matthew P. Goldman, Ryan Barnard, Santiago Saldana, Jeanette M. Stafford, Douglas Easterling, Gregory L. Burke, Edward H. Ip, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC
5:36 pm – 5:48 pm	22 **Tibioperoneal Occlusive Disease: A Review of Below the Knee Endovascular Therapies In Patients With Critical Limb Ischemia** Kathryn B. Muir, Patrick R. Cook, Maxwell R. Sirkin, Gilbert Aidinian - William Beaumont Army Medical Center, El Paso, TX
5:48 pm – 6:00 pm	23 **Transradial Embolization of the Internal Iliac Artery Prior To Endovascular Aneurysm Repair: Initial Results and Technique** Sean P. Wengerter, Christine E. Ghatan, Nora E. Tabori, Rahul S. Patel, Edward Kim, S. Francis Nowakowski, Peter L. Faries, Michael L. Marin, Robert A. Lookstein, Aaron M. Fischman - Mount Sinai Hospital, New York, NY

Schedule-At-A-Glance

6:00 pm – 7:15 pm **VESS MEMBER BUSINESS MEETING**

7:15 pm Free Evening

Saturday, February 6, 2016

6:00 am – 7:00 am Continental Breakfast

6:00 am – 9:30 am Registration

7:00 am – 9:00 am **SCIENTIFIC SESSION III**

7:00 am – 7:12 am
24
Normal Lower Extremity Duplex Findings In Patients With Left Ventricular Assist Devices: A Basis For Vascular Laboratory Interpretation
Sheena K. Harris, Matt Roos, Jeff Crawford, Dale Wilson, Enjae Jung, Erica Mitchell, Gregory Moneta - Oregon Health and Science University, Portland, OR

7:12 am – 7:24 am
25
Outcomes of Critical Limb Ischemia In A Public Hospital Population With High WIfI Amputation Scores
Robert Ward, Joie Dunn, Leonardo Clavijo, David Shavelle, Vincent Rowe, Karen Woo - Keck School of Medicine, University of Southern California, Los Angeles, CA

7:24 am – 7:36 am
26
Impact of Inferior Vena Cava Filter Placement On Short-Term Outcomes In Patients With Acute Pulmonary Embolism
Nathan L. Liang, Elizabeth A. Genovese, Efthymios D. Avgerinos, Michael J. Singh, Michel S. Makaroun, Rabih A. Chaer - University of Pittsburgh, Pittsburgh, PA

7:36 am – 7:48 am
27
Outcomes In Critical Limb Ischemia Compared By Distance From Referral Center
Peter Bartline, Bjoern Suckow, Benjamin Brooke, Larry Kraiss, Michelle Mueller - University of Utah, Salt Lake City, UT

7:48 am – 7:56 am
28 (CR)
Long-Term Morphologic Analysis of the Aortic Arch Following TEVAR In Patients With Acute Complicated Type B Aortic Dissection
Hector Crespo, Frank R. Arko, III, A. Carson Milner, M. Zachary Arko, Charles S. Briggs, Andrew B. Giggey, Stephen G. Lalka - Sanger Heart and Vascular Institute, Charlotte, NC

Schedule-At-A-Glance

7:56 am – 8:04 am	29 (RF) **CT FFR Can Accurately Identify Culprit Lesions In Aorto-Iliac Occlusive Disease Using Minimally-Invasive Techniques** Erin Ward[1], Daniele Schiavazzi[2], Divya Sood[1], John Lane[1], Erik Owens[1], Alison Marsden[2], Andrew Barleben[1] - [1]UCSD, San Diego, CA; [2]Stanford, Stanford, CA
8:04 am – 8:12 am	30 (RF) **Somatosensory Evoked Potentials and Electroencephalography During Carotid Endarterectomy Predict Late Stroke But Not Death** Natalie A. Domenick, Rabih Chaer, Partha Thirumala, Jeffrey Balzer, Michel Makaroun, Edith Tzeng, Efthimios Avgerinos - University of Pittsburgh, Pittsburgh, PA
8:12 am – 8:24 am	31 **Secondary Aorto-Enteric Fistulae : Results of Radical Open In Situ Treatment Using Cryopreserved Arterial Allografts** Marc A. Dennery, Jr., Fabien Koskas, Sr. - Hôpital Pitié-Salpêtrière, Paris, France
8:24 am – 8:32 am	32 (RF) **Factors Predictive of Outcome When Crossing A Chronic Total Occlusion** Jennifer Perri, Philip Goodney, David Stone - Dartmouth-Hitchcock Medical Center, Lebanon, NH
8:32 am – 8:44 am	33 **Carotid Endarterectomy Versus Stenting In Patients With Renal Transplants** Isibor Arhuidese, Dorry Segev, Tammam Obeid, Besma Nejim, Mahmoud Malas - Johns Hopkins Medical Institutions, Baltimore, MD
8:50 am – 9:00 am	**Introduction of the President** Thomas S. Maldonado, MD
9:00 am – 9:45 am	**PRESIDENTIAL ADDRESS** Sean Roddy, MD
3:00 pm – 6:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks – Last Chance To Visit Exhibits
4:00 pm – 6:00 pm	**SCIENTIFIC SESSION IV**
4:00 pm – 4:12 pm	34 **Compression vs. No Compression After Endovenous Ablation of the Great Saphenous Vein: A Prospective Randomized Controlled Trial** Diego Ayo, Todd Jones, Sheila Blumberg, Caron Rockman, Mikel Sadek, Neal Cayne, Mark Adelman, Lowell Kabnick, Thomas Maldonado, Todd Berland - New York University School of Medicine, New York, NY

Schedule-At-A-Glance

4:12 pm – 4:24 pm

35
Bundling of Reimbursement For Inferior Vena Cava Filter Placement and Procedural Utilization Volumes
Roan J. Glocker, Elaine L. Hill, Joseph J. Guido, Adam Doyle, Jennifer L. Ellis, Gary R. Morrow, Michael C. Stoner - University of Rochester, Rochester, NY

4:24 pm – 4:36 pm

36
Determinants of Symptomatic Recurrence and Repeat Intervention Following Endovascular Treatment of Chronic Mesenteric Ischemia In the Setting of Challenging Superior Mesenteric Artery Lesions
Thomas E. Reeve, IV, Matthew P. Goldman, Timothy E. Craven, Matthew S. Edwards, Matthew A. Corriere, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez - Wake Forest School of Medicine, Winston Salem, NC

4:36 pm – 4:48 pm

37
Patency of the Internal Iliac Artery After Placement of Common And External Iliac Artery Stents
Margarita Vinogradova[1], Hye J. Lee[1], Ehrin Armstrong[2], John Laird[1], Misty D. Humphries[1] - [1]University of California Davis Medical Center, Sacramento, CA; [2]VA Eastern Colorado Health Center, Denver, CO

4:48 pm – 4:56 pm

38 (RF)
Initial Experiences With Endovascular Management of Pulmonary Embolism - Is It Safe?
Timothy J. Fuller, Muhammad H. Zubair, Christopher M. Paprzycki, Lala R. Hussain, Patrick E. Muck - Good Samaritan Hospital, Cincinnati, OH

4:56 pm – 5:04 pm

39 (CR)
Endovascular Management of Concomitant Thoracic and Abdominal Aortic Ruptures Resulting From Brucellosis Aortitis
Samuel L. Chen, Isabella J. Kuo, Roy M. Fujitani, Nii-Kabu Kabutey - University of California, Irvine Medical Center, Orange, CA

5:04 pm – 5:12 pm

40 (RF)
Effects of Gender Differences On Short-Term Outcomes In Patients With Acute Type B Aortic Dissection
Nathan L. Liang, Elizabeth A. Genovese, Georges E. Al-Khoury, Eric S. Hager, Michel S. Makaroun, Michael J. Singh - University of Pittsburgh, Pittsburgh, PA

5:12 pm – 5:24 pm

41
Under-Utilization of Routine Ultrasound Surveillance After Endovascular Aortic Aneurysm Repair
Matthew Mell, Trit Garg, Laurence C. Baker - Stanford University, Stanford, CA

Schedule-At-A-Glance

5:24 pm – 5:36 pm	42 **Concomitant Parallel Endografting and Fenestrated Experience In A Regional Aortic Center** Mathew Wooster, Adam Tanious, Shiva Patel, Neil Moudgill, Martin Back, Murray Shames - University of South Florida, Tampa, FL
5:36 pm – 5:48 pm	43 **Patterns In the Management of Acute Limb Ischemia: A VESS Survey** Matthew R. Smeds[1], Harleen K. Sandhu[2], Samuel S. Leake[2], Charles C. Miller, III[2], Kristofer M. Charlton-Ouw[2] - [1]University of Arkansas for Medical Sciences, Little Rock, AR; [2]University of Texas Medical School at Houston, Houston, TX
5:48 pm – 5:56 pm	44 (RF) **Gender-Specific Differences In Saphenous Vein Conduit: A Link To Outcomes Disparities?** Emily Lagergren, Kelly Kempe, Timothy E. Craven, Susan T. Kornegay, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez, Matthew S. Edwards, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC
5:56 pm – 6:04 pm	45 (CR) **Endovascular Treatment of Acute Type B Dissection and SMA Thrombosis Using Aspiration Catheter** Max Wohlauer, Michael Park - Cleveland Clinic, Cleveland, OH
7:00 pm – 10:00 pm	**PRESIDENT'S DINNER** All registered attendees are welcome to attend. This is a ticketed event.

Sunday, February 7, 2016

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 **Hemodialysis Vascular Access: Rising Costs As A Surrogate Marker For Patency and Function of Arteriovenous Fistulas** Zachary M. Feldman, Lisa B. Liu, Stephen D. Abramowitz, Peter L. Faries, Michael L. Marin, Harry R. Schanzer, Victoria J. Teodorescu - Icahn School of Medicine at Mount Sinai, New York, NY

Schedule-At-A-Glance

7:12 am – 7:24 am

47
Ectatic Aortas (2.5-2.9 cm) Are At Risk For Progression To Abdominal Aortic Aneurysm
Michael S. Hong[1], Ashley S. Schmidt[2], Kevin C. Chun[2], Tanmayee Yenumula[2], Narges Zazi[2], Eugene S. Lee[2] - [1]UC Davis, Sacramento, CA; [2]Sacramento Veterans Administration Medical Center, Mather, CA

7:24 am – 7:36 am

48
The Impact of Functional Status On the Outcomes of Endovascular Lower Extremity Revascularization For Critical Limb Ischemia In the Elderly
Isidore Dinga Madou, Martin Slade, Kristine Orion, Timur Sarac, Cassius Iyad Ochoa Chaar - Yale New Haven Hospital, Yale School of Medicine, New Haven, CT

7:36 am – 7:48 am

49
Predicting Mortality In Ruptured Abdominal Aortic Aneurysms In the Endovascular Era
Michael Neilsen[1], David Clark[1], William P. Robinson[2], Andres Schanzer[3], Christopher T. Healey[1] - [1]Maine Medical Center, Portland, ME; [2]University of Virginia School of Medicine, Charlottesville, VA; [3]University of Massachusetts Medical School, Worcester, MA

7:48 am – 7:56 am

50 (RF)
Predicting ICU Readmission Among Vascular Surgery Patients: Development of A Predictive Nomogram
Katherine Reigstad, Ragheed Al-Dulaimi, Mary Mone, Joseph Tonna, Richard Barton, Larry S. Kraiss, Benjamin S. Brooke - University of Utah, Salt Lake City, UT

7:56 am – 8:04 am

51 (RF)
Simultaneous Peripheral Artery Disease and Venous Insufficiency Result In Increased Risk of Amputation
Julia Saraidaridis, Emel Ergul, Hassan Albadawi, Virendra I. Patel, Richard Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

8:04 am – 8:16 am

52
Do Patients Understand Their Cardiovascular Risk Factors and Impact On Complications?
Derrick L. Green[1], Jackquelin Loera[2], Peter Alden[2], Jesse Manunga[2], Andrew Cragg[2], Timothy Sullivan[2], Jason Q. Alexander[2] - [1]University of Minnesota, Minneapolis, MN; [2]Minneapolis Heart Institute, Minneapolis, MN

8:16 am – 8:28 am

53
Increased Prevalence of Moderate and Severe Pad In the Native American/Alaskan Native Population: A Study of 50,000 NA/AN
Andrew R. Baxter, Glenn Jacobowitz, Yu Guo, Jeffery Berger, Thomas Maldonado, Caron Rockman - NYU Langone Medical Center, New York, NY

Schedule-At-A-Glance

8:28 am – 8:40 am	54 **Surgical Management of Primary Mycotic Aortic Aneurysms: A 14-Year Single-Center Experience** Raymond E. Eid, Karim M. Salem, Michael Singh, Michel S. Makaroun, Donald T. Baril - University of Pittsburgh Medical Center, Pittsburgh, PA
8:40 am – 8:52 am	55 **Neurocognitive Outcomes and Microembolization Rates Following Carotid Artery Angioplasty and Stenting In Symptomatic Patients** Christian E. Pina, Jennifer Li, Bhakti Rawal, Aesha Patel, Christopher Faries, Ageliki Vouyouka, Prakash Krishnan, Rami Tadros, Michael Marin, Jose Wiley, Peter L. Faries - Icahn School of Medicine at Mount Sinai, New York, NY
8:52 am – 9:04 am	56 **Real-World Performance of Paclitaxel Drug-Eluting Bare Metal Stenting (Zilver PTX) For the Treatment of Femoropopliteal Occlusive Disease** Kenneth Tran, Brant W Ullery, Marcus Kret, Jason T. Lee - Stanford University, Stanford, CA
9:15 am	Meeting Adjourns

Notes

Full Program & Abstracts

Thursday, February 4, 2016

7:00 am – 5:00 pm	**Registration** *Location: Ballroom Pre-Function*
8:00 am – 9:00 am	**Fellows' Breakfast** *Location: Ballroom Pre-Function*
9:00 am – 12:30 pm	**2016 FELLOWS' PROGRAM** *Location: Kokopelli III*
10:30 am – 10:45 am	**Coffee Break** *Location: Ballroom Pre-Function*
12:30 pm – 1:30 pm	**Fellows' Lunch** *Location: Kokopelli II*
1:30 pm – 5:00 pm	**TECHNOLOGY FORUM – DIDACTIC & HANDS-ON** **Venous and Potpourri** Moderator: Todd Berland, MD *Location: Kokopelli III*
5:30 pm – 7:00 pm	**WELCOME RECEPTION** All attendees, guests & exhibitors are welcome. *Location: Kokopelli II*

Friday, February 5, 2016

6:00 am – 7:00 am	**Continental Breakfast** *Location: Kokopelli I*
6:00 am – 9:30 am	**Registration** *Location: Ballroom Pre-Function*

Full Program & Abstracts

7:00 am – 9:15 am **SCIENTIFIC SESSION I**
Moderators: John E. Rectenwald, MD & Faisal Aziz, MD
Location: Kokopelli II & III

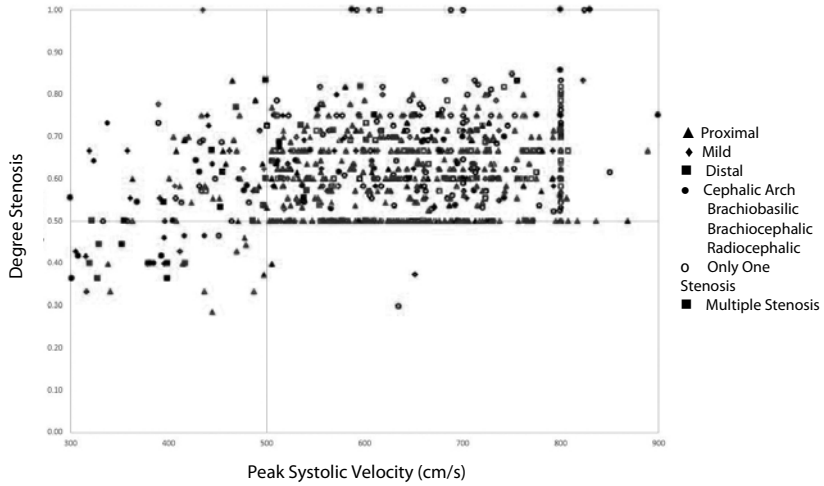
7:00 am – 7:12 am 1
Developing Duplex Ultrasound Criteria For Diagnosis of Arteriovenous Fistula Stenosis
Kellie Wo, Russell N. Harada - Pali Momi Medical Center, Aiea, HI

Introduction and Objectives: The purpose of this study was to quantify color-coded duplex ultrasound (US) criteria for detection of stenosis in arteriovenous fistulas (AVF) by comparing duplex US to the angiographic gold standard.

Methods: Included in this retrospective study were all patients who had both duplex US scans and angiograms of their AVF performed between December 2008 and July 2015. Comparisons were made between the preoperative US peak systolic velocity (PSV) measurements and the angiographic images looking at the percent diameter reduction of the stenosis. Sensitivity and positive predictive values (PPV) with 95% confidence intervals were calculated.

Results: This study included 780 cases of stenotic accesses (47 brachiobasilic, 361 brachiocephalic, and 372 radiocephalic). PSVs of ≥500 cm/s predicted a 50% or greater stenosis with a sensitivity of 89% [95% confidence interval, 87 to 91] and PPV of 99% [99 to 100]. At lower PSVs, sensitivity and PPV remained high, however there were an increased number of false positive cases compared to those at 500 cm/s or greater.

Conclusions: PSVs of ≥500 cm/s are generally reliable in predicting stenosis of 50% or greater in arteriovenous fistulas.



7:12 am – 7:24 am

2

Durability of A Brief Smoking Cessation Intervention For Patients With Vascular Disease: The Vascular Physician Offer and Report (VAPOR) Trial

Bjoern Suckow[1], Karina Newhall[2], Alik Farber[3], Adam Beck[4], Andrew Hoel[5], Andres Schanzer[6], Benjamin Brooke[7], Tze-Woei Tan[8], John Hallett[9], Philip P. Goodney[1] - [1]Dartmouth-Hitchcock Medical Center, Lebanon, NH; [2]The Dartmouth Institute, Lebanon, NH; [3]Boston Medical Center, Boston, MA; [4]University of Florida, Gainesville, FL; [5]Northwestern University, Chicago, IL; [6]University of Massachusetts, Worcester, MA; [7]University of Utah, Salt Lake City, UT; [8]Louisiana State University - Shreveport, Shreveport, LA; [9]Roper St. Francis, Charleston, SC

Introduction and Objectives: It is unclear how long vascular patients, often dedicated long-term smokers, retain advice from brief smoking cessation interventions. We examined the durability of a brief cessation intervention on behavior and perceptions of smoking health risks for patients in the Vascular Physician Offer and Report (VAPOR) trial.

Methods: The VAPOR trial is an ongoing SVS-funded, 8-center trial comparing a standardized smoking cessation intervention to usual care for patients facing vascular care. To date, in the intervention arm (n=65, 42%), physicians have provided standardized advice, referred patients to a state Quitline and offered nicotine replacement therapy. In the control arm, 91 patients (58%) received usual care. Surveys at baseline and 3 months assess changes in smoking status and behavior.

Results: At enrollment, 156 patients averaged 14 cigarettes daily and 40 years of smoking. In this interval analysis, 98/156 patients have reached 3-month follow-up. Survey results at enrollment indicated a high burden of risky behaviors in both groups (Table). However, at 3 months, intervention patients had larger declines in scores compared to control patients (41% vs. 16% decline, p=0.001), suggesting the intervention was durable in conveying risks of smoking. Further, 3 month risk perceptions from smoking were lower in both groups (12% intervention, 15% control, p=NS). Finally, of 98 patients, all provided smoking status, but 44 refused the survey (33 who quit and 11 who did not). Sensitivity analysis verified similar outcomes after accounting for incomplete follow-up surveys.

Conclusions: A physician-directed smoking cessation intervention combined with nicotine replacement therapy and Quitline counseling appears more effective in reducing smoking status compared to routine practice, and these benefits extend 3 months after the time of intervention.

Full Program & Abstracts

Table	Intervention Group				Control Group			
	Initial Visit	3 Month Visit	Decline	p-value	Initial Visit	3 Month Visit	Decline	p-value
Smoking Status								
I find myself reaching for cigarettes without thinking	3	2.2	-27%	0.01	2.1	2.1	0%	0.92
I drop everything to go and buy cigarettes	1.8	0.8	-56%	0.004	1.6	1	-38%	0.03
I smoke more before going into a situation where smoking is not allowed	2.2	1.2	-45%	0.008	1.9	1.9	0%	0.97
After not smoking a few hours, the craving gets intolerable	2	1.3	-35%	0.03	1.5	1.1	-27%	0.08
Mean change in perceptions of severity of smoking status			-41%				-16%	
Behavior Toward Smoking								
Smoking:								
...takes years off my life	3.1	2.8	-10%	0.45	2.5	2	-20%	0.14
...makes me worried about heart disease	2.7	2.2	-19%	0.12	1.6	1.2	-25%	0.16
...casuses me to get tired easily	1.9	1.6	-16%	0.45	1.2	1.3	8%	0.84
...makes me short of breath	2	2.2	10%	0.61	1.7	1.5	-12%	0.58
...irritates my mouth and throat	1.6	1	-38%	0.14	0.9	0.8	-11%	0.64
...lowers my quality of life	2.9	2.8	-3%	0.69	2.3	1.6	-30%	0.02
Mean change in severity of perceptions of health risk			-12%				-15%	

*Scores are on a Likert Scale rangin from 0-4, where higher scores indicate higher agreement with the statement.

Full Program & Abstracts

7:24 am – 7:36 am

3

Fluoroscopy Time Is Not Accurate As A Surrogate For Radiation Exposure

Edvard Skripochnik, Shang A. Loh - Stony Brook University, Stony Brook, NY

Introduction and Objectives: Increasing number of endovascular procedures raises concerns regarding patient and operator cumulative radiation exposure. The Food and Drug Administration (FDA) and the Vascular Quality Initiative (VQI) still utilize fluoroscopy time as a surrogate marker for procedural radiation exposure. This study seeks to demonstrate that fluoroscopy time does not accurately represent radiation exposure and that dose area product (DAP), the radiation exposure per unit area, and air kerma (AK), the amount of radiation delivered to the air, are more appropriate measures.

Methods: Single level lower extremity endovascular interventions between 2013-2015 performed at an academic medical center were identified. All procedures were performed using a Siemens Artis-Zee floor mounted c-arm. Procedure CPT code, DSA runs, total fluoroscopy time, fluoroscopy DAP, fluoroscopy AK, cine DAP, cine AK, total DAP, and total AK were collected and average procedure magnification level was calculated. Scatter plots were created and Pearson correlation coefficients calculated to assess for correlation. A strong correlation was indicated by an r-value approaching 1.

Results: Using CPT codes, 145 cases were identified. Mean AK and DAP across all cases were 380.27 mGy and 49 Gy-cm2. Iliac stenting cases generated the highest mean DAP (123 Gy-cm^2). There was no correlation between fluoroscopy time and total AK or DAP (r= 0.27 and 0.32). Total DAP was more strongly correlated to cine DAP than fluoroscopy DAP (r=0.92 vs. 0.84). Number of DSA runs and average frame rate did not affect AK or DAP levels. Mean magnification level showed moderate correlation with total AK (r= 0.53).

Conclusions: Fluoroscopy time shows no correlation with radiation delivered and therefore is a poor surrogate for radiation exposure during fluoroscopy procedures. Quality databases should collect DAP and AK to more accurately gauge radiation exposure. Magnification level is the main operator controlled factor that correlates with radiation exposure.

Full Program & Abstracts

7:36 am – 7:48 am

4

Are They Listening To Us? The Impact of Brief Surgeon-Delivered Smoking Cessation Intervention On Vascular Patient Attitudes About Smoking In the Vascular Physician Offer and Report (VAPOR) Trial

Karina A. Newhall[1], Bjoern Suckow[2], Benjamin Brooke[3], Alik Farber[4], Adam W. Beck[5], Andrew W. Hoel[6], Andres Schanzer[7], Tze-Woei Tan[8], John J. Hallett[9], Philip Goodney[2], VAPOR Investigators - [1]White River Junction Veterans Administration, White River Junction, VT; [2]Dartmouth-Hitchcock Medical Center, Lebanon, NH; [3]University of Utah School of Medicine, Salt Lake City, UT; [4]Boston University School of Medicine, Boston, MA; [5]University of Florida College of Medicine, Gainesville, FL; [6]Northwestern University Feinberg School of Medicine, Chicago, IL; [7]University of Massachusetts School of Medicine, Worchester, MA; [8]Louisiana State University Shreveport Health Sciences Center, Shreveport, LA; [9]Roper St. Francis Vascular Center, Charleston, SC

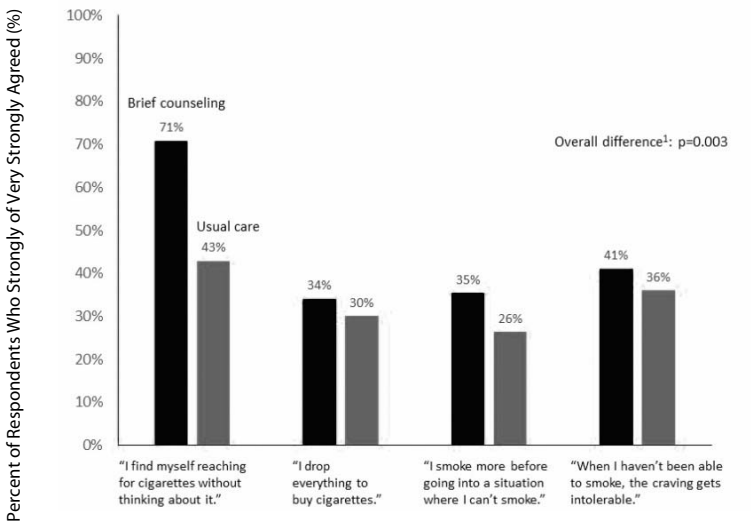
Introduction and Objectives: Despite the benefit of smoking cessation in patients with peripheral vascular disease, it is unclear if brief smoking cessation advice can effectively motivate these patients to quit. We investigated the impact of brief smoking cessation counseling on patient attitudes about quitting.

Methods: A cluster randomized control trial (Vascular Physician Offer and Report Trial) of smoking cessation counseling was conducted at 8 institutions from 9/2014-8/2015. Sites were randomized to either deliver brief smoking cessation counselling (with medications and Quitline referrals) or usual care. Following their appointment with the vascular surgeon, participants filled out a survey of their smoking history, interest in cessation, and agreement with statements regarding smoking harms and addictiveness. Responses to questions were analyzed using Mann-Whitney and Chi2 tests.

Results: All trial participants (n=156) completed surveys. Patients in both intervention and control groups were long-term smokers (29.1 vs 29.7 pack-years, p=0.8), who had failed previous quit attempts (77% vs 78%, p=0.8) and counselling by their PCP (77% vs 82%, p=0.4). Compared to usual care, more patients in the intervention group reported hearing advice to quit from their surgeon (98% vs. 77%, p<0.001), and more expressed "a lot" of interest in quitting (76 % vs 68%, p=0.03). Patients in the intervention group were more likely to acknowledge their addictive behaviors (Figure 1). For example, more patients in the intervention group acknowledged they "reached for cigarettes without thinking about it" (71% vs 43%, p=0.003).

Conclusions: Brief smoking cessation counseling by a vascular surgeon increases patient interest in smoking cessation and awareness of smoking harms. This evidence suggests that even brief counseling within a surgical clinic has potential to impact patient desire to quit.

Table: Patient Agreement With Statements Regarding Smoking Addiction After Initial Visit



1. By rank-sum test. For individual questions, left to right: p=0.003, p=0.31, p=022, p=0.03, respectively

Full Program & Abstracts

7:48 am – 7:56 am

5 (CR)

Novel Bail-Out Technique For Renal Artery Shuttering During Endovascular Aneurysm Repair

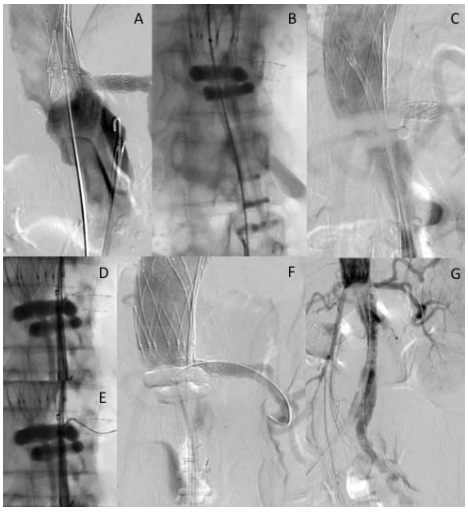
Marcus R. Kret, Donald R. Lynch, Jr., E. John Harris, Jr., Jason T. Lee - Stanford University, Stanford, CA

Introduction and Objectives: EVAR may rarely be complicated by complete or partial renal/visceral artery coverage, particularly with short aneurysm necks. We present a novel approach to manage inadvertent renal artery coverage.

Methods: An 84-year-old female was referred for management of a 6.5-cm juxtarenal AAA. She had remote history of hysterectomy/ oophorectomy with concurrent segmental bowel and right kidney resection for ovarian cancer. Access vessels were inadequate for fenestrated repair, while left subclavian artery occlusion prevented snorkel-EVAR.

Reesults: EVAR using the encroachment/endo-wedge technique was attempted to provide aneurysm exclusion while preserving flow to the solitary remaining left kidney. A 7-mm x 22-mm iCAST stent was deployed in the left renal artery (Figure A). Next a 29-mm Trivascular Ovation Prime main body device was positioned and deployed. During deployment the sealing ring was pushed cephalad to abut the left renal stent to attain proximal seal while maintaining renal perfusion (B). Angiogram following main body deployment demonstrated significant shuttering of the left renal artery by the proximal graft fabric (C). Attempts to regain wire access to the left renal artery were unsuccessful. Ultimately in situ fenestration of the main body aortic stent-graft using the Outback re-entry device was performed (D,E) with an additional 7-mm x 22-mm iCAST deployed to stent this fenestration (F). Completion aortogram demonstrated successful aneurysm exclusion, well perfused left renal artery and no evidence of endoleak.

Conclusions: In situ stent-graft fenestration is a useful bailout maneuver for inadvertent visceral vessel occlusion during endovascular aneurysm repair. We describe a novel approach using the Outback re-entry catheter. This technique may be particularly useful in patients with anatomy unsuitable for snorkel or fenestrated EVAR.



7:56 am – 8:04 am

6 (RF)

Techniques For Internal Iliac Artery Preservation: Options and Outcomes

Yaron Sternbach, John Taggert, Sean Roddy, Benjamin Chang, Paul Kreienberg, Jeffrey Hnath, Kathleen Ozsvath, R. Clement Darling, III - Albany Medical College, Albany, NY

Purpose: To describe options for internal iliac artery preservation and evaluate outcomes for both open and endovascular methods.

Methods: From a prospectively maintained database, review of patients who underwent elective internal iliac artery revascularization between 2007 and 2015 was undertaken. Endpoints evaluated included procedural morbidity and mortality, graft patency, freedom from symptoms of pelvic flow compromise and need for further intervention.

Results: Forty procedures were performed in 38 patients (33 men, 5 women) with a mean age of 69 years (Range 41-93). Open surgery (OS) was performed in 14 patients compared with 26 endovascular interventions (EV). The majority of procedures were performed as adjuncts in aortic surgery (EVAR 30) though some were performed as primary procedures for isolated aneurysmal disease (n=6) buttock claudication (n=2) and impotence (n=2). Early mortality was 0 in both groups. OS included bypasses from the common femoral arteries (n=6), external iliac arteries (n=4), or other reconstructions (n=4). EV revascularizations included external to internal iliac artery stent-grafts (n=4), branched devices (n=7), chimney/periscope techniques (n=9), double barrel conformations (n=3) and isolated IIA stent-grafts (n=3). Mean follow up was substantially longer in the OS group (49.71months , SD 36.34) than the EV group (25.52 months, SD 24.89), p=0.0397 and patency rates from 24 to 60 months were longer in the open surgery group (z=2.31, p=0.0207, 95%CI).

Conclusions: IIA preservation is feasible both by OS and EV techniques. Open surgery appears to confer superior durability, although evolving endovascular devices will likely require further evaluation.

Full Program & Abstracts

8:04 am – 8:12 am

7 (RF)

Patient-Reported Quality of Life After Endovascular Repair of Thoracoabdominal Aortic Aneurysms

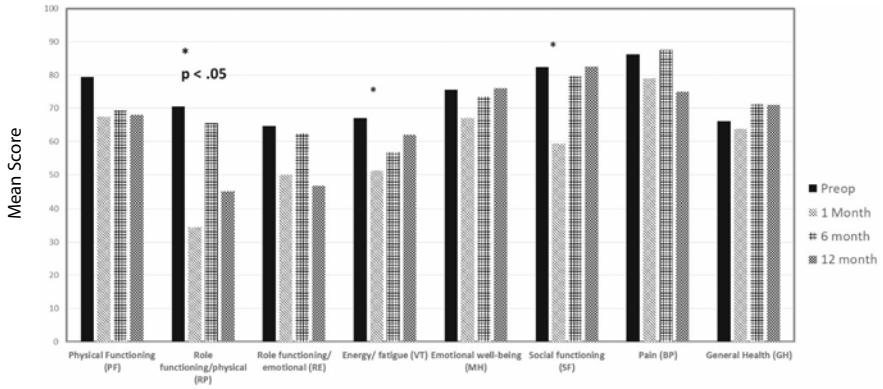
Andrew J. Meltzer, Peter H. Connolly, Sharif Ellozy, Darren B. Schneider - Weill Cornell Medical College, New York, NY

Introduction and Objectives: The purpose of this study was to assess patient-reported physical and emotional well-being during follow-up after endovascular repair of TAAA.

Methods: All patients were treated in the context of a physician-sponsored investigational device exemption clinical study for patients at high risk for open TAAA repair. To assess quality of life (QoL), the SF-36 instrument was administered preoperatively, and at 1, 6, and 12 months. Results were analyzed using paired t-tests, with sub-group comparisons to assess impact of adverse events and technical results on quality of life.

Results: To date, 17 patients have been enrolled (82% male). High risk characteristics include prior aortic surgery (65%); chronic kidney disease (29%) and age>75 years (76%). The majority of patients presented with extent III (41%) or IV (41%) aneurysms. Cumulative branch/fenestration patency was 100% and 96% and 1 and 6 months, respectively. At 1 month, patients reported lower scores across all 8 SF-36 domains (Figure). Scores in role functioning, vitality, and social functioning were significantly lower than preoperatively. At 6 months, patient-reported outcomes improved to approach pre-operative levels. While all patients reported lower QoL at 1 month, those who experienced grade 3 or 4 major adverse events (n=6, 35%) were more likely to experience persistent reduction in QoL.

Conclusions: Endovascular TAAA repair results in reduced physical and mental health in the acute setting - irrespective of technical success or adverse events. By 6 months, however, patient-reported well-being returns to baseline levels. Ongoing efforts will continue to assess the effectiveness of endovascular TAAA repair from the patient-centered standpoint.



Full Program & Abstracts

8:12 am – 8:24 am

8

Abdominal Visceral Fat Correlates With Adverse Outcomes In Open But Not Endovascular Aortic Repair

Lauren E. Trakimas, Doran S. Mix, Claudia I. Aghaie, Khurram Rasheed, Jennifer L. Ellis, Roan J. Glocker, Adam A. Doyle, Michael C. Stoner - University of Rochester, Rochester, NY

Introduction and Objectives: Abdominal visceral fat, rather than subcutaneous fat, is associated with greater risk of heart disease, hypertension, diabetes mellitus type 2, and the metabolic syndrome. Visceral fat is thought to represent an overall increase in inflammatory state. Furthermore, formation and enlargement of abdominal aortic aneurysms (AAA) is associated with pro-inflammatory mediators. We hypothesized that visceral fat area (VFA), not subcutaneous fat area (SFA) is an independent predictor of post -operative complications after AAA repair.

Methods: Patients who underwent elective infrarenal endovascular aortic repair (EVAR) and open repair were identified. Demographic characteristics were obtained. Pre-operative CT angiograms were reviewed. SFA and VFA were measured at the third lumbar vertebrae using a Hounsfield Unit restricted region growth algorithm. A composite complication score (CCS) was assigned for the presence of any complication or death. A univariate analysis was performed on the above variables. Then a multivariate analysis was conducted for both open and EVAR to analyze the independent effect of the comorbid characteristics affecting CCS.

Results: A total of 271 patients were identified. Mean age 72.66 ± 0.54, 82% male, and 94% Caucasian. Mean VFA was 247± 7.81 cm2. Ninety patients were identified as having a CCS event. Significant factors in initial univariate analysis included hyperlipidemia, statin use, and age. In multivariate analysis, VFA was significantly associated with CCS in open repair ($p = 0.02$), but not EVAR ($p=0.16$). SFA was not associated with CCS for either open ($p = 0.45$) or EVAR ($p = 0.83$).

Conclusions: This study shows that VFA is an independent predictor of poor outcomes in open AAA repair, not EVAR. The effect of VFA was significantly seen on multivariate analysis. The same effect was not seen for SFA. A patient's overall comorbid state, as represented by VFA, should be taken into consideration when selecting patient and approach for elective repair.

8:24am – 8:36 am

9

Fellows' Assessment of the Future of Vascular Surgery

Anil Hingorani, Amrit Hingorani, Natalie Marks, Justin Eisenberg, Ali Rizvi, Enrico Ascher - NYU Lutheran Medical Center, Brooklyn, NY

Introduction: In an attempt to identify the fellows' concerns about the future of the field of vascular surgery, we conducted a survey consisting of 20 questions at an annual national meeting from 2004 to 2015. In order to obtain accurate data, all surveys were kept anonymous.

Methods: The fellows were asked:1)what they anticipated the type of practice they would be in,2)what the new training paradigm for fellows should be,3)to assess their expectation of the needed manpower with respect to the demand for vascular surgeons,4)major threats to the future of vascular surgery,5)who should able to obtain vascular privileges and6)their interest in an association for vascular surgical trainees. 674 of 908 attendees (74%) completed the survey. Second-year (5+2) fellows made up 52% of those surveyed.

Results: Those expecting to join a private, academic or mixed practice made up 24%, 33%, and 28% of the respondents respectively. 80% anticipated entering a 100% vascular practice. 52% felt that 5 years of general surgery with 2 years of vascular surgery should be the training paradigm while 43% suggested 3 and 3 years. 64% felt that future demand would exceed the available manpower while 29% suggested that manpower would meet demand. The major challenges to the future of vascular surgery were felt to be competition from cardiology (84%) or radiology (29%) and a lack of an independent board (21%). 75% suggested that vascular privileges be restricted to board certified vascular surgeons. 79% were interested in forming an association for vascular trainees to address the issues of the future job market (74%), endovascular training during fellowship (42%), increasing focus on the vascular fellows at national meetings (41%) and representation for the fellows on the national councils (40%).

Conclusions: This survey suggests that several significant issues exist in the minds of vascular trainees that have not been addressed and may be present opportunities for further dialogue.

8:36 am – 8:48 am

10

The Effect of SCIP Measures On Complications and Mortality In Vascular Surgery

Kenneth R. Nakazawa, Natalia N. Egorova, Peter L. Faries, Ageliki G. Vouyouka - Icahn School of Medicine at Mount Sinai, New York, NY

Introduction and Objectives: As part of the Surgical Care Improvement Project (SCIP), the Joint Commission and CMS implemented a set of national hospital initiatives, including perioperative antibiotic prophylaxis (2006), venous thromboembolism (VTE) prophylaxis (2007), and beta-blocker treatment (2008) for surgical patients. We sought to evaluate the effects of SCIP guidelines on in-hospital surgical site infections (SSI), graft infections, VTE, myocardial infarctions (MI), cardiac complications, and mortality after vascular procedures.

Methods: From the Nationwide Inpatient Sample (2000-2012), we identified 1,735,060 elective vascular procedures among patients ?40 years old: open abdominal aneurysm repair (OAR, n=152,128), endovascular aneurysm repair (EVAR, n=171,662), carotid endarterectomy (CEA, n=916,270), lower extremity bypass (LEB) for claudication/rest pain (n=183,581), LEB for tissue loss (n=149,694), and major amputation (n=161,725). Logistic regression controlling for patient and hospital characteristics, and time trend was used to compare in-hospital outcomes before and after SCIP implementation (2000-2005 vs. 2009-2012).

Results: In the post-SCIP era, there were overall mild improvements in SSI (after EVAR and CEA), graft infections (after OAR, EVAR and LEB for tissue loss), VTE (after CEA), MI (after EVAR and LEB for tissue loss), cardiac complication (after EVAR, CEA, major amputation, and LEB), and mortality (after EVAR, CEA, major amputation, and LEB for tissue loss) ($p<0.05$). However after adjusting for covariates, SCIP independently had decreasing effects only for SSI after CEA and major amputation, graft infections after OAR and LEB for tissue loss, VTE after LEB for claudication/rest pain, and mortality after OAR (Table 1).

Conclusions: Implementation of SCIP measures led to slight improvements in only few in-hospital outcomes following vascular surgery. Ongoing analysis of these measures is necessary for overcoming many complicated challenges of managing vascular diseases.

Full Program & Abstracts

Table 1. Odd ratios from logistic regressions of post-operative events following vascular procedures in post-SCIP era (2009-2012) compared with pre-SCIP era (2000-2005)

	Surgical Site Infection	Graft Infection	Venous Thromboembolism	Myocardial Infarction	Cardiac Complication	In-Hospital Mortality
Open Abdominal Aneurysm Repair	ns 0.71 (0.37-1.36)	↓ 0.30 (0.13-0.69)	ns 0.92 (0.59-1.45)	ns 0.81 (0.52-1.25)	ns 0.98 (0.70-1.37)	↓ 0.63 (0.44-0.90)
Endovascular Aneurysm Repair	ns 0.69 (0.20-2.40)	ns 0.91 (0.14-5.88)	ns 0.78 (0.37-1.61)	ns 0.70 (0.33-1.50)	ns 0.96 (0.54-1.72)	ns 0.83 (0.37-1.84)
Carotid Endarterectomy	↓ 0.20 (0.07-0.61)	ns 1.00 (0.22-4.58)	ns 0.65 (0.36-1.18)	ns 0.90 (0.65-1.25)	ns 1.28 (0.98-1.67)	ns 1.18 (0.69-2.01)
Major Amputation	↓ 0.48 (0.29-0.81)	---- ----	ns 0.65 (0.40-1.05)	ns 0.72 (0.48-1.10)	ns 0.90 (0.51-1.58)	ns 0.77 (0.54-1.09)
Lower Extremity Bypass - C/RP	ns 0.92 (0.52-1.63)	ns 0.36 (0.10-1.21)	↓ 0.53 (0.30-0.93)	ns 0.84 (0.48-1.48)	ns 0.68 (0.42-1.08)	ns 1.03 (0.45-2.40)
Lower Extemity Bypass - TL	ns 0.80 (0.47-1.33)	↓ 0.33 (0.13-0.84)	ns 0.78 (0.45-1.33)	ns 1.06 (0.66-1.71)	ns 1.02 (0.82-1.27)	ns 0.84 (0.51-1.38)

Multivarate models adjusted for year, season, age, gender, race, insurance status, comorbid conditions, and hospital characteristics.
Values are presented as odd ratios with 95% confidence intervals (CI) in parenthesis.
↑: variable significantly increased in post-SCIP era, P < 0.05, 95% CI for odd ratios > 1.00.
↓: variable significantly decreased in post-SCIP era, P < 0.05, 95% CI for odd ratios < 1.00.
ns: no significant changes, P > 0.05.
---- : not applicable
C/RP: for claudication or rest pain.
TL: for tissue loss.

Full Program & Abstracts

8:48 am – 8:56 am

11 (CR)

Resolution of Unilateral Blindness Following Complete Embolization of ECA For Debilitating AVM

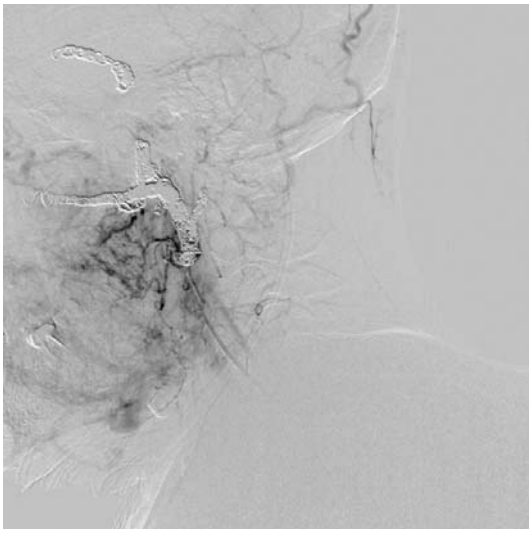
Jason E. Davis, Massimo Napolitano, Greg Simonian, Michael Wilderman, Anjali Ratnathicam, David O'Connor - Hackensack University Medical Center, Hackensack, NJ

Objectives: Despite advancements in endovascular technologies and open surgical techniques, management of complex arteriovenous malformations remains a challenge, often requiring multiple interventions with high failure rates. Lesions can present across diverse anatomic distributions and are associated with a variety of congenital syndromes. Therapy may be pursued for clinical indications ranging from cosmetic disfiguration to life -threatening or lifestyle-limiting conditions, and therapeutic interventions vary extensively due to the lack of an effective standardized approach.

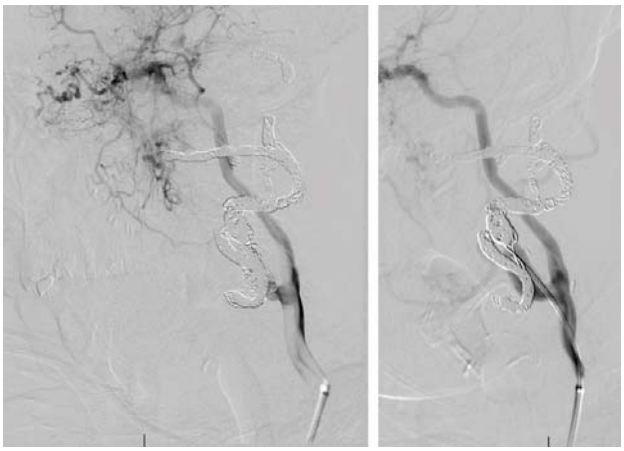
Methods: Along with a review of the latest pertinent literature including case reports and a few case series, we present here the case of a 50 year-old female referred for chronic Left eye blindness, impaired speech and swallowing, and painful disfiguring Left facial edema. Workup identified extensive congenital arteriovenous malformations derived primarily from her Left external carotid and ophthalmic arteries. Due to her debilitating symptoms, endovascular imaging and staged intervention were offered.

Results: At completion of her staged embolization, the patient reported being able to see from both eyes, speak more clearly, and swallow without pain for the first time in several decades. When seen for follow-up, this improvement continued with pronounced reduction in Left facial edema and hyperemia.

Conclusions: Congenital arteriovenous malformations can cause significant morbidity and represent a therapeutic challenge. This case represents a particularly debilitating and challenging AVM with a dramatic result following staged endovascular embolization of the patient's Left ECA and ophthalmic artery.



Full Program & Abstracts



Full Program & Abstracts

8:56 am – 9:04 am

12 (RF)

Surgical Management of Peripheral Vascular Manifestations of Loeys-Dietz Syndrome

Robert J. Beaulieu, Jennifer Lue, Bryan A. Ehlert, Caitlin W. Hicks, James H. Black, III - Johns Hopkins Hospital, Baltimore, MD

Introduction and Objectives: Loeys-Dietz Syndrome (LDS) is characterized by the triad of aortic aneurysm, vessel tortuosity, and hypertelorism. LDS patients are also appreciated to manifest aneurysms throughout the vasculature. The management of peripheral arterial manifestations has not been well evaluated. We sought to analyze our experience with the peripheral arterial manifestations of LDS.

Methods: Adult and pediatric LDS patients, confirmed by genotyping, who sought treatment at a single institution from 2005-2015 were retrospectively reviewed. Patients were included if radiographic or clinically-documented evidence existed of peripheral artery aneurysm or dissection. Statistical analysis was performed using Fisher Exact Tests where appropriate.

Results: 18 LDS patients (ages 1.3-59.3 years, average 27.8 years at diagnosis) with aortic (not including root, ascending or arch) vascular abnormalities were identified. Average follow up was 5.23 years. Fourteen (77.8%) patients had peripheral aneurysms, occurring most frequently in the carotid (35.7%), subclavian (35.7%) and visceral (28.6%) segments. Most patients had multiple peripheral segments involved (average 2, range 1-6). Nine (64%) patients with peripheral involvement underwent repair, for a total of 17 operations (average 1.89 operations per patient, range 1-4). Endovascular techniques were used in four operations (23.5%), without technical failures. Among patients requiring surgical repair, a history of abdominal aortic repairs was present in 77.8%, yielding a total of 36 vascular repairs (average 4, range 2-7). Perioperative morbidity was 13.9%, without mortalities. Prior aortic dissection was not associated with peripheral surgical repairs (p=0.58).

Conclusions: LDS is an aggressive vasculopathy which commonly affects the peripheral vasculature. Our data suggest open and endovascular procedures may be safe and effective in the LDS periphery. Additionally, multiple operations are common and aortic dissection did not predict peripheral arterial involvement in LDS. Therefore, vigilant peripheral surveillance of LDS is warranted, regardless of aortic status, and may be key to early identification and treatment success.

3:00 pm – 6:00 pm

Registration Re-Opens
Location: Ballroom Pre-Function

3:30 pm – 4:00 pm

Coffee/Snacks – Visit Exhibits
Location: Kokopelli I

Full Program & Abstracts

4:00 pm – 6:00 pm **SCIENTIFIC SESSION II**
Moderators: Katherine Gallagher, MD & Shang A. Loh, MD
Location: Kokopelli II & III

4:00 pm – 4:12 pm 13
Involvement of Senior Surgical Residents Is Associated With Worse Outcomes After Infra-Inguinal Bypass Operations
Erin K. Greenleaf, Christopher S. Hollenbeak, Faisal Aziz - Penn State Hershey Medical Center, Hershey, PA

Introduction: In an era of rapidly evolving surgical training, intra-operative teaching remains paramount to the education of surgical trainees. The impact of surgical trainees' level of expertise on outcomes after infra-inguinal bypass surgery, a technically demanding operation, remains unknown. The purpose of this study was to explore the effects of surgical residents' experience on outcomes after infra-inguinal bypass surgery.

Methods: Using the ACS National Surgical Quality Improvement Program database, we identified patients who underwent infra-inguinal bypass from 2005-2012. Patients were stratified according to training level of the most experienced operating resident. Univariate and multivariate analyses, as well as propensity score matched analysis, were performed to compare patient cohorts on operative time, length of hospital stay (LOS), bleeding, early graft failure and 30-day mortality.

Results: A total of 12,876 patients were identified, of which 35.5% were female and 64.5% were male. Mean age was 67.7 years. A PGY1 was the highest level resident operating on 3.8%, a PGY2-4 for 39.9%, and a PGY5+ for 56.3%. PGY5+s were more likely to operate on patients who were younger, with a history of cardiac interventions, on dialysis. In propensity score matched analysis, patients operated on by PGY5+s had longer operative time (4.26 vs 3.63 hours, $p<0.0001$), longer LOS (9.34 vs. 8.27 days, $p<0.0001$), greater rates of postoperative bleeding (9.93% vs 6.30%, $p<0.0001$) and early graft failure (5.92% vs. 4.50%, $p<0.0001$), but no statistically significant difference in perioperative mortality (see Table).

Conclusion: Operative involvement of senior residents was associated with worse patient outcomes after infrainguinal bypass, potentially reflecting a lesser extent of attending surgeon involvement with correspondingly lower likelihood of attending surgeons' intervention at times of compromised surgical technique.

Variable	PGY5+	< PGY5	95% Confidence Lower	95% Confidence Upper	P-value
Operative Time (hrs)	4.26	3.63	0.581	0.692	<0.0001
Length of Stay	9.34	8.27	0.687	1.389	<0.0001
Post-op Bleeding	9.93%	6.30%	0.027	0.045	<0.0001
Early Graft Failure	5.92%	4.50%	0.007	0.022	<0.0001
30-day Mortality	2.20%	1.89%	-0.001	0.007	0.166

Table. Propensity score matched analysis of PGY5+ and PGY1-4 cohorts on patient outcomes following infra-inguinal bypass.

4:12 pm – 4:24 pm

14

Change In Aortic Neck Diameter After Endovascular Aortic Aneurysm Repair

Marcus R. Kret, Kenneth Tran, Jason T. Lee - Stanford University, Stanford, CA

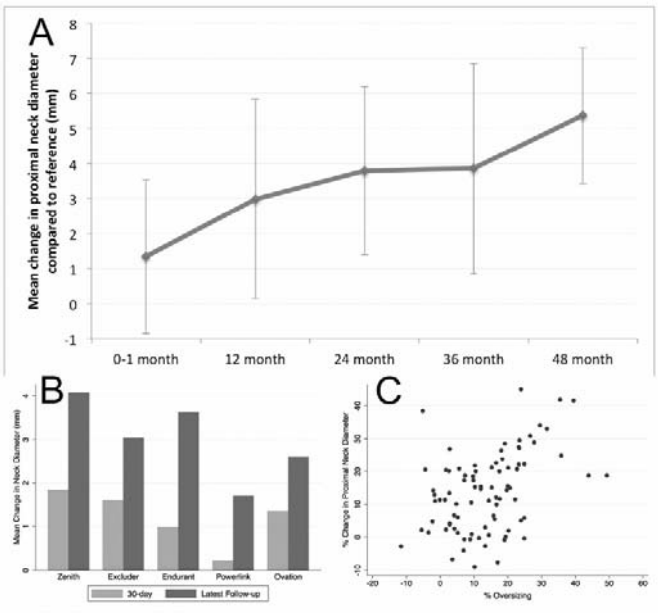
Introduction and Objectives: Implications of aortic neck dilatation following EVAR are unclear. Previous studies are limited to comparisons of individual, early-generation devices. We compared aortic neck dilatation among contemporary stent-grafts.

Methods: We reviewed pre- and post-op CTA for EVARs performed from 2008-2014. Images were analyzed using 3-D centerline reconstructions. Aortic neck diameter was measured in orthogonal planes at and 10 mm below the lowest renal artery. Device type and main body graft diameter were obtained from operative reports.

Results: 86 patients were analyzed with a median radiologic follow-up of 21.9 months (range 4-64). Stent-grants implanted included 26 Cook Zenith, 26 Gore Excluder, 22 Medtronic Endurant, 10 Endologix Powerlink, and 2 Trivascular Ovation devices. Mean device oversizing was 13.6±11.5% and did not vary by device type (P=.54). The majority of patients (86.0%) experienced increases in aortic neck diameter during follow-up, with a mean increase of 1.3±2.2mm (5.9±9.3%) and 3.3±0.6 mm (8.9±2.5%) at the 30-day and latest follow-up scans, respectively. Repeated measures analysis further demonstrated a significant increase in mean neck dilatation during follow-up (Fig 1A, P<.001). Neck dilatation was not significantly different across different devices (Fig. 1B, P=.233). However, there was a moderate positive correlation between percent change in neck diameter and degree of oversizing which was statistically significant (Fig1C, rs=.41, P<.001). Type 1a endoleak was observed in 2 patients, and was associated with greater mean neck dilatation (8.8±3.3mm vs. 3.35±2.71, p=.041). There was no relationship between changes in neck diameter and sac regression/expansion.

Conclusions: Aortic neck diameter increases consistently over time following EVAR. The degree of neck dilatation correlates with degree of device oversize, but not with device type.

Full Program & Abstracts



4:24 pm – 4:36 pm

15

Cost Effectiveness of Endovascular Revascularization Compared To Open Surgical Treatment For Acutely Thrombosed Lower Extremity Arterial Bypass Grafts

Elizabeth A. Genovese[1], Kenneth J. Smith[1], Neal R. Barshes[2], Michel S. Makaroun[1], Donald T. Baril[1] - [1]University of Pittsburgh Medical Center, Pittsburgh, PA; [2]Baylor College of Medicine, Houston, TX

Introduction and Objectives: Patients with acute limb ischemia (ALI) secondary to a thrombosed lower extremity arterial bypass (LEAB) have poor bypass patency and limb salvage rates. Endovascular revascularization (ER) of LEABs has decreased adverse events and mortality, with higher procedural costs. The goal was to investigate the cost effectiveness of ER compared to open revascularization (OR) for these ALI patients.

Methods: A Markov model simulated patient-oriented outcomes, including bypass revascularization, adverse events, limb salvage, and quality adjusted life years (QALY) for patients with Rutherford Classification IIa/IIb ALI secondary to a thrombosed LEAB, with a 5-year time horizon. The base patient was a 70-year old male with a thrombosed infrainguinal vein LEAB; a second iteration was performed examining thrombosed prosthetic LEAB. Parameter estimates were derived from published literature and primary data of ALI patients treated at our institution(2005-2011). Costs were adjusted to 2013 U.S. dollars and $100,000 per QALY gained was used as a willingness to pay threshold for a cost effective treatment strategy.

Results: Initial hospitalization cost estimates for ER and OR were $32,835 and $27,798, respectively. At 5 years, ER cost $89,334 per QALY gained compared to OR for thrombosed vein LEAB. In comparison, ER was more costly and less effective than OR for the treatment of thrombosed prosthetic LEAB. For vein LEAB thrombosis, sensitivity analysis demonstrates that ER remained cost effective when the ER initial costs remained below $34,095, ER initial success remained above 72% and these LEAB remained patent in 63% of patients. Moreover, ER was cost effective if OR cost rose above $26,202, OR initial success fell below 87% or if these LEAB had less than 56% overall long-term patency.

Conclusions: ER for ALI secondary to a thrombosed vein LEAB is a cost effective strategy compared to OR, while ER for a thrombosed prosthetic bypass has higher costs and decreased effectiveness.

4:36 pm – 4:48 pm

16

Natural History of Claudicants After Endovascular Therapy

Julia Saraidaridis, Emel Ergul, Virendra Patel, Richard Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

Introduction: The natural history of claudication is well characterized. However, as endovascular therapy has broadened the indications for intervention for peripheral artery disease, more claudicants have undergone procedures in an effort to improve their life-style limiting disease. This study sought to assess what the natural history of claudication is for patients who undergo at least one peripheral vascular intervention (PVI) for claudication.

Methods: All patients who underwent at least one PVI for claudication at a single institution from January 2007 to December 2013 were identified. Outcomes included secondary endovascular intervention, secondary bypass intervention, amputation, and survival. A cox proportional hazards model was created to assess risk factors for further intervention.

Results: 515 patients were identified as having undergone PVI for claudication during the study period. 43% were female, 37% had Diabetes, 9.4% had coronary artery disease, 26% were current smokers, 6.6% had congestive heart failure, 8.2% had a tibial lesion that was intervened upon, and 35% had a TASC II C/D lesion that was intervened upon. At 2 years 91.3% were alive, 92.1% were primarily patent, 94.3% were free from secondary intervention, and 98.8% were free from major amputation. Over the follow-up period 21.8% required some type of further intervention: either endovascular (17.7%) or open bypass (7.2%). A cox proportional hazards model adjusting for age, sex, and other comorbidities show that the two largest risk factors for requiring re-intervention were diabetes (HR 2.85, p=.03) and treatment of a tibial lesion (HR 4.2, p=.005). Mean follow-up time was 2.5 years and ranged from 1 month to 7 years.

Conclusion: The intervention upon claudication via endovascular techniques has not significantly altered the natural history of the disease. Certain patients (diabetics or those with tibial lesions) have a significant risk of failure of endovascular therapy and should be evaluated carefully regarding this intervention.

4:48 pm – 4:56 pm

17 (RF)

Endovascular Salvage of Proximal Fixation Loss In the Paravisceral Aorta

Adam Tanious[1], Megan Carroll[1], Mathew Wooster[1], Andrew Jung[1], Marcelo Giarelli[2], Martin Back[1], Peter Nelson[1], Murray Shames[1] - [1]University of South Florida, Tampa, FL; [2]Tampa General Hospital, Tampa, FL

Introduction and Objectives: Proximal fixation loss following endovascular aortic aneurysm repair (EVAR) creates a clinical dilemma when endovascular salvage jeopardizes visceral perfusion. We present our experience at a tertiary care center with endovascular management of proximal fixation loss using parallel stent grafting techniques to preserve visceral flow.

Methods: We conducted a retrospective review of 20 patients hospitalized and referred for treatment of proximal fixation loss between November 2006-May 2015. Data from all procedures, as well as entire hospital courses, and any documented follow up were captured and analyzed.

Results: The average age of the cohort was 83 (73-92). The average time from original EVAR to secondary treatment was 5.8 years (median time of 6.03). The most common endograft treated was the AneuRx stent graft at 35% (n=7). Ninety-five percent of patients were treated for an expanding aneurysm sac with 25% of patients being symptomatic at treatment. Open femoral access was used preferentially to a percutaneous approach (n=14 vs. 6). Adjunctive access was required in 60% of cases, with open axillary exposure (n = 5), percutaneous brachial (n=4), and open brachial (n=3) access. Eighteen patients received proximal cuffs in addition to parallel stent grafts while two patients required entire endograft relining in addition to the parallel visceral stents. Twenty-five total parallel stent grafts were placed, most commonly in a renal artery (n=20). The observed overall complication rate was 35% with an average follow up of 1.4 years. Primary technical success was achieved in 90% of cases, with an overall clinical success rate of 75%.

Conclusions: Though technically challenging, endovascular salvage of proximal fixation failure after EVAR is possible with extension to the paravisceral aorta. Comprehensive imaging and planning are paramount, understanding of adjunctive access options is critical, and a stringent follow up protocol is essential to monitor continued post-procedure clinical success.

Full Program & Abstracts

4:56 pm – 5:04 pm

18 (CR)

Supragenicular Approach To Release Popliteal Entrapment Without Distal Bypass Despite Preoperative Runoff Thrombosis

Christopher R. Ramos, Natalia Glebova - University of Colorado, Aurora, CO

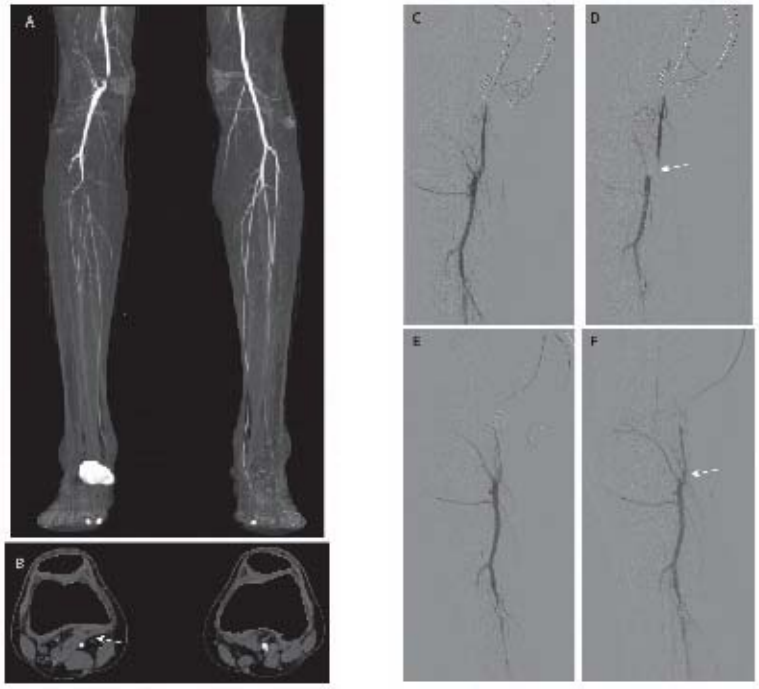
Introduction: Popliteal artery entrapment syndrome is a condition in which anatomic or functional popliteal artery compression causes arterial insufficiency. We present a case of popliteal entrapment with runoff thrombosis treated with supragenicular release of entrapment without distal bypass.

Methods: A 15 year old boy presented with right leg claudication severely limiting his activity. He had a palpable femoral pulse, but no palpable popliteal or foot pulses on the right. Non-invasive testing showed a partially thrombosed popliteal artery with an ABI of 0.69. Computed tomography scan revealed type III popliteal entrapment with distal thromboses (Figure 1A), and abnormal insertion of gastrocnemius muscle (arrow, Figure 1B).

Results: Popliteal entrapment release was performed via a medial supragenicular approach in consideration for distal bypass. The soleus was released first; intraoperative angiography showed continued popliteal compression with forced dorsiflexion (Figure1C neutral, Figure 1D forced dorsiflexion). This was followed by release of the gastrocnemius, found caudal and medial to the soleus as a tight band. Repeat angiography showed cessation of popliteal artery compression with dorsiflexion (Figure 1E neutral, Figure 1F forced dorsiflexion). Bypass was not performed due to improvement of distal flow seen on angiography. Postoperative recovery was unremarkable. On 1 month and 9 month follow up, he had a normal ABI and arterial duplex, is asymptomatic, and has returned to normal activities.

Conclusions: We describe supragenicular approach to popliteal release that may be useful if a distal bypass is planned. In this case, bypass was unnecessary despite the abnormal appearance of distal runoff on preoperative imaging, as the child's perfusion improved with entrapment release alone, and arterial remodeling over time resulted in normal perfusion and arterial appearance on duplex imaging.

Full Program & Abstracts



5:04 pm – 5:12 pm

19 (RF)

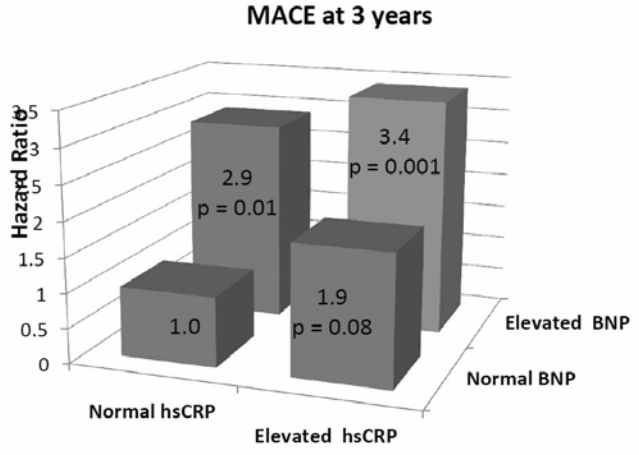
The Impact of Biochemical Markers On Major Adverse Cardiovascular Events and Contralateral Carotid Artery Stenosis Progression Following Carotid Interventions

Patrick Stone, Stephanie Thompson - WVU Charleston, Charleston, WV

Objective: To determine if elevated pre-intervention hsCRP and BNP levels associate with major adverse cardiovascular events (MACE) or disease progression following carotid revascularization.

Methods/Results: We retrospectively examined patients receiving elective carotid endarterectomy (CEA) or artery stenting (CAS) from 2007-2014. All included patients had preintervention hsCRP and BNP levels and >1 postoperative carotid duplex and/or angiogram. Examined outcome of interests at 3 years post-procedure included contralateral carotid disease progression (increased stenosis, need for revascularization) MACE (composite of death, stroke, myocardial infarction, need for coronary artery bypass graft or percutaneous coronary intervention). The relationship between baseline hsCRP and BNP levels and time to event was examined by multivariate Cox-proportional hazard regression analyses. A total of 248 patients were included in the analysis (mean age: 68±10years), with 14% receiving CAS and 86% CEA. A total of 61 patients (25%) had 1 or more MACE by 3 years. Elevated hsCRP (>3mg/L) trended toward associating with MACE, but failed to reach significance (hazard ratio (HR): 1.6[1.0-2.7],p=0.07). Multivariate analysis demonstrated elevated BNP (>100pg/mL, HR:2.2[1.3-3.7],p=0.002) and diabetes mellitus (HR: 1.9[1.2-3.2],p=0.01) predicted MACE. Having elevated preprocedural levels of both hsCRP and BNP significantly increased patients' likelihood of experiencing MACE (Figure 1, HR:3.4[1.6-7.1],p=0.001). 175 patients received contralateral carotid imaging post-procedure and of those patients, 31 (18%) experienced stenosis progression and/or revascularization within 3 years. However, neither elevated hsCRP (HR: 1.2[0.6-2.3], p=0.68) nor BNP (HR:1.1[0.5-2.5],p=0.88) associated with disease progression.

Conclusion: Hs-crp in this cohort was not associated with disease progression of carotid stenosis. However BNP was strongly associated with MACE, and when combined with elevated Hs-crp correlates with significant events.Figure 1. Examining the effect of elevated hsCRP and BNP in combination on MACE at 3 years.



5:12 pm – 5:24 pm

20

Superior Lower Extremity Vein Graft Bypass Patency Among Married Patients With Peripheral Arterial Disease

Emily Lagergren, Kelly Kempe, Timothy E. Craven, Susan T. Kornegay, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez, Matthew S. Edwards, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC

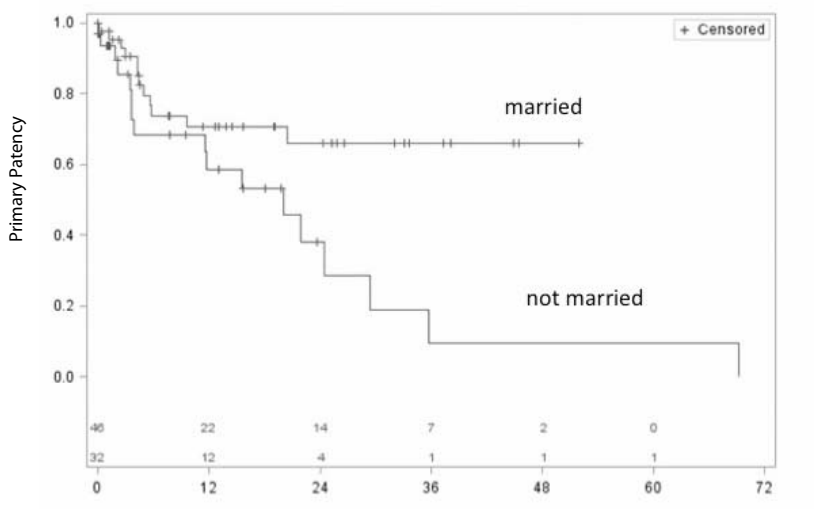
Introduction and Objectives: Outcomes disparities associated with lower extremity bypass (LEB) for peripheral arterial disease (PAD) have been identified but are poorly understood. Marital status may affect outcomes through factors related to health risk behaviors, adherence, and access to care but has not been characterized as a predictor of surgical outcomes and is often omitted from administrative datasets. We evaluated associations between marital status and vein graft patency following LEB using multivariable models adjusting for established risk factors.

Methods: Consecutive patients undergoing autogenous LEB for PAD were identified and analyzed. Survival analysis and Cox proportional hazards models were used to evaluate patency stratified by marital status [married versus single, divorced, or widow (er)] adjusting for demographic, comorbidity, and anatomic factors in multivariable models.

Results: 69 patients undergoing LEB with autogenous vein were analyzed. 20% were women and 59% were married; mean age was 65±11 years. 24 month primary patency was 66% for married versus 38% for unmarried patients (figure). Married status was associated with superior primary patency (HR 0.33, 95% CI [0.11-0.99], P=0.05) in a multivariable model adjusting for graft inflow/outflow, medications, gender, age, race, smoking, diabetes, and minimum vein graft diameter; other predictive covariates included preoperative antiplatelet therapy (HR=0.27, 95% CI [0.10-0.74], P=0.01) and diabetes (HR 2.56, 95% CI [0.93- 7.04], P=0.07).

Conclusions: Marital status is strongly associated with vein graft patency following LEB. Further investigation into the mechanistic explanation for improved patency among married patients may provide insight into social or behavioral factors influencing other disparities associated with LEB outcomes.

Figure. Lower Extremity Vein Graft Primary Patency Stratified By Marital Status



5:24 pm – 5:36 pm

21

Cumulative Number of Treatment Interventions Predicts Health-Related Quality of Life In Patients With Critical Limb Ischemia

Matthew P. Goldman, Ryan Barnard, Santiago Saldana, Jeanette M. Stafford, Douglas Easterling, Gregory L. Burke, Edward H. Ip, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC

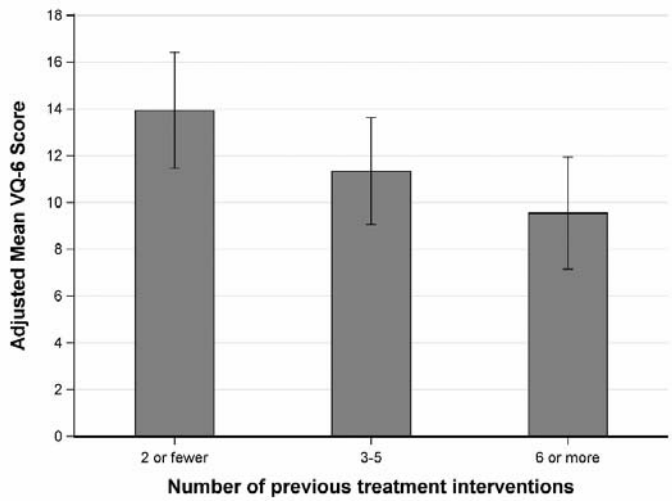
Introduction and Objectives: The impact of treatment on health-related quality of life (QOL) is usually assessed after a defined interval following a single intervention, but critical limb ischemia (CLI) is a chronic condition where multiple interventions are often required over a lifetime. We hypothesized that the positive impact of CLI treatment interventions diminishes in the setting of severe comorbidities and/or multiple previous interventions. We performed a prospective, cross-sectional study evaluating associations between comorbidity, number of previous treatment interventions, and disease severity with QOL.

Methods: Participants with CLI [abnormal ankle brachial index (ABI) plus rest pain and/or tissue loss] were prospectively enrolled and completed a disease specific QOL assessment, [VascuQol-6 (VQ-6)]. Minimum ABI was used to assess disease severity, and comorbidity was evaluated based on Charlson Comorbidity Index. Cumulative number of treatment interventions was defined based on the lifelong total for both legs. QOL associations were evaluated using a multivariable linear regression model adjusted for age and gender.

Results: 32 patients with CLI participated. Mean age was 63±10 years, 23% were men, and 63% were white; mean ABI was 0.6±0.2. Mean VQ-6 score was 11.6±4.2, and QOL was lower in patients with more previous interventions (Figure). Multivariable models demonstrated that an increasing number of previous treatment interventions negatively impacted QOL (P=0.047), while positive associations were identified for female gender (P=0.006) and ABI (P=0.006). No association between comorbidity and QOL was identified.

Conclusions: Vascular-specific factors appear to be key determinants of QOL among patients with CLI, while comorbidity appears less important. Strategies focused on definitive and durable revascularization may reduce cumulative interventions and potentially maximize QOL for patients with CLI.

Full Program & Abstracts



Full Program & Abstracts

5:36 pm – 5:48 pm

22

Tibioperoneal Occlusive Disease: A Review of Below the Knee Endovascular Therapies In Patients With Critical Limb Ischemia

Kathryn B. Muir, Patrick R. Cook, Maxwell R. Sirkin, Gilbert Aidinian - William Beaumont Army Medical Center, El Paso, TX

Introduction and Objectives: Tibioperoneal occlusive disease is one of the most difficult disease processes to successfully treat. Previous studies have reported outcomes in this patient population after endovascular intervention; however, the majority of these study cohorts are composed of patients who have undergone concomitant aortoiliac or femoral procedures. Our objective was to present the outcomes of patients treated with endovascular intervention for isolated below-the-knee atherosclerotic disease causing critical limb ischemia (CLI).

Methods: We performed a retrospective review of all patients who underwent isolated endovascular treatment of the below-knee popliteal, tibial, and/or peroneal arteries for critical limb ischemia (Rutherford class 4-6). Primary outcomes include wound healing, re-intervention rates, and amputation-free survival out to five years, as well as 1-year primary patency rates.

Results: 116 patients were identified as having undergone a tibial endovascular intervention. 92 had concomitant aortoiliac or femoropopliteal interventions; after excluding those patients, we identified 24 limbs that were treated for isolated below-knee popliteal, tibial, and/or peroneal occlusive disease using an endovascular modality. 62.5% of limbs had successful wound healing, while 37.5% eventually required a major amputation. Mean time to amputation was 514.6 days (standard error: 57.3). Of those patients with successful limb salvage (n=15), 66.7% required only the index procedure to heal; the remaining 33.3% required a repeat endovascular intervention, an arterial bypass, or a combination to successfully heal. The mean time to reintervention was 780.1 days (standard error 179.5). The 1-year primary patency rate was 52.6% (n=19).

Conclusions: Patients with CLI secondary to isolated below-the-knee atherosclerotic occlusive disease are a difficult population to successfully treat; despite this, these patients still benefit from an initial attempt at endovascular limb salvage. In our experience this approach resulted in respectable limb salvage rates, 62.5%, and did not compromise open surgical solutions in the event of non-healing.

Full Program & Abstracts

5:48 pm – 6:00 pm

23

Transradial Embolization of the Internal Iliac Artery Prior To Endovascular Aneurysm Repair: Initial Results and Technique

Sean P. Wengerter, Christine E. Ghatan, Nora E. Tabori, Rahul S. Patel, Edward Kim, S. Francis Nowakowski, Peter L. Faries, Michael L. Marin, Robert A. Lookstein, Aaron M. Fischman - Mount Sinai Hospital, New York, NY

Introduction and Objectives: Transradial access (TRA) has been shown to decrease bleeding complications compared to transfemoral access (TFA). The axis angle of the internal iliac artery (IIA) makes antegrade catheterization favorable. TFA prior to endovascular aneurysm repair (EVAR) can create scarring making future large bore access more difficult. This study evaluates the safety and feasibility of IIA embolization (IIAE) via TRA.

Methods: Retrospective review of all pre-EVAR IIAE via left TRA was performed utilizing a prospectively maintained database. The radial artery was assessed with the Barbeau test to confirm collateralization. In all cases, a hydrophillic sheath was placed using US guidance. Heparin (3000 units), verapamil (2.5 mg), and nitroglycerin (200 mcg) were administered intra-arterially. A 4F 125cm catheter (Cordis, Bridgewater, NJ) was used to cannulate the IIA. IIAE was performed with 0.018" and/or 0.035" coils (Interlock; Boston Scientific, Marlborough, MA). At conclusion, hemostasis was achieved with a TR band (Terumo). Patient demographics, anatomic characteristics, imaging, technical success (complete IIA occlusion), fluoroscopy time (FT), time to ambulate (TTA), and major and minor adverse events (AEs) were reviewed.

Results: From 01/2013 to 12/2014, 11 IIAE (6 right, 5 left) were performed in 10 patients (9 male, mean age 71, range 53-84). Mean diameter of the IIA was 17.5 mm (range 7-38 mm), and mean axis angle was 132 degrees (range 107-151 deg.). Mean FT was 28.5 min (range 6.5-62.4 min). Technical success was 100%. There were no major AEs. Mean interval from IIAE to EVAR was 18 days (range 8-43 d). Angiograms at EVAR showed 100% vessel occlusion. No post EVAR IIA-related endoleaks were observed, with mean follow-up interval 194 days (range 12-477 d).

Conclusion: Embolization of the IIA via TRA is a feasible and safe alternative to TFA. TRA allows for adequate preparatory IIA occlusion while maintaining both TFA sites for EVAR free of possible access-related complications.

6:00 pm – 7:15 pm **VESS MEMBER BUSINESS MEETING**
Location: Kokopelli II & III

7:15 pm **Free Evening**

Full Program & Abstracts

Saturday, February 6, 2016

6:00 am – 7:00 am	**Continental Breakfast** *Location: Kokopelli I*
6:00 am – 9:30 am	**Registration** *Location: Ballroom Pre-Function*
7:00 am – 9:00 am	**SCIENTIFIC SESSION III** Moderators: Venita Chandra, MD & Peter R. Nelson, MD *Location: Kokopelli II & III*
7:00 am – 7:12 am	24 **Normal Lower Extremity Duplex Findings In Patients With Left Ventricular Assist Devices: A Basis For Vascular Laboratory Interpretation** Sheena K. Harris, Matt Roos, Jeff Crawford, Dale Wilson, Enjae Jung, Erica Mitchell, Gregory Moneta - Oregon Health and Science University, Portland, OR

Introduction and Objectives: Left ventricular assist devices (LVADs) have been shown to cause hemodynamic changes in carotid artery duplex findings; however, effect on lower extremity arterial duplex (LEAD) findings have not been characterized. We sought to characterize normal LEAD findings in LVAD patients to establish a basis for vascular laboratory interpretation.

Methods: We performed a retrospective review at a single institution of all patients with LEAD after LVAD implantation 2003-2014. Peak systolic velocity (PSVs) of common femoral (CFA), superficial femoral (SFA), popliteal, and posterior tibial arteries (PTA) in asymptomatic extremities of LVAD patients were compared to a control group of patients at our institution without LVADs receiving LEAD for nonischemic indications. ABIs and CFA waveform acceleration time (AT) were also measured.

Results: There were 248 LVAD patients, 29 had LEAD of at least one lower extremity (34 extremities, 22 asymptomatic, 12 symptomatic). There were 136 patients in the control group, which consisted of non-LVAD patients with nonischemic LEAD indications. Mean PSVs (cm/s) in the control CFA, mid SFA, popliteal, and PTA were 137 +/- 4.8, 104.2 +/- 4.5 , 65.2 +/- 2.8 , and 64.6 +/-3.2. PSVs were significantly decreased for the LVAD patients: 49.5 +/- 4.9 , 40.6 +/-3.7, 27.2 +/-2.2 and 25.5 +/- 2.3, $p < 0.001$ for each comparison. Average ABI for control limbs was 0.91 +/- 0.05 compared to 1.17 +/- 0.35 in LVAD extremities ($P<0.001$). Mean CFA AT was 97 msec in the controls and 207 msec in LVAD patients, $p < 0.001$.

Conclusions: This is the first study characterizing LEAD in lower extremity arteries in LVAD patients. PSV is significantly decreased throughout lower extremity vessels, and common femoral artery acceleration time increased. This serves as a basis for interpreting normal LEAD findings in LVAD patients.

7:12 am – 7:24 am

25

Outcomes of Critical Limb Ischemia In A Public Hospital Population With High WIfI Amputation Scores

Robert Ward, Joie Dunn, Leonardo Clavijo, David Shavelle, Vincent Rowe, Karen Woo - Keck School of Medicine, University of Southern California, Los Angeles, CA

Objectives: Patients presenting to a public hospital with critical limb ischemia (CLI) typically have advanced disease with significant co-morbidities. The objective of this study is to assess the one-year major amputation (OYMA) rate of this population classified according to the Wound, Ischemia, and foot Infection (WIfI) system.

Methods: A retrospective review of patients who presented to a public hospital with CLI from February 2010 to July 2014 was performed. Patients were classified according to the WIfI system. Only patients with complete data who survived at least 12 months after presentation were included.

Results: 93 patients with 98 affected limbs were included. The mean age was 62.8 with the majority being diabetic (DM) and hypertensive (HTN). 50 (57.5%) limbs had Trans -Atlantic Inter-Society Consensus (TASC) C or D femoral-popliteal lesions and 82 (98%) had significant infra-popliteal disease. The majority had moderate or high WIfI amputation and revascularization scores. 84 (86%) limbs underwent open, endovascular or hybrid revascularization. Overall OYMA rate was 26.5%. In limbs with high WIfI amputation score, the OYMA was 34.5%: 21.4% in those who were revascularized and 57% in those who weren't. On univariable analysis, factors associated with increased risk of OYMA were: non -revascularization (P=0.005), hyperlipidemia (P=0.06), hemodialysis (P= 0.005), gangrene (P=0.02), ulcer classification (P=0.05), WIfI amputation score (P=0.026) and WIfI wound grade (P=0.04). On multivariable analysis, increasing WIfI amputation score (OR 1.84, 95% CI 1.0-3.39) was associated with increased risk of OYMA while revascularization (OR 0.24, 95% CI 0.07-0.80) was associated with decreased risk of OYMA.

Conclusions: The OYMA rates in this population were consistent with those predicted by the WIfI classification system. In this population, revascularization significantly reduced the risk of amputation. Co-morbidities, including DM and TASC classification did not moderate the association of WIfI amputation score with risk of one-year major amputation.

7:24 am – 7:36 am

26

Impact of Inferior Vena Cava Filter Placement On Short-Term Outcomes In Patients With Acute Pulmonary Embolism

Nathan L. Liang, Elizabeth A. Genovese, Efthymios D. Avgerinos, Michael J. Singh, Michel S. Makaroun, Rabih A. Chaer - University of Pittsburgh, Pittsburgh, PA

Introduction: Inferior vena cava filters (IVCF) have been associated with improved survival in patients with acute pulmonary embolism (PE) in some studies. However, without randomization, those with early mortality who did not receive an IVCF may have died prior to treatment decision about filter placement, falsely contributing a survival advantage to those receiving IVCF and biasing the results of previous observational studies. The objective of this study is to evaluate the impact of IVCF on in-hospital mortality after adjusting for this survivor treatment selection.

Methods: National Inpatient Sample datasets from 2009-2012 were analyzed to assess the impact of IVCF placement on in-hospital mortality in all patients with acute PE. Subgroup analyses were performed in those with high-risk PE (hemodynamic shock) and also for those with both shock and concomitant thrombolysis. Inverse-propensity-score-weighting was used to balance clinical and comorbid differences between filter and non-filter groups. To account for survivor treatment selection bias, an extended Cox model was fitted with IVCF placement as a time-dependent covariate.

Results: We identified 263,955 patients with acute PE over this period; 36,702 (13.9%) received IVCF. Those receiving IVCF in the unadjusted cohort were older (IVCF: 66.3±15.9 vs. non-IVCF:62.4±17.4;$p<0.001$) with higher rates of shock (6.8% vs. 3.8%;$p<0.001$), deep venous thrombosis (32.8% vs. 13.9%;$p<0.001$), thrombolytic therapy (5.9% vs. 1.6%;$p<0.001$), and lower crude mortality (6.0% vs. 6.7%;$p<0.001$). Propensity-weighted extended Cox analysis showed that IVCF placement did not significantly decrease mortality hazard compared to an untreated patient (HR 0.97, 95% CI[0.91-1.03]). Similar results were seen in the high-risk (HR 1.2, 95% CI[1.11-1.38]) and combined high-risk and thrombolysis (HR 0.85, 95% CI[0.60-1.21]) subgroups.

Conclusions: Placement of IVCF in all patients with acute PE, in high-risk patients, or in high-risk patients concurrently treated with thrombolysis is not significantly associated with improvement of in-hospital mortality when accounting for survivor treatment selection bias.

Full Program & Abstracts

7:36 am – 7:48 am

27

Outcomes In Critical Limb Ischemia Compared By Distance From Referral Center

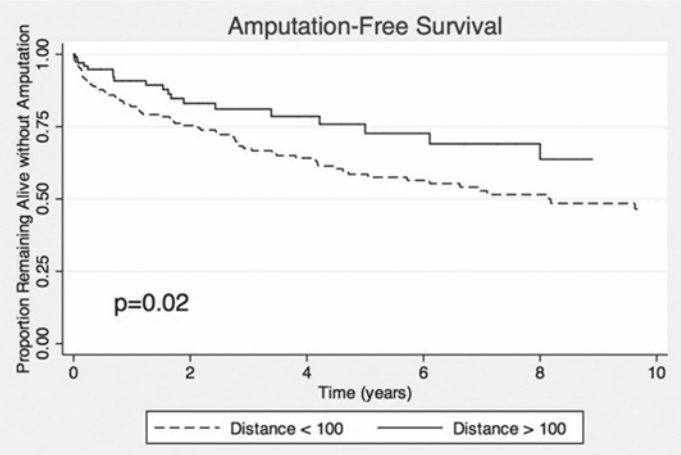
Peter Bartline, Bjoern Suckow, Benjamin Brooke, Larry Kraiss, Michelle Mueller - University of Utah, Salt Lake City, UT

Introduction and Objectives: Little data exist regarding the effect of referral distance on outcomes after revascularization for critical limb ischemia (CLI). We tested the assumption that patients referred over longer distances have worse outcomes.

Methods: We identified a retrospective cohort of 300 CLI patients who underwent revascularization between Jan 1, 2000 and Dec 31, 2010 at a single academic medical center. Patients were stratified into two groups based on distance greater than or less than 100 miles from the referral center. Outcome measures were length of stay (LOS), post -operative functional status, hospital disposition, patient follow-up, and amputation-free survival (AFS).

Results: 118 (39%) patients travelled >100 miles for CLI revascularization. The two groups had similar baseline characteristics. Overall, 211 (70%) patients underwent an open revascularization, 60 (20%) an endovascular and 29 (10%) a hybrid procedure. Those living >100 miles away less commonly underwent an endovascular procedure (14 vs. 24%, p= 0.05). LOS was similar between near and far groups (7.3 days vs. 8.9 days, p=0.1), as was post-operative functional status (ambulatory = 73% vs. 68% p=0.34) and discharge to home (68% vs 74% p=0.34). Long-term follow-up (mean=2.07 yrs) was similar between distance groups (p=0.6). Five-year AFS (73% vs 56%, p=0.02) was superior in the distance >100 group (Figure). In multivariate analysis, distance >100 miles (HR=0.6, p=0.05), preoperative warfarin use (HR=0.5, p=0.02), and independent ambulatory status (HR=0.5, p=0.002) were associated with improved AFS.

Conclusions: Patient referral distance did not adversely affect AFS or long-term follow-up after revascularization for CLI. Patients traveling from rural settings for revascularization can expect similar outcomes as patients located near tertiary centers.



7:48 am – 7:56 am

28 (CR)

Long-Term Morphologic Analysis of the Aortic Arch Following TEVAR In Patients With Acute Complicated Type B Aortic Dissection

Hector Crespo, Frank R. Arko, III, A. Carson Milner, M. Zachary Arko, Charles S. Briggs, Andrew B. Giggey, Stephen G. Lalka - Sanger Heart and Vascular Institute, Charlotte, NC

Introduction: This study aims to examine and quantify aortic morphology from the sinotubular junction to the aortic bifurcation following TEVAR in patients with acute TBAD.

Methods: Between 2012 and 2015 85 patients underwent TEVAR following acute TBAD. CTA of the aorta was analyzed preoperatively to last follow-up. Imaging was performed at 1-, 6- months, and yearly. Morphologic analysis was performed from the ascending aorta to the aortic bifurcation.

Results: There was no difference in the size of the ascending aorta. There was a significant increase in size of the aortic arch [32.61 +/- 4.43 mm versus 35.13 +/- 4.43 mm (p=0.00014)], [30.3 +/- 4.58 mm versus 34.10 +/- 4.65 mm (p=0.0001)]. There was a significant decrease in the size of the false lumen [32.24 +/- 9.3 mm versus 21.12 +/- 14.11 mm (p<0.00001)] and an increase in the size of the true lumen [24.78 +/- 7.76 mm versus 32.78 +/- 4.78 mm (p<0.00001)] of the descending aorta. Statistical increase in the true lumen [20.81 +/- 4.04 mm versus 24.45 +/- 8.55 mm (p=.00765)], false lumen [25.8 +/- 7.02 mm versus 17.8 +/- 12.32 mm (p=0.000035)] at the celiac, true lumen [19.8+/- 4.3 mm versus 22.35 +/- 8.18 mm (p=0.0474)], false lumen [23.88 +/- 6.83 mm versus 18.11 +/- 11.32 mm (p=0.00030)] at the SMA, true lumen [19.00 +/- 4.26 mm versus 22.22 +/- 7.44 mm (p=0.0039)], false lumen [22.07 +/- 6.75 mm versus 19.19 +/- 10.38 mm (p=.0363)] at the right renal and false lumen [22.29 +/- 7.30 mm versus 18.47 +/- 8.76 mm (p=.045)].

Conclusion: TEVAR with acute complicated dissections is associated with aortic remodeling. However, there is an associated increase in the size of the aortic arch. Continued surveillance of the aortic arch is important as these patients are at risk for potential late term complications.

Full Program & Abstracts

7:56 am – 8:04 am

29 (RF)

CT FFR Can Accurately Identify Culprit Lesions In Aorto-Iliac Occlusive Disease Using Minimally-Invasive Techniques

Erin Ward[1], Daniele Schiavazzi[2], Divya Sood[1], John Lane[1], Erik Owens[1], Alison Marsden[2], Andrew Barleben[1] - [1]UCSD, San Diego, CA; [2]Stanford, Stanford, CA

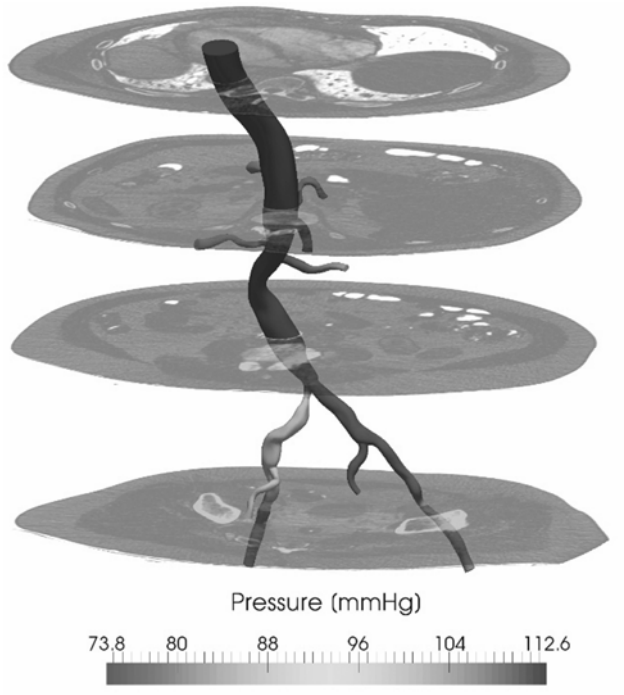
Introduction and Objectives: Peripheral arterial occlusive disease contributes to significant morbidity and mortality with many diagnostic and therapeutic modalities; currently the gold standard for significant iliac lesions depends on invasive angiography. Fractional flow reserve (FFR) has successfully been utilized with promising clinical results in coronary artery disease. Improvements in numerical hemodynamics have allowed for an accurate and minimally invasive approach to estimating FFR utilizing cross sectional imaging in a minimally-invasive fashion. We aim to demonstrate a similar approach to aorto-iliac occlusive disease (AIOD).

Methods: A retrospective review evaluated four prospectively recruited patients with severe claudication and cross-sectional imaging showing AIOD. Patients underwent conventional angiogram with pull-back pressures in a retrograde fashion. To estimate CT FFR, CTA image data was analyzed using the SimVascular software suite to create a computational fluid dynamics (CFD) model of the aorto-iliac system. Using previous echo data, inlet flow conditions were derived based on cardiac output, while three-element Windkessel outlet boundary conditions were optimized to match the expected systolic and diastolic pressures (Figure 1), with outlet resistance distributed based on Murray's law.

Results: All patients had evidence of AIOD on CT and life-style limiting claudication. After angiographic FFR, all patients were successfully treated for their lesions, restoring the FFR to 1.0, abolishing symptoms without complication. All lesions with significant pressure drops were identified successfully using both modalities. CT FFR ranged from 0.64 - 0.94 (Avg. 0.76) and measured FFR 0.48 - 0.85 (0.73) and were statistically similar ($p > 0.05$).

Conclusions: CT FFR successfully identified aorti-iliac lesions with significant pressure drops. This has potential to provide a minimally-invasive approach to identify flow-limiting stenosis.

Full Program & Abstracts



8:04 am – 8:12 am

30 (RF)

Somatosensory Evoked Potentials and Electroencephalography During Carotid Endarterectomy Predict Late Stroke But Not Death

Natalie A. Domenick, Rabih Chaer, Partha Thirumala, Jeffrey Balzer, Michel Makaroun, Edith Tzeng, Efthimios Avgerinos - University of Pittsburgh, Pittsburgh, PA

Introduction and Objectives: Late stroke and death rates are anticipated to be higher in patients undergoing carotid endarterectomy (CEA), however little is known regarding predictors. We seek to determine if dual intraoperative Somatosensory Evoked Potentials (SSEP) and electroencephalogram (EEG) monitoring can predict long-term strokes and death.

Methods: Consecutive patients who underwent CEA under dual SSEP and EEG intraoperative monitoring (IOM) between 1/1/2000 and 12/31/2007 were analyzed. Patients were divided in two groups, those with and those without IOM changes. Endpoints were time to stroke and death. Logrank tests and Cox regression analysis were used to identify predictors of postoperative stroke and death.

Results: 858 CEAs (mean age 70.6±9.5 years, 58.7% male, 38.9% symptomatic) were performed during the study period with a mean clinical follow up of 48±38 months. 217 patients (25.3%) had significant SSEP or EEG changes during IOM. Baseline characteristics, including rates of bilateral disease, statin use, and antiplatelet use, were similar between groups, except for female gender and symptomatic disease being more frequent in the group with the IOM changes. The overall stroke-free survival rate at 5 years was significantly higher in patients without IOM changes (95.8% vs. 88.7%, $p<0.05$) and at 10 years (89.8% vs. 76.8%, $p<0.05$). Despite these differences, overall survival at 10 years was not different between groups (50.8% in patients with IOM changes vs. 46.9% in patients without, $p=0.57$). Renal failure was a significant predictor of late stroke (HR = 2.16, $p<0.05$); statins were significantly protective (HR = 0.48, $p<0.05$). However, IOM changes were the strongest predictor of long-term risk of stroke after CEA (HR = 2.19, $p<0.05$).

Conclusions: IOM changes are predictive of late stroke but not death following CEA indicating a need for further elucidation and management of the underlying risk factors driving the elevated stroke risk in this subset of CEA patients.

Full Program & Abstracts

8:12 am – 8:24 am

31

Secondary Aorto-Enteric Fistulae : Results of Radical Open In Situ Treatment Using Cryopreserved Arterial Allografts

Marc A. Dennery, Jr., Fabien Koskas, Sr. - Hôpital Pitié-Salpêtrière, Paris, France

Introduction: We present our experience with open repairs of infected abdominal aortic protheses with enteric fistulae using cryopreserved arterial allografts (CAA).

Methods: All procedures from 1996 to 2013 were retrospectively reviewed and survivors were followed up to present time. All cases were treated by the complete removal of all synthetic vascular material, enteric repair and revascularization using CAA.

Results: 55 patients presenting with infected protheses after aortic reconstruction (39,2 % for AAA, 39,2 % for occlusive disease, 21,6 % associated) were treated in our center with CAA. The initial surgery was an aorto-bifemoral bypass in 33 patients (60%), the rest equally divided between strictly aortic and aorto-iliac bypasses. The mean age was 65 years old, 90% male. The mean delay from initial surgery was 60 months (0-228). 49 patients (89%) required emergency surgery. 57,9 % of patients needed supra-renal clamping of the aorta for proximal control. 50,1 % of the patients required bowel resection, while as the others needed a direct suture of the fistula. In 26 cases (49,1%), 3 or more organisms were found in intraoperative samples. The mean follow-up period was 45 months (range, 1-160). The 30-day surgical mortality rate was 21,8 % (12/55), with 3 patients from CAA complications. Non-fatal postoperative complications included : pulmonary (24,6%), renal (35,1%, 4 patients needing definitive dialysis), peripheral ischemia (9,1%). 20 patients (24,5%) required a secondary surgical procedure precociously. Four involved the allograft (7,3%) : one rupture, 2 pseudoanerysms, one thrombosis and one enteric fistula recurrence. 5 patients (9,1%) required a major amputation. 16 patients died during long-term follow-up, none related to CAA. The one-year primary patency was 96.4%.

Conclusions: Given the major challenge of secondary aorto-enteric fistulae, CAA replacement deserves to be our first choice strategy. Long-term results with CAA seem sustainable, while those with endovascular procedures remain undetermined.

Full Program & Abstracts

8:24 am – 8:32 am

32 (RF)

Factors Predictive of Outcome When Crossing A Chronic Total Occlusion

Jennifer Perri, Philip Goodney, David Stone - Dartmouth-Hitchcock Medical Center, Lebanon, NH

Objective: In an aggressive endovascular surgery practice, physicians often rely on crossing chronic total occlusions (CTO) to deliver treatment. At present it remains unknown how extensive these efforts should be, and what factors are associated with success versus failure. The purpose of this study is to determine physician and patient modifiable factors associated with positive outcomes in crossing a CTO.

Methods: Between January 1, 2012 and December 31, 2014, 439 patients at Dartmouth-Hitchcock Medical Center underwent diagnostic lower extremity angiography. 261 had evidence of CTOs. Inclusion criteria for the study cohort included TASC B, C, or D lesion, iliac or femoral/popliteal disease, plus attempt at crossing the lesion with a minimum of two wire and catheter combinations.

Results: 46 patients (corresponding with 46 lower extremities) met inclusion criteria. Average age was 72, lesion length 11.4 cm, 65% male, 51% having coronary artery disease. There was no significant difference in fluoroscopy time or numbers of wires/catheters used in cases where lesions were crossed. Decrease in age (μ 64.6 vs. 73.4), lesion length (μ 10.5 vs. 11.6) and calcification score (μ 1.5 vs. 2) were associated with higher probability of success.

Conclusion: Retrospective analysis of attempts made to cross a chronic total occlusion indicate on average physician "effort" such as time spent does not have an impact. Rather it is patient characteristics such as age and lesion length that are better indicators of outcome. These findings should be considered before expending time and resources performing an endovascular intervention.

Full Program & Abstracts

8:32 am – 8:44 am

33

Carotid Endarterectomy Versus Stenting In Patients With Renal Transplants

Isibor Arhuidese, Dorry Segev, Tammam Obeid, Besma Nejim, Mahmoud Malas - Johns Hopkins Medical Institutions, Baltimore, MD

Introduction: There has been an increase in the prevalent end stage renal disease population and their survival with renal transplantation (RT) has improved over the decades. This has resulted in an increase in the number of RT patients seeking treatment for carotid artery stenosis in recent times. Outcomes after carotid revascularization in these patients are unknown. In this study, we evaluate outcomes after carotid endarterectomy (CEA) versus angioplasty and stenting (CAS) in a contemporary cohort of RT patients.

Methods: We studied all RT patients who underwent CEA and CAS in the United States Renal Disease System (USRDS) database between January 2006 and December 2011. Patient data were linked to the Medicare database to capture long-term outcomes. Propensity score matched logistic and cox regression analyses were employed to evaluate outcomes.

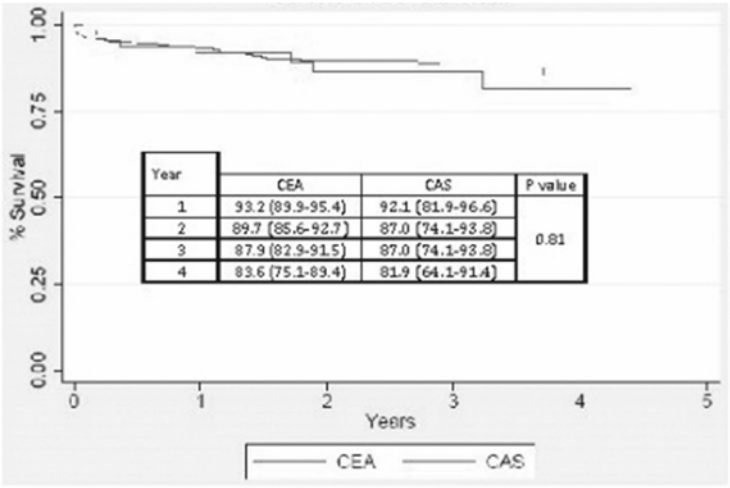
Results: There were 462 (CEA: 387-84%; CAS: 75-16%) carotid revascularizations with a mean duration of 2 (S.D:1.3) years. Patients that underwent CEA vs CAS were similar about their age (mean: both 57 years), male gender (69 vs 73%), race (Caucasian: 85 vs 79%) and comorbidities. Perioperative outcomes after CEA vs CAS were: stroke (4.7 vs 5.3%; p=0.8), death (1.3 vs 4.0%) and myocardial infarction (4.4 vs 2.7%; p=0.49). Long term stroke-free survival after CEA and CAS was 93% vs 92% at 1 year, 90% vs 87% at 2 years, and 84% vs 82% at 4 years (Figure 1).

Conclusions: This is the first study to evaluate outcomes after CEA and CAS in patients with functioning renal transplants. Outcomes in these patients are worse than those reported in the general population. These results should guide the expectations of patients and their surgeons prior to carotid revascularization.

Full Program & Abstracts

Figure 1. Long Term Stroke Free Survival After CEA and CAS In Patients With Functioning Renal Transplants.

Stroke Free Survival



Year	CEA	CAS	P value
1	93.2 (89.9-95.4)	92.1 (81.9-96.6)	0.81
2	89.7 (85.6-92.7)	87.0 (74.1-93.8)	
3	87.9 (82.9-91.5)	87.0 (74.1-93.8)	
4	83.6 (75.1-89.4)	81.9 (64.1-91.4)	

8:50 am – 9:00 am **Introduction of the President**
Thomas S. Maldonado, MD
Location: Kokopelli II & III

9:00 am – 9:45 am **PRESIDENTIAL ADDRESS**
Sean Roddy, MD
Location: Kokopelli II & III

3:00 pm – 6:00 pm **Registration Re-Opens**
Location: Ballroom Pre-Function

3:30 pm – 4:00 pm **Coffee/Snacks – Last Chance To Visit Exhibits**
Location: Kokopelli I

Full Program & Abstracts

4:00 pm – 6:00 pm **SCIENTIFIC SESSION IV**
Moderators: Justin Hurie, MD & Thomas Maldonado, MD
Location: Kokopelli II & III

4:00 pm – 4:12 pm 34
Compression vs. No Compression After Endovenous Ablation of the Great Saphenous Vein: A Prospective Randomized Controlled Trial
Diego Ayo, Todd Jones, Sheila Blumberg, Caron Rockman, Mikel Sadek, Neal Cayne, Mark Adelman, Lowell Kabnick, Thomas Maldonado, Todd Berland - New York University School of Medicine, New York, NY

Introduction and Objectives: The goal of this study is to determine if compression therapy after endovenous ablation (EVA) of the great saphenous vein (GSV) improves efficacy and patient reported outcomes of pain, ecchymosis and quality of life.

Methods: This was a prospective randomized controlled trial from 2009 to 2013 comparing the use of thigh-high 30-40mmHg compression therapy for 14 days vs no compression therapy following endovenous ablation of the GSV. Severity of venous disease was measured by CEAP class and the venous clinical severity score (VCSS). Quality of life assessments were carried out with a CIVIQ-2 questionnaire at days 1, 7, 14, 30 and 90, with the visual analog pain scale daily for the first week, and with the bruising score. Post ablation venous duplex was also performed.

Results: 70 patients and 85 limbs with EVA were randomized. EVA modalities included radiofrequency ablation (91%) and GSV laser (9%).CEAP class and VCSS scores were equivalent between the two groups (Table 1). There was no significant difference in patient reported outcomes of post-procedural pain scores at day 1(P=0.948) and at day 7 (P=0.147), CIVIQ-2 scores at 1 week (P=0.954), mean (35.1+/-16) vs (36.9+/-13.6) , at 90 days (P=0.954) with mean (25.9+/-13) vs (22.5+/-4.5), and bruising score (P=0.561) mean (1.03+/-0.77) vs (1.09+/-0.9) in the compression vs no compression groups respectively. Additionally, there was a 100% rate of GSV closure between the two groups and no DVTs as assessed by post-ablation duplex.

Conclusions: Compression therapy does not significantly affect patient reported and clinical outcomes and may be an unnecessary adjunct following GSV ablation.

Results

Variable	Compression	No Compression	P Value (<0.5)
CEAP Class			0.765
Varicose Veins	28%	22%	
Edema	44%	48%	
Skin Changes	18%	24%	
Healed Ulcer	10%	6%	
Pain Scale			
Day 1			0.948
Mild	76%	74%	
Moderate	19%	18%	
Severe	5%	7%	
Day 7			0.147
Mild	80%	96%	
Moderate	17%	4%	
Severe	3%	0%	
Bruising Score			0.561
None	29%	27%	
Mild	42%	42%	
Moderate	29%	31%	
CIVIQ-2 Score Pre-Operative	42.4,SD+/-19.4	40.8,SD+/-16.4	0.686
Day 7	35.1,SD+/-16	36.9,SD+/-13.6	0.594
Day 90	29.1,SD+/-20	22.5,SD+/-4.5	0.367
VCSS Pre-Operative	5.7,SD+/-2.7	5.6,SD+/-2.5	0.899
Day 7	4.3,SD+/-1.5	3.1,SD+/-2.5	0.491
GSV Closure	100%	100%	

4:12 pm – 4:24 pm

35

Bundling of Reimbursement For Inferior Vena Cava Filter Placement and Procedural Utilization Volumes

Roan J. Glocker, Elaine L. Hill, Joseph J. Guido, Adam Doyle, Jennifer L. Ellis, Gary R. Morrow, Michael C. Stoner - University of Rochester, Rochester, NY

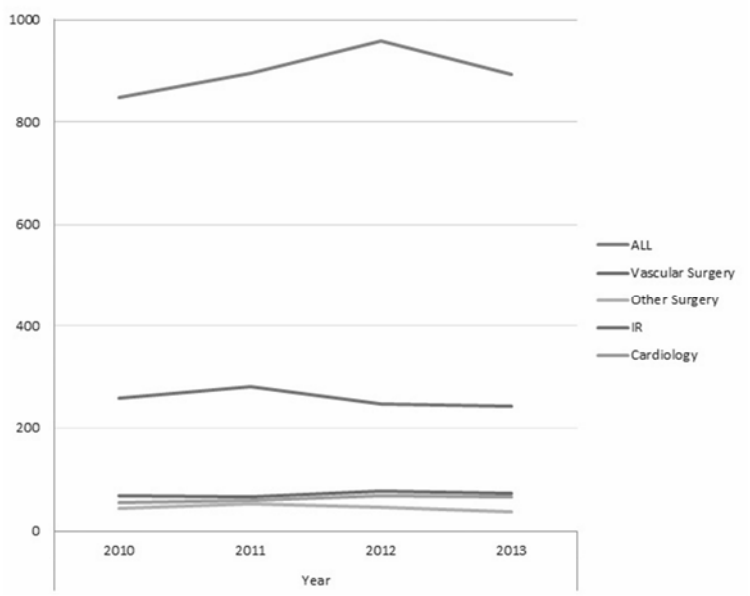
Introduction and Objectives: Bundling of procedural payments by the Centers for Medicare and Medicaid Services (CMS) is increasing. Recent studies have shown that procedural utilization decreases after bundling. On January 1st of 2012 reimbursement for inferior vena cava filter (IVCF) placement became bundled. Before bundling, the CPT codes for IVCF placement (37620) as well as the associated catheter placement and diagnostic procedures (36010, 75825-26, 75940-26) yielded 15.6 relative value units (RVUs). After bundling, IVCF placement (37191) yielded 4.71 RVUs, a 70% decrease. Whether this change in reimbursement has impacted procedural utilization of IVCF placement is not known.

Methods: Utilizing 5% Inpatient, Outpatient, and Carrier files of Medicare Limited Data Sets we analyzed IVCF utilization before and after bundling across specialty types controlling for total diagnosis of deep vein thrombosis (DVT) and pulmonary embolism (PE) (ICD - 9 codes 453.xx and 415.xx).

Results: The placement rates of IVCF per 10,000 diagnoses of DVT/PE in the two years prior to bundling (2010 and 2011) were 848 and 894 respectively. In the two years after bundling (2012 and 2013) the placement rates were 957 and 892 respectively. These differences were not significant ($p = 0.06$). Using the NPI numbers in the dataset with the NPPES database, placement specialty was discernible for 49% of IVCF placements. No significant differences were noted amongst placement rates for vascular surgeons, non-vascular surgeons, interventional radiologists, and interventional cardiologists ($p= 0.66$) (Figure 1).

Conclusions: In contrast to other procedures, these data indicate that IVCF utilization was not affected by a substantial decrease in reimbursement. As bundling becomes more common across specialties more data are needed on its effects on procedural utilization.

Figure 1. IVCF Placed Per10,000DVT/PE



4:24 pm – 4:36 pm

36

Determinants of Symptomatic Recurrence and Repeat Intervention Following Endovascular Treatment of Chronic Mesenteric Ischemia In the Setting of Challenging Superior Mesenteric Artery Lesions

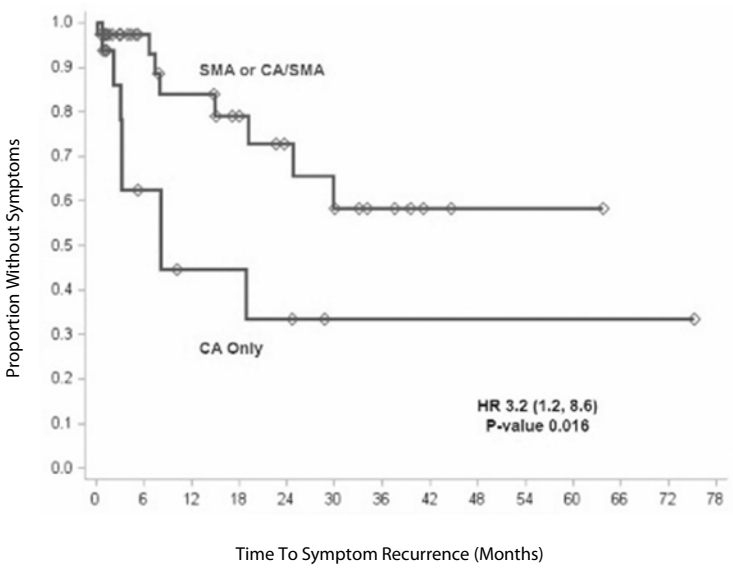
Thomas E. Reeve, IV, Matthew P. Goldman, Timothy E. Craven, Matthew S. Edwards, Matthew A. Corriere, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez - Wake Forest School of Medicine, Winston Salem, NC

Introduction: Endovascular intervention is first-line treatment for chronic mesenteric ischemia (CMI) when feasible. Two-vessel revascularization is most definitive when celiac (CA) and superior mesenteric arteries (SMA) are diseased, but single-vessel intervention may be needed with two vessel disease due to anatomic/technical factors. We evaluated predictors of clinical outcomes associated with endovascular treatment of CMI among patients with challenging SMA lesions.

Methods: Patients with endovascular revascularization over 10 years were identified. Patients with challenging SMA lesions (occlusion, severe long-segment calcific disease extending to secondary branches) were selected for analysis. Between-group comparisons based on inclusion of SMA revascularization were evaluated using T-test and chi-square. Freedom from symptomatic recurrence or repeat intervention was analyzed using proportional hazards regression.

Results: Fifty-four patients with CMI and challenging SMA lesions were analyzed. Sixteen (29.6%) had CA-only intervention, 38 (70.4%) had SMA with or without CA intervention. No significant differences in demographics or comorbidity were identified. In CA-only intervention group, 8/16 (50%) patients developed symptomatic recurrence compared to 8/31 (21.1%) of patients whose intervention included the SMA. Patients without SMA intervention had decreased freedom from symptomatic recurrence (HR 3.2; 95% CI 1.2-8.6; P=0.016) (Figure 1) and repeat intervention (HR 5.5; 95% CI 1.8-16.3; P=0.001).

Conclusion: Among patients with CMI and challenging SMA lesions, SMA revascularization appears to be the key determinant for symptomatic outcomes and repeat intervention. Increased symptomatic recurrence should be anticipated in these patients when endovascular intervention is limited to single vessel CA treatment. Patient counseling should include potential future need for surgical revascularization if endovascular SMA treatment cannot be accomplished. Improved outcomes with two-vessel intervention may reflect the importance of including the SMA rather than a purely quantitative effect.


Proportion Without Symptoms
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
SMA or CA/SMA
CA Only
HR 3.2 (1.2, 8.6)
P-value 0.016
0
6
12
18
24
30
36
42
48
54
60
66
72
78
Time To Symptom Recurrence (Months)

4:36 pm – 4:48 pm

37

Patency of the Internal Iliac Artery After Placement of Common And External Iliac Artery Stents

Margarita Vinogradova[1], Hye J. Lee[1], Ehrin Armstrong[2], John Laird[1], Misty D. Humphries[1] - [1]University of California Davis Medical Center, Sacramento, CA; [2]VA Eastern Colorado Health Center, Denver, CO

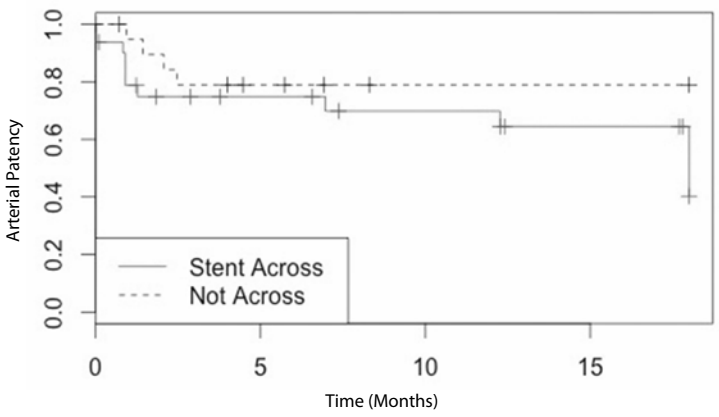
Introduction and Objectives: Treatment of Aortolliac Occlusive Disease (AIOD) frequently requires long segment stenting of the common and external iliac arteries. This study evaluated IIA patency after placement of stents extending from the common iliac artery (CIA) into the external iliac artery (EIA).

Methods: A retrospective analysis of all patients that underwent de novo ipsilateral stent placement in the CIA and EIAs between 2006 and 2013 was performed. Kaplan Meier analysis was used to analyze patency of the IIA.

Results: We identified 80 patients with ipsilateral common and external iliac artery stent placement in 96 limbs. Review of all pre-intervention angiograms revealed 55 (57%) patent ipsilateral IIAs. Stents were placed across the origin of the IIA in 32 (33%) limbs and staggered around the origin in 23 (24%) limbs. Angiography showed three IIA with stents across the origin (9%) occluded at the completion of the procedure. Patency was assessed by Duplex surveillance performed at six-month intervals. Over an18 month period 12 IIAs that were covered thrombosed compared to 4 arteries that were uncovered. Kaplan-Meier analysis demonstrated a 40% patency in covered IIAs compared to 80% patency in uncovered arteries, although this did not reach statistical significance (p=0.08). (Figure) Five (9%) of the patients with IIA occlusion developed buttock claudication, which resolved at 1 year in only 1 patient.

Conclusions: Placement of stents across the origin of the IIA may not result in immediate occlusion, but long-term patency of covered IIAs is decreased compared to uncovered IIAs. This study is limited by a small sample size, but when treating AIOD avoiding coverage of the internal iliac origin should be avoided to maintain patency of the pelvic circulation.

Figure. Internal Iliac Patency After Stent Crossing



4:48 pm – 4:56 pm

38 (RF)

Initial Experiences With Endovascular Management of Pulmonary Embolism - Is It Safe?

Timothy J. Fuller, Muhammad H. Zubair, Christopher M. Paprzycki, Lala R. Hussain, Patrick E. Muck - Good Samaritan Hospital, Cincinnati, OH

Objective: Interventional strategies for massive and submassive PE (smPE) have historically included either systematic intravenous thrombolytic alteplace (IV TPA) or surgical embolectomy. However, with the advent of endovascular techniques, recent studies have suggested that an endovascular approach to the treatment of acute smPE may be both safe and effective with excellent outcomes. The purpose of this study was to evaluate the outcomes of patients who have undergone catheter directed therapy (CDT) for smPE at our institution.

Methods: A retrospective review was conducted from 2012 – 2015 to identify patients whom underwent CDT in the treatment of a smPE at our institution. Outcome variables were classified as serious or minimally adverse events. Serious events included death, stroke, myocardial infarction, and bleeding complications. Minimally adverse events included groin hematoma, development of arteriovenous fistula, and bleeding not requiring interruption of procedure or transfusion. Additionally, effectiveness based off of pre- and post-interventional clinical exam and radiographic findings were evaluated.

Results: A total of 27 patients undergoing CDT for smPE at our institution were evaluated. The review found only three minimally adverse events among three separate patients. The three adverse events all included minor bleeding from access sites not requiring cessation of intervention or transfusion of blood products. The average reduction in RV/LV ratio on follow-up imaging was 38% and, via chart review, all patients reported significant cessation of shortness-of-breath and resolution of chest pain with associated decrease in supplemental oxygen requirement.

Conclusions: Current evidence suggests that CDT should be considered as the first-line therapy for smPE. Our experiences demonstrated that CDT in the treatment of smPE is safe, while providing immediate resolution of both RV strain and clinical symptoms such as shortness-of-breath. We hope this data will allow other institutions to consider CDT as a plausible option in the treatment of smPE.

4:56 pm – 5:04 pm

39 (CR)

Endovascular Management of Concomitant Thoracic and Abdominal Aortic Ruptures Resulting From Brucellosis Aortitis

Samuel L. Chen, Isabella J. Kuo, Roy M. Fujitani, Nii-Kabu Kabutey - University of California, Irvine Medical Center, Orange, CA

Introduction: Acute aortic infection due to Brucellosis, a zoonosis, is rare. We present a case of endovascular management of acute multifocal thoracic and abdominal aortic ruptures arising from Brucellosis aortitis.

Methods: A 71 year-old Hispanic male with a history of atrial fibrillation and prior stroke on chronic anticoagulation, presented with shortness of breath and malaise. One year prior to presentation, he was treated for Brucella melitensis bacteremia after eating fresh, unpasteurized cheese in Mexico. CT angiography demonstrated an acute rupture of the descending thoracic aorta just proximal to the celiac trunk and synchronous rupture of the abdominal aorta its bifurcation.

Results: He was taken emergently to the hybrid operating room, where synchronous supraceliac thoracic aortic stent graft and abdominal aortoiliac stent graft were deployed under local anesthesia. Completion angiography demonstrated total exclusion of the thoracic and abdominal extravasation with no evidence of endoleak. Twenty hours post-operatively, the patient became acutely obtunded and hypotensive. Repeat CT angiography demonstrated contrast extravasation at the level of the excluded aortic bifurcation. Emergent angiography confirmed a type II endoleak with free extraluminal rupture. Multiple coils were placed at the level of the aortic bifurcation between the left limb of the stent graft and the aortic wall to tamponade the endoleak. No further extravasation was noted on final aortography. Post-operatively, blood cultures grew Brucella melitensis. The patient was treated with systemic Doxycycline, Gentamicin and Rifampin. Resolution of the acute event occurred without additional sequelae and he was discharged from the hospital.

Conclusion: This case represents a very rare description of multifocal aortic rupture arising from Brucellosis aortic infection. The mortality associated with this condition is very high; however this patient was successfully treated with thoracic and abdominal endovascular stent graft exclusion, coiling and long-term targeted antibiotics. Long-term results from this therapy are yet to be determined.

5:04 pm – 5:12 pm

40 (RF)

Effects of Gender Differences On Short-Term Outcomes In Patients With Acute Type B Aortic Dissection

Nathan L. Liang, Elizabeth A. Genovese, Georges E. Al-Khoury, Eric S. Hager, Michel S. Makaroun, Michael J. Singh - University of Pittsburgh, Pittsburgh, PA

Introduction: Gender-related differences in acute type B aortic dissection (TBAD) are not well understood. The objective of this study is to assess the impact of gender on short-term outcomes in patients with TBAD.

Methods: Patients with TBAD were identified from National Inpatient Sample datasets from 2009-2012 according to previously published methods. An inverse propensity-weighted regression was used to balance comorbid differences. Subgroup analyses were performed on those undergoing endovascular (TEVAR) and open repair. Primary outcomes were in-hospital mortality and major complications (renal, cardiac, pulmonary, paraplegia, and stroke-related).

Results: We identified 9855 patients with TBAD; females were fewer (43.6%, n=4293), and presented at a later age (69.8±15.5 vs. 62.8±15.6, p<0.001). Females had more comorbidities (median Elixhauser 4 [IQR 2-5] vs. 3 [IQR 2-5],p<0.001), and were more often managed non-operatively (87.4% vs. 81.8%,p<0.001) compared to males. For those undergoing intervention, 58% (n=903) had open repair. TEVAR rates were higher in females compared to males (45.6% vs. 40.0%,p<0.001). Unadjusted mortality rates did not differ significantly by gender (11.6% vs. 10.7%). In an adjusted propensity-weighted regression, gender did not significantly affect mortality or stroke, but females were less likely than males to have renal or paraplegia complications overall and more likely to experience cardiac events in the open repair subgroup. Gender did not significantly affect the adjusted paraplegia risk in the open repair or TEVAR subgroups (Table).

Conclusions: In comparison to men, females with TBAD presented at a later age, were more likely to undergo TEVAR, sustain a perioperative cardiac event with open surgery, and less likely to experience paraplegia in a non-operative setting. Future studies should attempt to identify anatomic and epidemiologic reasons for these differences.

	Total Cohort			Subgroup: TEVAR			Subgroup: Open Repair		
	OR	95% CI	P	OR	95% CI	P	OR	95% CI	P
Mortality	0.91	[0.79, 1.06]	0.2	0.74	[0.37, 1.45]	0.4	0.93	[0.61, 1.42]	0.7
Renal	0.68	[0.60, 0.76]	<0.001	0.49	[0.31, 0.77]	0.002	0.68	[0.49, 0.95]	0.02
Cardiac	1.11	[0.96, 1.28]	0.1	1.21	[0.67, 2.19]	0.5	1.45	[1.01, 2.11]	0.04
Pulmonary	0.97	[0.87, 1.09]	0.75	0.72	[0.50, 1.12]	0.2	1.16	[0.83, 1.61]	0.4
Paraplegia	0.60	[0.40, 0.90]	0.01	0.66	[0.26, 1.67]	0.4	1.8	[0.64, 4.92]	0.3
Stroke	0.91	[0.52, 1.57]	0.7	0.52	[0.12, 2.21]	0.4	1.02	[0.50, 2.04]	0.9

5:12 pm – 5:24 pm

41

Under-Utilization of Routine Ultrasound Surveillance After Endovascular Aortic Aneurysm Repair

Matthew Mell, Trit Garg, Laurence C. Baker - Stanford University, Stanford, CA

Introduction and Objectives: Since 2009 the Society for Vascular Surgery has advocated annual surveillance imaging with ultrasound (US) after the first post-operative year for uncomplicated endovascular aneurysm repairs (EVAR). We sought to describe diffusion of US into long-term routine surveillance and to estimate potential cost savings among Medicare beneficiaries after EVAR.

Methods: Using Medicare claims data, we identified patients receiving EVAR from 2002 to 2010 and included only those who did not subsequently have re-interventions, late aneurysm-related complications or death. We collected all relevant postoperative imaging (CT and US) through 2011. Patients with follow-up less than 1 year were excluded. We estimated cost-savings with increased use of US after the first postoperative year.

Results: The cohort comprised 24,615 patients with a mean follow-up of 3.9 +/- 2.3 years. Mean number of images decreased from 2.23 in the first postoperative year to 0.31 in the tenth year. Utilization of US at the first post-operative year remained low but increased from 15.2% in 2003 to 28.8% in 2011 ($p<0.001$). By the tenth post-operative year the proportion of patients receiving US increased from 8.2% to 37.8%, while use of CT only remained high but decreased from 60.8% to 42.1%. Mean cost of surveillance imaging was $2,132 per CT and $234 per US. Performing US in 50% - 75% of patients beginning one year after EVAR would decrease costs by 14% - 48% per year. This translates to a mean cost savings of $338- $1135 per imaged patient per year, with an estimated savings to Medicare of $111 million to $316 million over 10 years.

Conclusions: CT remains the primary modality of surveillance for up to 10 years after EVAR for patients without re-interventions or aneurysm-related complications. Increasing the use of US and decreasing the use of CT would save cost without compromising outcomes.

5:24 pm – 5:36 pm

42

Concomitant Parallel Endografting and Fenestrated Experience In A Regional Aortic Center

Mathew Wooster, Adam Tanious, Shiva Patel, Neil Moudgill, Martin Back, Murray Shames - University of South Florida, Tampa, FL

Objective: Parallel endografting has been criticized in favor of custom fenestrated endografts. There remain limited direct comparisons, between concurrent patient populations treated by similarly experienced operators. Hence, we seek to evaluate the relative efficacy of the techniques in treating complex aortic pathology.

Methods: All patients treated by parallel endografting (PE) or with Cook Zenith Fenestrated (Zfen) devices from January 2010 to June 2015 were reviewed, excluding those treated for rupture. Patients were evaluated for open repair as well as for fenestrated devices since its availability at our center in July 2013. Patients predating fenestrated access or not meeting anatomic IFU criteria and preferring endovascular therapy were treated with parallel endografting.

Results: 103 patients were treated during the period reviewed, 64 (62.1%) by PE and 39 (37.9%) with Zfen. The two procedures required similar length of surgery (243 minutes PE vs. 239 minutes Zfen) and contrast (112cc PE vs 133cc Zfen). PE was associated with greater length of stay (10.5 vs 6.5 days) and blood loss (680cc vs 409cc), while requiring less fluoroscopy time (52.8 vs 64.6 minutes). At mean 202 days follow up, Zfen required three reinterventions (2 type III endoleaks and 1 SMA stenosis causing mesenteric ischemia) and there have been zero branch vessels lost. At mean 387 days follow up, PE patients experienced 5 stent occlusions (two repaired endovascularly) and required 9 additional interventions (2 type I endoleaks, 3 type II endoleaks with sac growth, 3 type III endoleaks, and 1 graft infection). Reintervention rates for PE and Zfen were 15.5% and 7.7% respectively, with branch patency rates of 96% and 97%.

Conclusions: Parallel endografting is associated with increased blood loss, length of stay, and rate of reintervention compared to the Zenith fenestrated device. However, it is associated with reduced fluoroscopy time and maintains similarly high branch patency.

5:36 pm – 5:48 pm

43

Patterns In the Management of Acute Limb Ischemia: A VESS Survey

Matthew R. Smeds[1], Harleen K. Sandhu[2], Samuel S. Leake[2], Charles C. Miller, III[2], Kristofer M. Charlton-Ouw[2] -
[1]University of Arkansas for Medical Sciences, Little Rock, AR; [2]University of Texas Medical School at Houston, Houston, TX

Objectives: Treatment strategies for acute limb ischemia (ALI) are abundant with few established guidelines. We sought to determine nationwide ALI treatment patterns in the modern era.

Methods: Anonymous electronic surveys examining the management of ALI involving native vessel and bypass occlusion were sent to all VESS members (N=738). Treatment options included catheter-directed (CDT) or phrmacomechanical (PMT) thrombolysis, and open surgery (OS). CDT was evaluated for lytic and heparin dosing, fibrinogen monitoring, and treatment duration. Influence of time from training, practice type, hospital size, region, and protocol use was assessed. Data were analyzed by univariate contingency tables, and multinomial regression analysis.

Results: 115 (16%) surveys were completed. The most common management of bypass thrombosis of both prosthetic and vein conduit was CDT for Rutherford Category (RC) 2a patients (58% and 67%) and OS in both RC 2b (43% and 40%) and RC 3 (87% and 87%) patients with significant variability. Similarly, native vessel occlusion was managed by CDT (58%) in RC 2a and OS in RC 2b and 3 (57% and 92%). TPA dosing during CDT was usually 1 mg/hr (84%) with variable concentrations and duration of initial treatment of 8-24h (81%). TPA concentration used were lower and rates of fibrinogen monitoring to adjust TPA dosing were higher in institutions where the majority of ALI cases were managed by vascular surgeons ($p<.03$ and $p<.02$). The majority of respondents (77%) deliver heparin at 500u/hr via sheath without systemic dosing. Most respondents indicated having developed their own protocols and patterns of treatment varied but were influenced by training and practice environment variables.

Conclusions: Management strategies vary widely in ALI. Some effects of provider training and individual protocol development were observed, and TPA protocols were influenced by increased institutional responsibility for thrombolysis. Further efforts are needed to develop consensus guidelines for ALI management.

5:48 pm – 5:56 pm

44 (RF)

Gender-Specific Differences In Saphenous Vein Conduit: A Link To Outcomes Disparities?

Emily Lagergren, Kelly Kempe, Timothy E. Craven, Susan T. Kornegay, Justin B. Hurie, Nitin Garg, Gabriela Velazquez-Ramirez, Matthew S. Edwards, Matthew A. Corriere - Wake Forest University School of Medicine, Winston Salem, NC

Introduction and Objectives: Inferior lower extremity bypass (LEB) patency has been observed among women, but the mechanisms behind this disparity are unknown. We hypothesized that gender-based differences in great saphenous vein (GSV) diameter might contribute to inferior patency outcomes, and performed a gender-based analysis among patients with peripheral arterial disease (PAD) undergoing lower extremity vein mapping to test this hypothesis.

Methods: Consecutive patients undergoing ultrasound vein mapping for planned LEB were analyzed. Minimum above- and below-knee GSV diameters were obtained in addition to demographic, procedural, and clinical data. Associations between gender and GSV diameter were evaluated using multivariable mixed models accounting for anatomic location and within-patient correlation (including unilateral versus bilateral studies).

Results: 105 patients were analyzed. Mean patient age was 65±11 years, 25% were women, and 78% were white. Mixed model estimates of minimum GSV diameters were 3.14±0.09mm above-knee and 2.74±0.09 below knee for men versus 3.23±0.14 above-knee and 2.49±0.14 below-knee for women. A gender-based interaction between anatomic location and GSV diameter was identified, with women having a greater difference between above- and below-knee GSV diameters (or taper) (mean difference of 0.73±0.12 versus 0.41±0.17 mm; P=0.017).

Conclusions: GSV taper (difference between above- and below-knee diameter) is greater in women and may contribute to inferior patency following LEB with vein conduit, particularly for below-knee target vessels. Further research is necessary to evaluate specific hemodynamic effects of graft taper and links with other clinical endpoints. In addition to minimum diameter, vein graft taper may warrant consideration when planning LEB.

Full Program & Abstracts

5:56 pm – 6:04 pm

45 (CR)

Endovascular Treatment of Acute Type B Dissection and SMA Thrombosis Using Aspiration Catheter

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

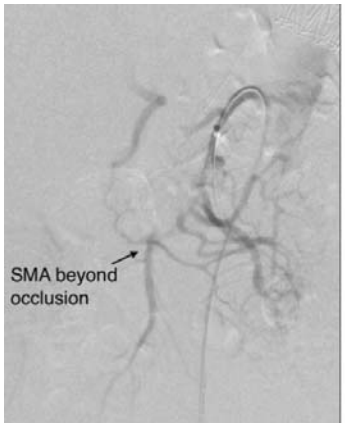
Introduction and Objectives: Acute mesenteric ischemia (AMI) is a highly morbid and frequently lethal medical condition. Improvements in endovascular therapy have revolutionized treatment for embolic and thrombotic AMI; however, there is a paucity of data using this adjunct in the treatment of dissection.

Methods: A middle-aged male presented to a local ED with acute onset back and abdominal pain. He was on Coumadin for SMV thrombosis and had recently had a peritoneal drain placed by interventional radiology for ruptured appendicitis. CT scan revealed Type B Aortic Dissection (TBAD) with SMA thrombosis. He was transferred to our acute aortic syndrome ICU for further management.

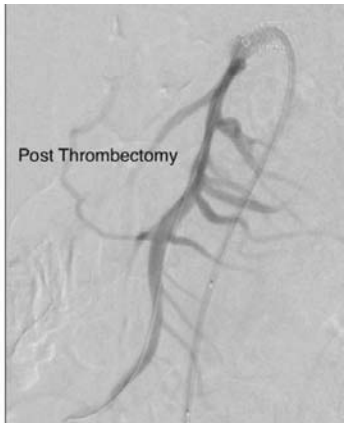
Results: On physical exam, the patient had abdominal pain out of proportion to physical exam. He was emergently transferred to the hybrid operating room. Percutaneous access was achieved and IVUS used to confirm wire location in the true lumen. A thoracic stentgraft covered the primary entry tear and was extended to the celiac axis with a second device. An 8x30 balloon expandable stent was placed in the SMA; thrombus was removed with .014 aspiration catheter. The general surgery team made a small midline laparotomy, noted bowel to be healthy, and performed appendectomy. He had complete relief of his abdominal pain, and was discharged home in good condition.

Conclusions: Endovascular treatment can be effective in the treatment of dissection-related SMA thrombosis.

Full Program & Abstracts



SMA Before Thrombectomy



SMA After Thrombectomy

7:00 pm – 10:00 pm

PRESIDENT'S DINNER
All registered attendees are welcome to attend. This is a ticketed event.

Location: Red Pine Lodge

Full Program & Abstracts

Sunday, February 7, 2016

6:30 am – 7:00 am	**Continental Breakfast** *Location: Ballroom Pre-Function*
6:30 am – 9:00 am	**Registration** *Location: Ballroom Pre-Function*
7:00 am – 9:00 am	**SCIENTIFIC SESSION V** Moderators: Benjamin S. Brooke, MD & Jason T. Lee, MD *Location: Kokopelli II & III*
7:00 am – 7:12 am	46 **Hemodialysis Vascular Access: Rising Costs As A Surrogate Marker For Patency and Function of Arteriovenous Fistulas** Zachary M. Feldman, Lisa B. Liu, Stephen D. Abramowitz, Peter L. Faries, Michael L. Marin, Harry R. Schanzer, Victoria J. Teodorescu - Icahn School of Medicine at Mount Sinai, New York, NY

Introduction and Objectives: Establishment and maintenance of vascular access for hemodialysis is life-sustaining for patients needing renal-replacement therapy. Arteriovenous fistulas (AVFs) are the preferred type of access, but the costs associated with creation and maintenance are poorly characterized, especially with respect to patient characteristics.

Methods: A prospectively maintained registry has been established at The Mount Sinai Hospital for patients undergoing access procedures since 2007. We studied 151 patients undergoing successfully placed and cannulated AVFs as their first permanent access and for whom 3-year follow-up was available, including 15 patients with failed contralateral access. Records were analyzed for institutional inpatient and outpatient procedures related to access maturation, imaging, catheter-related procedures, and revisions. We determined costs for three AVF locations, assessing the contribution of various factors to variation in costs and patency.

Results: The average first-year cost of patent AVFs was $12,674, with $5,724 attributable to initial creation. For fistulas remaining patent over 3 years, cumulative 3-year costs totaled $17,552, with $1,533 attributable to imaging and $16,019 to creation and interventions. Fistulas with patent lifetimes of 19-24 months (3.3%) had cumulative costs of $35,404. Those with patent lifetimes of 6 months or shorter (7.3%), or 36 months or longer (79.5%) had cumulative costs of $15,967 and $16,842, respectively. Right-sided fistulas were associated with higher 1-year (35%) and 3-year (45%) costs. HIV status was associated with higher 3-year costs. Prior history of contralateral access was also associated with higher costs. Patient age negatively correlated with patency lifetime.

Conclusions: Hemodialysis access maintenance contributes significantly to the healthcare burden of renal disease. Our data suggest that particular patient characteristics factor into patency and costs. Short-term mounting costs associated with AVF maintenance may portend poor long-term patency. Rising healthcare costs cannot be easily controlled without understanding the clinical factors driving them.

Full Program & Abstracts

7:12 am – 7:24 am

47

Ectatic Aortas (2.5-2.9 cm) Are At Risk For Progression To Abdominal Aortic Aneurysm

Michael S. Hong[1], Ashley S. Schmidt[2], Kevin C. Chun[2], Tanmayee Yenumula[2], Narges Zazi[2], Eugene S. Lee[2] - [1]UC Davis, Sacramento, CA; [2]Sacramento Veterans Administration Medical Center, Mather, CA

Introduction and Objectives: Current AAA surveillance guidelines recommend no further follow up for aortas less than 3.0 cm in diameter. Recent studies however demonstrated late aneurysm related deaths in subjects with aortas measuring 2.5-2.9 cm. We aimed to determine the natural history of the ectatic abdominal aorta 2.5-2.9 cm identified in a large aortic screening program.

Methods: 9,751 men ages 65-75 with a smoking history, were screened for AAA between 2007 and 2011. Patients with 2.5-2.9 cm aortic diameter, with at least two imaging studies separated by 180+ days, were identified for analysis.

Results: 1,160 patients (11.9%) of 9,751 screened patients were identified to have an ectatic aorta. Of these patients, 265 (22.8%) underwent a subsequent imaging study of the aorta and were available for analysis. 76 patients (28.6%) developed an AAA ≥ 3.0 cm. The remaining patients (n=189) showed little to no growth and were classified as aortas < 3.0 cm. The mean follow up period for aortic follow up was 30 ± 19 months [Range: 6-87 months]. During the follow up period, 42 patients died (15.8%) and 1 patient had an aneurysm diameter of 5.4 cm. The overall expansion rate was 0.07 ± 0.3 cm/year. However, patients who developed aneurysms ≥ 3.0 cm had significantly greater expansion rates (0.3±0.3 cm/year vs. 0.0±0.2 cm/year, P < .001).

Conclusions: Patients with an ectatic aorta have a moderate likelihood of expanding to an AAA ≥ 3.0 cm. There is dichotomy in patients with stable and expanding aortas, and those identified with ectatic aortas on initial screening merit additional surveillance studies. Further investigation should be performed to evaluate clinical characteristics to identify the expanding subgroup.

Table. Follow-Up Outcomes of Ectatic Aortas

	Aortas < 3.0 cm n=189	Aortas ≥ 3.0 cm n=76	p-value
Age (Years)	73.7±5.5	74.5±5.8	0.3
Initial Aortic Size (cm)	2.6±0.1	2.7±0.1	<0.001
Follow-Up Aortic Size (cm)	2.6±0.3	3.2±0.4	<0.001
Expansion Rate (cm/year)	0.0±0.2	0.3±0.3	<0.001

7:24 am – 7:36 am

48

The Impact of Functional Status On the Outcomes of Endovascular Lower Extremity Revascularization For Critical Limb Ischemia In the Elderly

Isidore Dinga Madou, Martin Slade, Kristine Orion, Timur Sarac, Cassius Iyad Ochoa Chaar - Yale New Haven Hospital, Yale School of Medicine, New Haven, CT

Introduction: Functional status is an important predictor of outcomes after infrainguinal bypass surgery. The effects of functional status on endovascular lower extremity revascularization has not been yet studied.

Methods: ACS-NSQIP files targeting lower extremity endovascular interventions for the years 2011-2013 were reviewed. Elderly patients (Age ? 70) undergoing revascularization for critical limb ischemia (CLI) were included. The patients were divided into 2 groups based on functional status prior to surgery: Independent (IND) or Dependent (DEP) which included partially dependent as well as totally dependent patients. The 2 groups were compared with respect to demographics, comorbidities, complications, length of stay, and mortality. Statistical analysis was performed using student's t-test for continuous variables and Fisher exact test for categorical variables.

Results: There were 1055 patients (DEP = 253, 24%). There was no difference in gender or race but DEP patients were older than IND (p=0.0054). DEP patients were significantly more likely to have history of congestive heart failure (p=0.003), hypertension (0.0419), and diabetes (p<0.0001). There was no difference in emergent surgeries between the 2 groups (p=1.00). DEP patients had more tibial interventions compared to IND (p=0.0027). DEP developed more pneumonia (p=0.0008) and septic shock (p=0.0156) and had a trend towards more urinary tract infections (p=0.051) after endovascular revascularization. There was no significant difference in operating time (0.2765) or major amputation (p=0.129). DEP had significantly longer length of hospital stay (p=0.0068). DEP had significantly higher mortality (6.32% vs 2.49%, p=0.0083). (Table)

Conclusions: Functional status should be carefully assessed when considering endovascular revascularization in the elderly as DEP have significantly higher morbidity and mortality.

Table. Characteristics and Outcomes of DEP and IND Patients.

Parameter	Dependent n (%)	Independent n (%)	P value
Age/category			
70-80	114 (45.06%)	438 (54.61%)	0.0054
80-90	105 (41.50%)	301 (37.53%)	
90 plus	34 (13.44%)	63 (7.86%)	
Gender			
Female	136 (53.75%)	388 (48.38%)	0.1493
Race			
White	179 (80.27%)	592 (82.22%)	0.5852
Black or African American	40 (17.94%)	110 (15.28%)	
Other	4 (1.79%)	18 (2.50%)	
Comorbidity			
Diabetes	170 (67.19%)	423 (52.74%)	<.0001
COPD	35 (13.83%)	94 (11.72%)	0.3793
History of CHF	25 (9.88%)	37 (4.61%)	0.0033
Hypertension	233 (92.09%)	700 (87.28%)	0.0419
Dialysis (pre-op)	33 (13.04%)	81 (10.10%)	0.2015
Emergency case	12 (4.74%)	38 (4.74%)	1.0000
Total operation time (min)	104.2 ± 69.2565	109.7 ± 70.2212	0.2765
Type of intervention			
Femoropopliteal	156 (62.15%)	576 (72.27%)	0.0027
Tibial	95 (37.85%)	221 (27.73%)	
Total Hospital Stay (days)	7.28 ± 18.1	4.01 ± 10.57	0.0068
Morbidity			
Superficial surgical site infection	1 (0.40%)	16 (2.00%)	0.0895
Pneumonia	8 (3.16%)	3 (0.37%)	0.0008
Progressive renal insufficiency	4 (1.58%)	5 (0.62%)	0.2302
Urinary tract infection	8 (3.16%)	10 (1.25%)	0.0510
CVA/Stroke	1 (0.40%)	5 (0.62%)	1.0000
Myocardial infarction	3 (1.19%)	17 (2.12%)	0.4363
Bleeding	24 (9.49%)	76 (9.48%)	1.0000
Sepsis	6 (2.37%)	10 (1.25%)	0.2357
Septic shock	6 (2.37%)	4 (0.50%)	0.0156
Major amputation	17 (6.72%)	34 (4.24%)	0.1290
Mortality	16 (6.32%)	20 (2.49%)	0.0083

7:36 am – 7:48 am

49

Predicting Mortality In Ruptured Abdominal Aortic Aneurysms In the Endovascular Era

Michael Neilsen[1], David Clark[1], William P. Robinson[2], Andres Schanzer[3], Christopher T. Healey[1] - [1]Maine Medical Center, Portland, ME; [2]University of Virginia School of Medicine, Charlottesville, VA; [3]University of Massachusetts Medical School, Worcester, MA

Introduction and Objectives: Previous risk prediction models of mortality after ruptured abdominal aortic aneurysm (rAAA) repair have been limited by imprecision, complexity, or inclusion of variables not available in the preoperative setting. Furthermore, these prediction models have been derived and validated prior to the adoption of EVAR as a treatment for rAAA. We sought to build a new risk prediction tool using only easily obtainable pre-operative variables in patients with rAAA who are being considered for repair in the Endovascular Era.

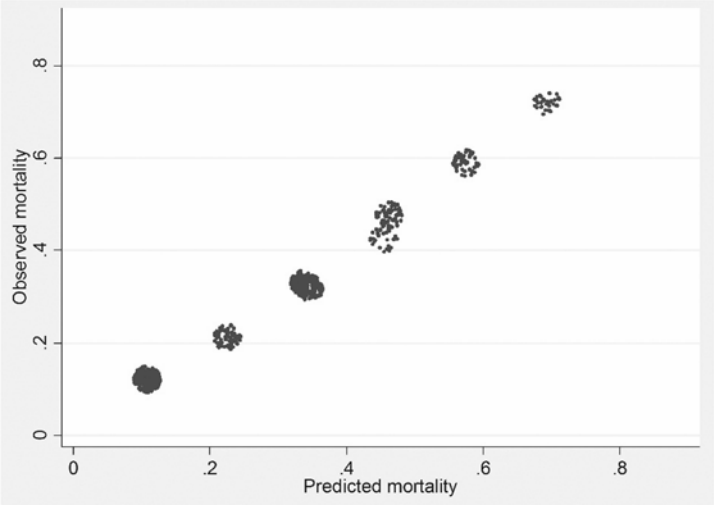
Methods: We queried the VSGNE registry for patients (n=781) who underwent repair of RAAA from 2003-2015. Variables were entered into a logistic regression to identify independent predictors of 30-day mortality. Linear regression was used to develop an equation to predict risk of 30-day mortality.

Results: From 2003-2015, 67.3% of patients underwent an open repair and 32.6% underwent an EVAR. The overall mortality associated with rAAA was 33.8% (open, 36%, EVAR, 28%). The predictive power of the models came from older age (>76 years vs. 1.5 mg/dl vs. <=1.5 mg/dl), and lowest SBP (BP=70 torr). A logistic regression model had an area under an ROC curve of 0.72. The corresponding linear model predicted 30-day mortality (%) as:

Mortality =11 + 24*(age>76) + 12*(creatinine>1.5) + 23*(BP<70).

Conclusions: In the Endovascular era where both open and endovascular treatment is offered for the treatment of rAAA, three variables, easily obtained in an emergency setting, accurately predict 30-day mortality for patients operated on for rAAA. This easy to use risk prediction tool could be used as a point of care decision aid to help the clinician in counseling patients and their families on treatment of those presenting with rAAA.

Full Program & Abstracts



7:48 am – 7:56 am

50 (RF)

Predicting ICU Readmission Among Vascular Surgery Patients: Development of A Predictive Nomogram

Katherine Reigstad, Ragheed Al-Dulaimi, Mary Mone, Joseph Tonna, Richard Barton, Larry S. Kraiss, Benjamin S. Brooke - University of Utah, Salt Lake City, UT

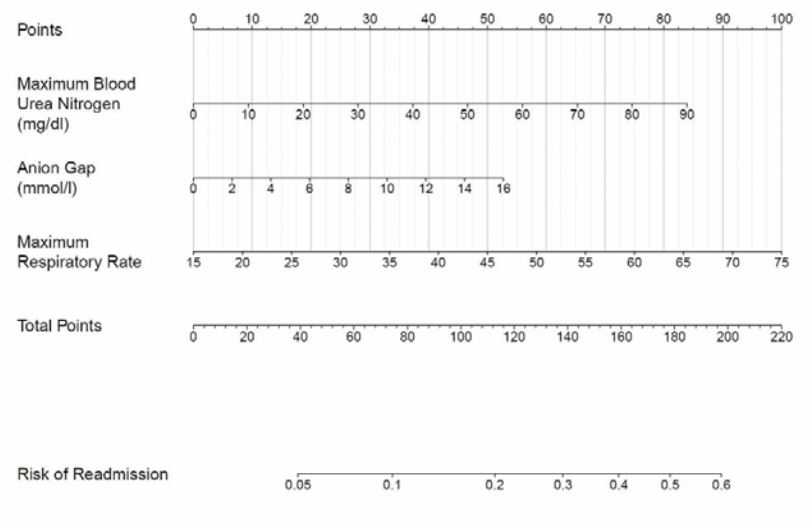
Introduction and Objectives: Readmission to the intensive care unit (ICU) within 72-hours is an established measure of postoperative care quality. The purpose of this study is to evaluate predictors of ICU readmission among vascular surgery patients and to create a nomogram to predict ICU readmission.

Methods: We retrospectively evaluated all vascular surgery patients who were admitted to the surgical ICU at an academic medical center between April 2010 and Sept 2014. A comprehensive assortment of risk-factors associated with ICU care was evaluated, including vital signs, laboratory values, comorbidities, and ICU-related interventions. We examined variables collected within 24 hours before ICU discharge and their association with ICU readmission within 72 hours using multivariate regression models. Variable selection for the nomogram model was based on clinical & statistical significance and area under the ROC curve (AUC) was used to assess model accuracy.

Results: Among 265 ICU admissions (44% non-elective cases), there were a total of 22 (8%) patients readmitted within 72 hours. This included a broad spectrum of vascular surgery patients, including lower extremity revascularization (46%) and intra-abdominal vascular (25%) procedures. Out of 179 different candidate predictors, a reduced model was developed that included anion gap [OR:1.07 (95%CI:0.9-1.27)], maximum blood urea nitrogen [OR:1.02 (95%CI:0.99-1.05)], and maximum respiratory rate [OR:1.04 (95%CI:0.99-1.08)] within 24-hours before discharge. This reduced model demonstrated moderate statistical performance (AUC= 0.70) and was used to develop a nomogram for predicting ICU readmission (Figure).

Conclusions: ICU readmission for vascular surgery patients can be predicted based on assessing 3 common physiologic variables within 24-hours before discharge. Our predictive nomogram may be useful for identifying high-risk patients before they leave the ICU and introducing interventions to reduce readmissions.

Full Program & Abstracts



7:56 am – 8:04 am

51 (RF)

Simultaneous Peripheral Artery Disease and Venous Insufficiency Result In Increased Risk of Amputation

Julia Saraidaridis, Emel Ergul, Hassan Albadawi, Virendra I. Patel, Richard Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

Introduction: Previous studies have established that chronic venous insufficiency (CVI) has an adverse effect on arterial perfusion. However, it is unclear what proportion of patients with peripheral artery disease (PAD) suffer from simultaneous CVI. In addition, conventional therapeutics for venous insufficiency (compression) are contraindicated in patients with PAD. The aims of this study were to assess the incidence of simultaneous CVI in a PAD population and to assess clinical outcomes in patients with both diseases.

Methods: All patients who underwent Peripheral Vascular Intervention (PVI) at a single institution for PAD from January 2002 to December 2013 were identified. Hospital ICD-9 codes were queried for a diagnosis of varicose veins or venous insufficiency. Outcomes included survival, limb salvage, and primary patency. Cox proportional hazards models were created to assess risk factors for death, amputation, and loss of primary patency.

Results: 1852 patients were identified as having undergone PVI for claudication (54%) and CLI(46%). 213 were found to have venous disease(11.5%). There were more females (48.3% vs. 35.8%; p=0.001) in the venous disease cohort, but otherwise cohorts were similar in demographics. In unadjusted analysis, there was no difference in survival between the two groups. However, those with venous disease were more likely to undergo amputation (11.3% vs.7.1%; p=0.03) and lose primary patency (45.1% vs.34.7%; p=0.002) than the cohort without venous disease. In a multivariate Cox proportional hazards model, venous disease was predictive of amputation (HR 1.70, p=0.05) as was rest pain (HR 2.79, p=0.01), ESRD (HR 2.98, p<.001), and tissue loss as an indication (HR 6.93, p<.001). Median follow-up time was 3.5 years.

Conclusion: Venous disease in the presence of arterial disease is associated with an increased risk of failure of primary patency and amputation. Patients with simultaneous PAD and venous disease warrant special consideration and a treatment plan that addresses both entities.

8:04 am – 8:16 am

52

Do Patients Understand Their Cardiovascular Risk Factors and Impact On Complications?

Derrick L. Green[1], Jackquelin Loera[2], Peter Alden[2], Jesse Manunga[2], Andrew Cragg[2], Timothy Sullivan[2], Jason Q. Alexander[2] - [1]University of Minnesota, Minneapolis, MN; [2]Minneapolis Heart Institute, Minneapolis, MN

Introduction and Objectives: While considerable research exists about cardiovascular disease, there is limited data regarding patients' understanding of their own cardiovascular disease risk factors and cardiovascular complications. We set out to assess patients understanding of their own cardiovascular risk factors and complications of cardiovascular disease. In particular we were curious as to patients' fears of stroke and myocardial infarction (MI) related to recent publications regarding risks related to carotid interventions.

Methods: This was an IRB approved study which included five hundred new patients referred for evaluation of vascular disease. Patients were given a questionnaire regarding fears of amputation, MI, and stroke associated with cardiovascular disease. Patients were also queried regarding the impact they felt an array of risk factors would have on their cardiovascular disease.

Results: Of the 500 patients surveyed, demographics demonstrated that the mean age was 67, 61% male, 69% with a smoking history, 45% with a family history of MI. Patients were more fearful of having a stroke during their lifetime compared to MI or amputation ($p<0.001$). Younger patients and those with a positive family history of MI were more fearful of MI ($p<0.001$ and <0.026 respectively). Patients with carotid stenosis demonstrated an increased fear of stroke ($p<0.011$). Females were more fearful than males of both MI and stroke ($p<0.001$). History of peripheral vascular disease and diabetes increased the fear of amputation ($p<0.001$).

Conclusions: Vascular patients are more fearful of stroke than MI or amputation. Individual risk factors influence this fear. This information from the patients should be taken into account when counseling patient about their risk factors and when recommending procedures particularly interventions to proposed to decrease the rate of stroke or MI.

8:16 am – 8:28 am

53

Increased Prevalence of Moderate and Severe Pad In the Native American/Alaskan Native Population: A Study of 50,000 NA/AN

Andrew R. Baxter, Glenn Jacobowitz, Yu Guo, Jeffery Berger, Thomas Maldonado, Caron Rockman - NYU Langone Medical Center, New York, NY

Introduction and Objectives: Peripheral arterial disease (PAD) disproportionally affects racial groups in the United States. Few studies have analyzed the rates of PAD in the American Indian (AI)/ Alaskan Native (AN) population. In this paper we compare the prevalence of PAD in the AI/AN to white and non-white Americans.

Methods: The study data were provided by Life Line Screening. The cohort consists of self-referred individuals who paid for vascular screening tests. Moderate and severe PAD were defined as having an ankle brachial index (ABI) < .9 and <.5 respectively. Univariate and multivariate analysis were performed to compare the rates of PAD between AI/AN, Caucasians, and non-whites.

Results: The original sample for which this study was obtained included 3,696,778 people. Of this group 64.5% (2,122,456) were female and 35.5% (1,168,926) were males. The Native American population was 2.8% of the sample or 87,757 people. Caucasian subjects comprised 89.9% (2,845,936). The nonwhite group was comprised of African Americans 3.1% (97,502), Hispanics 2.4% (75,240), and Asians 2.0% (60,982). In our univariate analysis AI/AN had the highest rates of moderate and severe PAD when compared to whites (OR 1.78 and 2.14 respectively) and non-whites (OR 1.52 and 1.82 respectively). We then controlled for atherosclerotic risk factors in our multivariate analysis and the AI/NA cohort had persistently higher rates of both moderate and severe PAD compared to whites (OR 1.32 and 1.40 respectively) but not compared to non-whites (OR .95 and .92 respectively).

Conclusions: Here we present the largest epidemiology study of PAD in AI/NA to date. AI/NA people have disproportionately high rates of both moderate and severe PAD when compared to whites and non-white Americans. A combination of diet and increasingly sedentary lifestyle is likely responsible for the high rates of PAD in this population.

8:28 am – 8:40 am

54

Surgical Management of Primary Mycotic Aortic Aneurysms: A 14-Year Single-Center Experience

Raymond E. Eid, Karim M. Salem, Michael Singh, Michel S. Makaroun, Donald T. Baril - University of Pittsburgh Medical Center, Pittsburgh, PA

Introduction and Objectives: Mycotic aortic aneurysms (MAA) have high rates of morbidity and mortality. There is increasing usage of endovascular repair for MAAs, however the optimal treatment remains unknown. The goal is to evaluate outcomes of different surgical treatments of symptomatic MAA.

Methods: A single institution, retrospective review of patients treated for symptomatic MAAs (1/2000-12/2011) was conducted; primary outcome was survival, and secondary outcomes included postoperative complications and freedom from reinfection.

Results: Thirty-six patients were treated for symptomatic MAA; nine had endovascular therapy, 12 in-situ reconstruction with Rifampin-soaked graft, and 15 aortic debridement with an extraanatomic bypass. There were no significant differences in demographics, comorbidities or presentation between treatment groups (Table). Mean follow-up was 36.5±40.4 months. Aortic rupture was the most common initial presentation (55.6% endovascular, 41.7% in-situ reconstruction and 64.3% extraanatomic, p=.58). MSSA and gram-negative organisms were the most common tissue organisms isolated. The most common postoperative morbidities were renal and respiratory failure. Thirty-day mortality was 11.1% for the endovascular group, 16.7% for the in-situ group and 50.0% for the extraanatomic group (p= .097), while 1-year mortality was 44.4%, 25.0% and 57.1.0%, respectively (p = .254). Freedom from infection at 1-year, 71.5% for the endovascular group, 88.9% in the in-situ group and 100% in the extraanatomic group (p=.35).

Conclusions: Primary aortic infections carry a very high risk of both early and late morbidity and mortality. Endovascular and in-situ reconstruction had comparable morbidity and mortality to the extraanatomic approach. However, both alternate therapies have a trend at higher reinfection rates.

Table. Clinical Demographics and Presenting Symptoms

	Endovascular (9)		In-Situ (12)		Open (15)		P
Age (years)	66.0	± 11.7	65.6	± 11.3	68.4	± 12.3	.806
Gender (male)	6	66.7%	3	25.0%	9	64.3%	.805
Ethnic (white)	2	22.2%	2	16.7%	1	7.1%	.591
Diabetes	4	44.4%	0	0.0%	1	7.1%	.013
Renal Insufficiency	1	11.1%	0	0.0%	2	14.3%	.461
ESRD	2	22.2%	0	0.0%	0	0.0%	.061
Hypertension	8	88.9%	8	66.7%	9	64.3%	.461
Dyslipidemia	4	44.4%	4	33.3%	5	35.7%	.910
CAD	5	55.6%	1	8.3%	4	28.6%	.077
COPD	4	44.4%	3	25.0%	3	21.4%	.516
TIA/CVA	1	11.1%	0	0.0%	1	7.1%	.718
Smoking No Yes Former	 2 4 3	 22.2% 44.4% 33.3%	 3 7 2	 25.0% 58.3% 21.4%	 6 5 3	 42.9% 35.7% 21.4%	.710
Presenting Symptoms							
Pain	7	77.8%	12	100.0%	9	64.3%	.062
Fever/Sepsis	2	22.2%	3	25.5%	8	57.1%	.138
Pseudoaneurysm	2	22.2%	1	8.3%	3	21.4%	.623
Rupture	5	55.6%	5	41.7%	9	64.3%	.580
Aortoenteric Fistula	1	11.1%	2	16.7%	5	35.7%	.397

8:40 am – 8:52 am

55

Neurocognitive Outcomes and Microembolization Rates Following Carotid Artery Angioplasty and Stenting In Symptomatic Patients

Christian E. Pina, Jennifer Li, Bhakti Rawal, Aesha Patel, Christopher Faries, Ageliki Vouyouka, Prakash Krishnan, Rami Tadros, Michael Marin, Jose Wiley, Peter L. Faries - Icahn School of Medicine at Mount Sinai, New York, NY

Introduction and Objectives: Intraoperative microembolization is one of the major factors leading to increased cerebrovascular accidents following percutaneous carotid artery revascularization. Distal embolic protection filtering devices have resulted in reduced occurrence of microembolization and ischemic lesions but have not resulted in their complete elimination. We prospectively investigated whether higher microembolization signals seen on transcranial Doppler results in decreased neurocognitive outcomes in patients undergoing carotid artery angioplasty and stenting.

Methods: A total of 150 patients will be enrolled in this study. A preliminary analysis was done in 20 patients (male 65%; mean age 66.3) undergoing carotid angioplasty and stenting. The ipsilateral MCA was intraoperatively monitored for microembolic signals (MES) using transcranial Doppler. Demographic analysis of 4 common cardiovascular risk factors (diabetes, hypertension, hyperlipidemia, smoking history) and presence of stroke symptoms was performed retrospectively. A Mini-Mental Status Exam (MMSE) was administered to each patient pre-operatively and post-operatively within 72 hours of each procedure to detect changes in cognition following CAS.

Results: Results show an average significant decrease in MMSE scores among symptomatic patients undergoing CAS (-0.64 vs. +1.00, p=0.02). Symptomatic patients also demonstrated significantly increased MES rates during CAS (63 + 31 vs. 30 + 10, p=0.004). We also found non significant decreases in average MMSE scores in CAS patients with diabetes (p=0.07), hypertension (p=0.38), and hyperlipidemia (p=0.29).

Conclusions: Preliminary results suggest significantly increased microembolic potential with risk of cognitive deficits in symptomatic patients undergoing carotid angioplasty and stenting. There is a positive trend towards lower MMSE scores in CAS patients with comorbidities Neurocognitive data is being correlated with NIH Stroke Scale,Montreal Cognitive Assessment , and microinfarct area detected by cerebral DW-MRI for greater sensitivity and specificity compared to MMSE alone.

8:52 am – 9:04 am

56

Real-World Performance of Paclitaxel Drug-Eluting Bare Metal Stenting (Zilver PTX) For the Treatment of Femoropopliteal Occlusive Disease

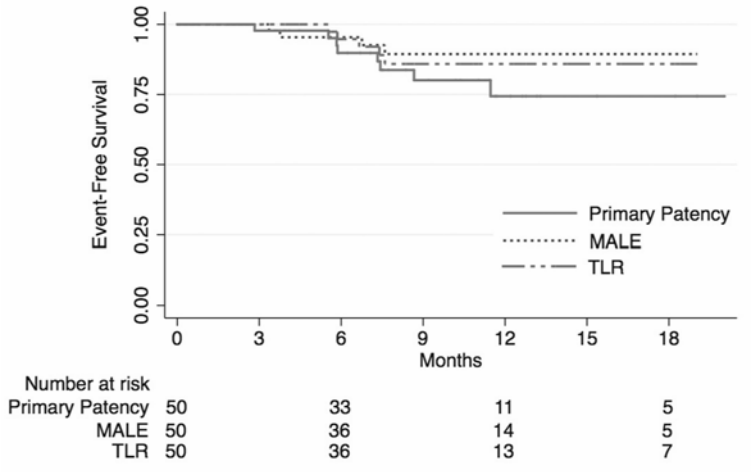
Kenneth Tran, Brant W Ullery, Marcus Kret, Jason T. Lee - Stanford University, Stanford, CA

Introduction and Objectives: To evaluate the performance of paclitaxel drug-eluting bare metal stenting for the treatment of femoropopliteal disease.

Methods: This study involved retrospective review of consecutive patients treated from 2013-2015 for femoropopliteal disease with the Zilver PTX stent after FDA approval. Kaplan-Meier methods and cox-proportional hazard models were used to assess outcomes.

Results: Zilver PTX stents were placed in 55 limbs in 49 patients (74.5% male, mean age 73.1 years) with a median follow-up of 10.7 (range, 1-25) months. Indications included life-disabling claudication (76.3%) and critical limb ischemia (23.6%). The severity of disease was highly variable, with 22 (40%) of limbs with TASC C or D lesions and 17 (30.9%) treated for re-stenosis after prior revascularization. During follow-up, eight (14.5%) limbs experienced loss of graft patency (6 occlusions, 2 >50% re-stenosis). Five limbs underwent target lesion revascularization, two required open bypass, one underwent thrombolysis and one required major amputation. Primary patency was 89.8%, 74.3%, and 74.3% at 6, 12, and 18 months, respectively. Treated lesion length (HR 2.83 [1.13-7.06, 95% CI]) was the only independent predictor of patency loss. Freedom from major adverse limb events (MALE, composite of thrombolysis, major amputation, bypass operation) was 95.4%, 89.4%, 89.4% at 6, 12, and 18 months, respectively. While coronary disease (p=.10), renal insufficiency (p=.02), Rutherford class (p=.03) and distal stent location (p=.10) were associated with worse outcomes, no independent predictors of MALE was found.

Conclusions: Our experience supports the continued use of Zilver PTX for treating the femoropopliteal segment with acceptable one-year outcomes in a real-world cohort. Careful attention to treating longer lesion lengths remains important for maximizing graft patency.



9:15 am **Meeting Adjourns**

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Newly Elected Active Members ('15)

Margaret Arnold ..... Johns Hopkins Bayview Medical Center
Andrew Barleben ..... UCSD/San Diego VA
Charudatta Bavare ..... Huntsville Memorial Hospital
Elizabeth Blazick ..... Maine Medical Center
Katherine Brown ..... University of Illinois at Chicago
Vanita Chandra ..... Stanford University
Dawn Coleman ..... University of Michigan
Jason Comeau ..... Albany Medical Center
Gregory Crenshaw ..... Oschner Health System
Randall DeMartino ..... Mayo Clinic
Karan Garg ..... New York University
Roan Glocker ..... University of Alabama
Lorena Gonzalez ..... SUNY Upstate Medical University
Richard Hershberger ..... Loyola University Medical Center
Jade Hiramoto ..... University of California San Francisco
Andrew Hoel ..... Northwestern University
Aaron Hurd ..... Carolinas Medical Center
Brian Knipp ..... Naval Medical Center, Portsmouth
Angela Kokkosis ..... Mt. Sinai
Peter Kreishman ..... Madigan Army Medical Center
Cheong Lee ..... Medical College of Wisconsin
Joanelle Lugo ..... Lenox Hill Hospital
Harry Ma ..... University of Oklahoma-Tulsa
Rafael Malgor ..... University of Oklahoma, Tulsa
Daniel Martin ..... Phoebe Putney Memorial Hospital
Ryan McEnaney ..... University of Pittsburgh Medical Center
Samantha Minc ..... Mount Sinai Hospital
Marvin Morris ..... Baystate Heart & Vascular
Nicolas Mouawad ..... Ohio State
Patrick Neville ..... Good Samaritan
David O'Connor ..... Mt. Sinai
Nicholas Osborne ..... University of Michigan
Victor Phillips ..... VP Medical, LLC
Reagan Quan ..... Wellstan Health Network
Jean Marie Ruddy ..... Emory University
Carlos Rueda ..... Texas A & M
Timothy Ryan ..... Cleveland Clinic
Neha Sheng ..... Loma Linda University Medical Center
Jeffrey Siracuse ..... Boston University
Denise Smith ..... University of Cincinnati
Rami Tadros ..... Mt. Sinai
Gale Tang ..... VA Puget Sound Health Care System
Tze-Woei Tang ..... Boston University Medical Center
Raghuveer Vallabhaneni ..... University of North Carolina
Grace Wang ..... Hospital of the University of Pennsylvania
Mohamed Zayed ..... Washington University School of Medicine

Newly Elected Candidate Members (‘15)

William Ashwander ..... Emory University School of Medicine
Jennifer Avise ..... Wake Forest
Marcos Bachman ..... University of Massachusetts Medical School
Ian Bailey ..... SUNY Upstate Medical University
Philip Batista ..... Thomas Jefferson University Hospital
Matthew Bennett ..... Houston Methodist Hospital
Rodney Bensley ..... University of Florida
Reshma Brahmbhatt ..... Emory University School of Medicine
Charles Briggs ..... University of Chicago Medical Center
Michael Buckley ..... University of Tennessee Knoxville
Thomas Carruthers ..... University Surgical Associates
John Charitable ..... Upstate Medical University
Kevin Claudeanos ..... Greenville Health System
Michael Clemens ..... San Antonio Military Medical Center
Rachel Cobos ..... University of Arkansas Medical Sciences
Sarasijhaa Desikan ..... University of Washington Medical Center
Julie Duke ..... University of Arkansas for Medical Sciences
Jeffrey Edwards ..... Emory University School of Medicine
Sammy Eghbalieh ..... Albany Medical Center
Justin Eisenberg ..... Lutheran Hospital
Benjamin Flink ..... Emory University
Lisa Foley ..... University of Colorado
Matthew Goldman ..... Wake Forest Baptist Health
Taylor Gwin ..... Louisiana State University
Thomas Heafner ..... San Antonio Military Medical Center
Rachel Heneghan ..... Virginia Mason Medical Center
Cindy Huynh ..... SUNY Upstate Medical University
Mila Ju ..... Northwestern University
Anne Klemens ..... Carolinas Medical Center
Yihan Lin ..... University of Colorado Hospital
Kira Long ..... Tulane University
Anna Marjan ..... Stritch School of Medicine
Loren Masterson ..... Ohio State University
Jamil Matthews ..... University of Washington School of Medicine
Ryan McEnaney ..... University of Pittsburgh Medical Center
Graeme McFarland ..... University of Alabama Hospital
Aleem Mirza ..... Mayo Clinic
Courtney Morgan ..... Northwestern University
Daiva Nevidomskyte ..... University of Washington
Gregory Nissen ..... Christiana Care Health Services
Mary Ottinger ..... Rhode Island Hospital
Douglas Overbey ..... University of Colorado
Syed Peeran ..... Mayo Clinic
Jennifer Perri ..... Dartmouth-Hitchcock Medical Center
Laura Peterson ..... Wake Forest Baptist Medical Center
Steven Plato ..... University Hospitals/Case Western Reserve
Christopher Ramos ..... University of Colorado Health Sciences Center
Animesh Rathore ..... Mayo Clinic

Newly Elected Candidate Members *(continued)*

Taimur Saleem ..... SUNY Upstate Medical University
Joseph Salfity ..... Indiana University School of Medicine
Ritoban Sen ..... University of Oklahoma (Tulsa)
Anjan Talukdar ..... Indiana University
Adam Tanious ..... University of Southern Florida
Danielle Taylor ..... Louisiana State University School of Medicine
Areck Ucuzian ..... UPMC
Guido van Bogerijen ..... University of Michigan
Edward Villella ..... Loyola University Medical Center
Karen Walker ..... Dartmouth-Hitchcock Medical Center
Linda Wang ..... Massachusetts General Hospital
Shihuan Wang ..... Indiana University
Jeniann Yi ..... University of Colorado
Nicolas Zea ..... Ochsner Clinic Foundation
Jill Zink ..... East Carolina University

Active Membership Roster

ABOU-ZAMZAM, JR., AHMED M.
Loma Linda University Medical Center
Cardiovascular and Thoracic Surgery
11175 Campus Street, #21123
Loma Linda, CA 92354
909-558-4354
azamzam@llu.edu

ACOSTA, IGNACIO
I. Acosta, MD, Inc.
1808 Verdugo Blvd., Suite 409
Glendale, CA 91208-1481
818-790-8020

ADAMS, ERIC D.
210 Alexis Drive
Williamsport, PA 17701
570-321-2805
eadams@susquehannahealth.org

ADCOCK, G. K.*
400 S. Maitland Avenue
Maitland, FL 32751
407-539-2100

ADEDUNTAN, AZEEZ P.*
Victory Vascular & General Surg. of GA
2167 Northlake Pkwy.
Bldg. 2, Suite 106
Tucker, GA 30084
770-492-8636
vvgs@aol.com

ADELMAN, MARK A.*
N.Y.U. Medical Center
530 First Avenue, #6F
New York, NY 10016
212-263-7311
mark.adelman@nyumc.org

ADINOLFI, MICHAEL F.*
810 Crystal Street
New Orleans, LA 70124
504-486-7415

AIELLO, FRANCESCO A.
19 Ridgefield Circle
Boylston, MA 01505-1551
508-856-5599
francesco.aiello@umassmemorial.org

AKERS, JR., DONALD L.*
1840 Regents Park Road
Knoxville, TN 37922
504-587-7520
dakersjr@bellsouth.net

ALEXANDER, JASON
Minneapolis Heart Institute
Vascular Specialists of Minnesota
920 East 28th Street
Minneapolis, MN 55407
612-863-6800
jason.alexander@allina.com

ALI, AHSAN T.
University of Arkansas Medical Center
4301 W. Markham, #520-2
Little Rock, AR 72205
501-686-6176

AL-KHATIB, WEESAM K.
2625 Somerset Circle
Woodland, CA 95776-5303
650-725-5227
walkhatib@yahoo.com

ALMOND, BRETT A.
Bay Surgical Specialists
Division of Vascular Surgery
960 7th Avenue N
St. Petersburg, FL 33705
352-273-5484
dr.almond@baysurgicalspecialists.com

ALVAREZ-TOSTADO, JAVIER A.
Marymount Vascular Surgery
12000 McCracken Road, Suite 351
Garfield Heights, OH 44125
216-587-4280
alvarej3@ccf.org

AMANKWAH, KWAME S.
University of New York at Syracuse
Vascular & Endovascular Surgery
750 E. Adams Street
Syracuse, NY 13210-2342
315-464-6241
amankwak@upstate.edu

*Senior Member

Active Membership Roster

ANDERSEN, CHARLES A.*
1302 28th Avenue Court
Milton, WA 98354
253-952-2135
cande98752@aol.com

ANGLE, NIREN
5288 Derby Hill Point
San Diego, CA 92130
925-676-2600
nangle@niren-angle.net

ANNEST, STEPHEN J.*
Vascular Institute of the Rockies
1601 E. 19th Avenue, Suite 3950
Denver, CO 80218-3950
303-830-8822

APPLE, JEFFREY M.
3410 Day Star Cove
Austin, TX 78746
512-459-8753
jtapple1@yahoo.com

ARKO, III, FRANK R.
Sanger Heart and Vascular Institute
Vascular & Endovascular Surgery
1001 Blythe Blvd, Suite 200
Charlotte, NC 28203-5866
704-446-4907
farkomd@gmail.com

ARNOLD, MARGARET W.
1224 Harbor Island Walk
Baltimore, MD 21230
410-550-4335
mhwalkup@gmail.com

ARTHURS, ZACHARY M.
7515 Stonewall HL
San Antonio, TX 78256-1669
210-916-1174
arthursz@mac.com

ATKINS, MARVIN D.
Scott & White Hospital & Clinic
Division of Vascular Surgery
2401 S. 31st
Temple, TX 76508
254-724-0657
marvin_atkins_md@hotmail.com

ATKINSON, CLINTON K.
Pinehurst Surgical Clinic
35 Memorial Drive
Pinehurst, NC 28374
910-295-0884
ckatkinson@hotmail.com

AULIVOLA, BERNADETTE
Loyola University Medical Center
Vascular & Endovascular Surgery
2160 South First Avenue
EMS Bldg. 110, Room 3216
Maywood, IL 60153
708-327-2686
baulivola@lumc.edu

AUSTIN, JOSEPH P.
6871 Glenlake Pkwy., Apt. J
Atlanta, GA 30328-7289

AZIZ, FAISAL
Penn State Univ./Hershey Medical Ctr.
Vascular Surgery
Mail Code H053, Room C4632
Hershey, PA 17033
717-531-8898
faziz@hmc.psu.edu

BACK, MARTIN
University of South Florida
Vascular Surgery
2 Tampa General Circle, Suite 7001
Tampa, FL 33606
813-259-0956
mback@health.usf.edu

BAKKEN, ANDREW
3774 Dorothea Ct. S
Fargo, ND 58104
701-234-2251
abakken@medicine.nodak.edu

BALDWIN, ZACHARY K.
St. Dominic Hospital
Vascular & Endovascular Surgery
971 Lakeland Drive
Jackson, MS 39216
601-200-2780
zkbaldwi@hotmail.com

*Senior Member

Active Membership Roster

BALLARD, JEFFREY L.*
St. Joseph Hospital
1140 W. La Veta Avenue, Suite 850
Orange, CA 92868
714-560-4450
jeffreyballard@visoc.org

BALLINGER, BETH ANN
Mayo Clinic
Trauma, Critical Care & General Surgery
200 First Street, SW
Rochester, MN 55905
502-255-4789
ballinger.beth@mayo.edu

BARIL, DONALD T.
University of Pittsburgh
Division of Vascular Surgery
200 Lothrop Street, Suite A1010
Pittsburgh, PA 15213-2536
barildt2@upmc.edu

BARLEBEN, ANDREW
UCSD/San Diego VA
Dept. of Surgery
3350 La Holla Village Drive
Mail Code 112E
La Jolla, CA 92161
858-657-7404
andrewbarleben@gmail.com

BARSHES, NEAL R.
37 Combwell Garden
Missouri City, TX 77459
781-690-4312
neal.barshes@gmail.com

BATSON, ROBERT *
LSU School of Medicine
1111 Medical Center Blvd., #713
Marrero, LA 70072
504-349-6713

BAVARE, CHARUDATTA
Huntsville Memorial Hospital
Dept. of Surgery
130 Medical Center Pkwy., Suite 10
Huntsville, TX 77340
936-435-0833
cbavare@gmail.com

BAXTER, B. TIMOTHY*
University of NE Medical Center
83280 Nebraska Medical Center
Omaha, NE 68198-3280
402-559-7300
btbaxter@unmc.edu

BAZAN, HERNAN A.
Ochsner Clinic Foundation
Vascular/Endovascular Surgery
1514 Jefferson Hwy., 8th Floor
New Orleans, LA 70121
504-842-4053
hbazan@ochsner.org

BEAVERS, FREDERICK P.
Washington Hospital Center
106 Irving Street NW
POB North, Rm 3150
Washington, DC 20010
202-877-8050
suavejazz@hotmail.com

BECHARA, CARLOS F.
Methodist DeBakey Heart Center
Vascular Surgery
6550 Fannin Street
Smith Tower, Suite 1401
Houston, TX 77030
713-441-5200
becharacmnj@gmail.com

BELL, III, WILLIAM H.*
Coastal Surgical Specialists
2203 Neuse Blvd.
New Bern, NC 28560-4311
252-639-8118
drbell@coastalsurgicalspecialists.com

BENVENISTY, ALAN I.*
Columbia University
St. Luke's Roosevelt Hospital Center
1090 Amsterdam Avenue, 12th Floor
New York, NY 10025
212-523-4706
alan.benvenisty@gmail.com

BERGAMINI, THOMAS M.*
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139
t.bergamini@insightbb.com

*Senior Member

Active Membership Roster

BERGER, ALAN*
1259 S. Cedar Crest Blvd.
Allentown, PA 18103
610-439-0372
tyb4cut@hotmail.com

BERLAND, TODD
171 W 71st Street, 11C
New York, NY 10023-3801
917-209-2212
toddberland@gmail.com

BERMAN, SCOTT S.*
Tucson Vascular Institute
1815 W. St. Mary's Road
Tucson, AZ 85745-5727
520-628-1400
sberman@azvasc.com

BERNIK, THOMAS R.
Beth Israel Medical Center
Vascular Surgery
1st Avenue & 16th Street
Fierman Hall, 12th Floor
New York, NY 10003
212-838-3055
bernik@optonline.net

BEST, IRWIN M.*
Emory University School of Medicine
Cardiovascular and Interventional Radiology
1364 Clifton Road NE
Atlanta, GA 30322
404-712-7033
imb@hotmail.com

BHATIA, DEVINDER S.
Southeast Texas Cardiovascular, PA
8901 FM 1960 Bypass, Suite 303
Humble, TX 77338
281-397-7000
dbhatiamd@aol.com

BIGATEL, DAVID A.
3553 W. Chester Pike, No 142
Newtown Square, PA 19073
610-527-3791
dbigatel@ptd.net

BISMUTH, JEAN
The Methodist Hospital
DeBakey Heart & Vascular Center
6560 Fannin Street, Suite 1401
Houston, TX 77005
713-441-9319
JBismuth@tmhs.org

BJELLUM, KARL E.†
Mayo Clinic
200 First Street SW
Rochester, MN 55905
507-255-1610
bjellum.karl@mayo.edu

BLACK, III, JAMES H.
Johns Hopkins Hospital
Vascular and Endovascular Surgery
Halsted 668
600 North Wolfe Street
Baltimore, MD 21287-0001
410-955-1708
jhblack@jhmi.edu

BLAZICK, ELIZABETH
Maine Medical Center
887 Congress Street, Suite 400
Portland, ME 04102
207-774-6368
eblazick@mmc.org

BOGEY, JR., WILLIAM M.*
Brody School of Medicine at ECU
Vascular Surgery
115 Heart Drive
Greenville, NC 27834
252-744-4668
bogeyw@ecu.edu

BOHANNON, W. TODD
Scott and White Hospital and Clinic
Vascular Surgery
2401 South 31st Street
Temple, TX 76508
254-724-0657
wbohannon@swmail.sw.org

BORROMEO, JOSE R.M.
5880 University Avenue
West Des Moines, IA 50266
515-633-3600
jborromeo@iowaheart.com

*Senior Member †Associate Member

Active Membership Roster

BOSHER, L. PAUL*
Virginia Surgical Associates
417 Libbie Avenue
Richmond, VA 23226-2678
804-288-1953

BOWER, THOMAS C.*
Mayo Clinic
200 First Street SW
Rochester, MN 55905
507-284-1443
bower.thomas@mayo.edu

BOWSER, ANDREW
207 Estancia Lane
Boerne, TX 78006
830-997-7138
ab5329@yahoo.com

BRECKWOLDT, WILLIAM L.*
955 Main Street, #G2A
Winchester, MA 01890
617-729-2020

BREWSTER, LUKE P.
676 North Parkwood Road
Decatur, GA 30030
404-727-8413
lukebrewst@aol.com

BRIGHAM, ROBERT A.*
Reading Vascular Surgical Associates
301 S. 7th Avenue, #1070
West Reading, PA 19611-1493
610-378-9667
brighamr@readinghospital.org

BROOKE, BENJAMIN S.
Univ. of Utah School of Medicine
Division of Vascular Surgery
30 North 1900 East, 3C344 SOM
Salt Lake City, UT 84132
801-581-8301
benjamin.brooke@hsc.utah.edu

BROWN, JEFF A.
Viginia Surgical Associates
8237 Meadowbridge Road
Mechanicsville, VA 23116-2336
804-559-7634
ayersv@vasurgical.com

BROWN, KATHERINE E.
University of Illinois at Chicago
Division of Vascular Surgery
840 S. Wood Street, Suite 376, CSN 840
Chicago, IL 60612
312-996-8459
katherb@uic.edu

BROWN, KELLIE R.
Medical College of Wisconsin
Division of Vascular Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
krbrown@mcw.edu

BROWN, LYLE L.*
Nacogdoches Memorial Hospital
Department of Surgery
4848 NE Stallings Drive, Suite 103
Nacogdoches, TX 75965
936-559-0800
dubllb@yahoo.com

BROWN, O. WILLIAM*
31700 Telegraph Road, Suite 140
Bingham Farms, MI 48025
248-433-0881
owbmd@aol.com

BRUMBERG, ROBERT S.
Vascular Surgery Associates
1040 Green Hill Trace
Tallahassee, FL 32317-8633
850-877-8539
rbrumberg@pol.net

BUCHBINDER, DALE *
Good Samaritan Hospital
Russell Morgan Bldg.
5601 Loch Raven Blvd., Suite 412B
Baltimore, MD 21239
443-849-2393

BULGER, CHRISTOPHER M.
Vein Clinics of America
95 Glastonbury Blvd., Suite 202
Glastonbury, CT 06033
860-652-8400
cbulger@veinclinics.net

*Senior Member

Active Membership Roster

BUNCH, CHRISTOPHER T.
Duluth Clinic
400 East Third Street
Duluth, MN 55805
218-786-3231
ctbunch_2000@yahoo.com

BURKE, JR., PAUL M.*
Vascular Assoc. of Merrimack Valley
10 Research Place, Suite 207
North Chelmsford, MA 01863-2439
978-453-6900
pmbjrmd@aol.com

BUSH, RUTH L.
Texas A&M Health Science Center
College of Medicine Bryan/College
Station Campus
8447 State Hwy 47, Suite 3060
Bryan, TX 77807
979-436-0223
rbush@medicine.tamhsc.edu

BUSUTTIL, STEVEN J.
121 Wellington Drive
Roaring Brook Twp, PA 18444-9551
703-280-5858
SJB@Busuttil.me

CALIK, MUSTAFA K.
Kadikoysifa Hospital Atasehir
Vascular Surgery-Damar Cerrahisi
Isiklar caddesi,No:35/A,Atasehir
Istanbul 34805
Turkey
mkcalik@gmail.com

CALTON, JR., WILLIAM C.
Medical Group of the Carolinas
Cardiothoracic and Vascular Surgery
225 E. Wood Street
Spartanburg, SC 29303-3050
864-560-4420
wcalton@srhs.com

CAMBRIA, ROBERT A.*
Vascular Care of Maine
489 State Street
Bangor, ME 04401
207-973-6670
rcambria@emhs.org

CAMPBELL, JESSICA B.*
1246 Ashland Avenue, Suite #101
Zanesville, OH 43701
740-453-0730
jboc@columbus.rr.com

CAPARRELLI, DAVID J.
Flagstaff Medical Center
Cardiac and Vascular Surgery
1215 North Deaver Street, Suite 203
Flaggstaff, AZ 86001
928-773-2300
david.caparrelli@nahealth.com

CAPUTO, FRANCIS J.
Cooper University Hospital
Dept. of Surgery, Suite 411
Three Cooper Plaza
Camden, NJ 08103
856-342-2151
caputo-francis@cooperhealth.edu

CARLON, DOUGLAS J.
Banner Health Clinic
14420 West Meeker Blvd.
Bldg. A, Suite 200
Sun City West, AZ 85375
623-524-8960
dougcarlonmd@gmail.com

CARNEY, JR., WILFRED I.*
2 Dudley Street, #470
Providence, RI 02905
401-553-8325

CARSON, JOHN G.
Dept. of Veterans Affairs - Sacramento
Vascular Surgery
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-0448
jcarsonmd@gmail.com

CARSTEN, CHRISTOPHER G.
Greenville Hospital System
Dept. of Vascular Surgery
701 Grove Road
Greenville, SC 29605
864-455-7886
ccarsten@ghs.org

*Senior Member

Active Membership Roster

CASEY, KEVIN M.
3812 Park Blvd. #414
San Diego, CA 92103
619-532-6400
irishnola@yahoo.com

CAYNE, NEAL S.
530 1st Avenue, Suite 6F
New York, NY 10016
212-263-7311
neal.cayne@nyumc.org

CHAER, RABIH A.
UPMC Presbyterian
Vascular Surgery
200 Lothrop Street, Suite A1011
Pittsburgh, PA 15213-2536
412-802-3025
chaerra@upmc.edu

CHAIKOF, ELLIOT L.*
Beth Israel Deaconess Medical Center
Dept. of Surgery
110 Francis Street, Suite 58
Boston, MA 02215

CHAMBERS, CHRISTOPHER M.
Spectrum Health Medical Group
Vascular Surgery
4069 Lake Drive, Suite 312
Grand Rapids, MI 49546
616-459-8700
christopher.chambers@spectrum-health.org

CHANDRA, ANKUR
Scripps Green Hospital
Division of Vascular Surgery
10666 N. Torrey Pines Road, SW 209
LaJolla, CA 92037
858-554-8988
chandra.ankur@scrippshealth.org

CHANDRA, VENITA
400 Davey Glen Road, Apt 4508
Belmont, CA 94002
650-723-3639
vchandra@stanford.edu

CHANG, BENJAMIN B.*
The Vascular Group, PLLC
43 New Scotland Avenue, (MC-157)
Albany, NY 12208-3479
518-262-5640
changb@albanyvascular.com

CHARLTON-OUW, KRISTOFER M.
University of Texas
Dept. of Cardiothoracic and Vasc. Surg.
6400 Fannin Street, Suite 2850
Houston, TX 77030-1540
713-486-5100
kristofer.charltonouw@uth.tmc.edu

CHARNEY, KIM J.*
1140 W. LaVeta Street, #620
Orange, CA 92868
714-550-0600

CHAUVAPUN, JOE
14374 Borego Road, Apt. 1301
Victorville, CA 92392
310-953-5502
joechauvapun@yahoo.com

CHERR, GREGORY S.
Buffalo General Hospital
Department of Surgery
100 High Street
Buffalo, NY 14203
716-859-2810
gcherr@buffalo.edu

CHETTER, IAN C.
Academic Vascular Surgical Unit
Hull Royal Infirmary
Anlaby Road
Hull HU3 2JZ
United Kingdom
Ian.Chetter@hey.nhs.uk

CHIRIANO, JASON T.
Jerry L Pettis VA Hospital Loma Linda
Dept. of Surgery
11201 Benton Street (112)
Loma Linda, CA 92357
909-825-7084
jason.chiriano@va.gov

*Senior Member

Active Membership Roster

CHOI, LORRAINE
4505 Hazard Street
Houston, TX 77098
216-903-4819
lori.y.choi@gmail.com

CHURCH, PHILLIP J.*
Cardiothoracic & Vascular Surgeons
1010 W. 40th Street
Austin, TX 78756
512-459-8753
pchurch@ctvstexas.com

CIKRIT, DOLORES F.*
Indiana University
Vascular Surgery
1801 N. Senate, MPC 2, Suite D
Indianapolis, IN 46202
317-962-2193
dcikrit@iupui.edu

CIOCCA, ROCCO G.*
1268 Parkside Drive, E
Seattle, WA 98122-3718
206-215-5921
rocco.ciocca@swedish.org

CIRES, GIANCARLO
469 Caravelle Drive
Jupiter, FL 33458-8206
561-422-8262
giancarlo.cires@va.gov

CLAIR, DANIEL G.*
Cleveland Clinic Foundation
Dept. of Vascular Surgery
9500 Euclid Avenue, F30
Cleveland, OH 44195-0001
216-444-3857
claird@ccf.org

CLARK, ELIZABETH T.*
2150 East Lake Cook Road, Suite 40-C
Buffalo Grove, IL 60089
847-465-6064
elizabeth.clark@comcast.net

CLOUSE, W. DARRIN
Massachusetts General Hospital
Vascular & Endovasc. Surgery
15 Parkman Street, WACC 440
Boston, MA 02114-3177
617-726-3567
wclouse@partners.org

COHN, JR., EDWARD J.
Savannah Vascular Institute
4750 Waters Avenue, Suite 500
Savannah, GA 31404
912-629-7800
jcohn@savannahvascular.com

COLE, C. WILLIAM*
PO Box 1505
Port Elgin NB E4M2K0
Canada
cwmcole@hotmail.com

COLEMAN, DAWN M.
2740 Bent Tree Drive
Dexter, MI 48130
734-936-5786
dawnbarn@umich.edu

COLL, DAVID
111 Hunts Bluff Road
Sparks, MD 21152
410-512-8686
david.p.coll@medstar.net

COLLINS, DAVID E.
224 Teakwood Drive
Huntsville, AL 35801
dec67dec@hotmail.com

COLLINS, P. S.*
960 7th Avenue N
St. Petersburg, FL 33705
727-821-8101
sclpac@aol.com

COLLINS, JR., JOHN T.*
315 East Lindsey Street, Apt. #3
Chattanooga, TN 37403

COMEAU, JASON
639 Richmond Drive
Lancaster, PA 17601
717-735-7410
jaycomeau@gmail.com

COMEROTA, ANTHONY J.*
Jobst Vascular Institute
Conrad Jobst Tower
2109 Hughes Drive, Suite 400
Toledo, OH 43606
419-291-2088
marilyn.gravett@promedica.org

*Senior Member

Active Membership Roster

CONNERS, III, MICHAEL S.
CVT Surgical Center
7777 Hennessey, Suite 1008
Baton Rouge, LA 70808
225-766-0416
msconners@cox.net

CONNOLLY, PETER
1330 1st Avenue, Apt. 1708
New York, NY 10021-4837
646-660-2240
pec9018@med.cornell.edu

CONRAD, MARK F.
Massachusetts General Hospital
15 Parkman Street, WAC 440
Boston, MA 02114
617-724-7660
mconrad@partners.org

CONTE, MICHAEL S.*
400 Parnassus Avenue
Room A-581, Box 0222
San Francisco, CA 94143-0222
415-353-4366
michael.conte@ucsfmedctr.org

COOGAN, SHEILA M.
6400 Fannin Street, Suite 2850
Houston, TX 77030
713-486-1150
Sheila.M.Coogan@uth.tmc.edu

COOK, PATRICK
525 Via De Los Arboles
El Paso, TX 79932
706-442-1693
patcook915@gmail.com

COOPER, SHELBY
Bassett Healthcare
Dept. of Surgery
1 Atwell Road
Cooperstown, NY 13326
607-547-3474
shelby.cooper@bassett.org

CORRIERE, MATTHEW A.
Wake Forest Univ. Baptist Med Center
Vascular & Endovasc. Surgery
Medical Center Blvd.
Winston-Salem, NC 27157
336-716-9502
macorrie@wakehealth.edu

CORRY, DAVID C.
University of Colorado Health
Vascular Surgery
1400 E. Boulder Street, Suite 600
Colorado Springs, CO 80909
719-364-6487
david.corry@uchealth.org

CORSO, J. EDUARDO
Peachtree Vascular Associates, PC
550 Peachtree Street NE, Suite 1085
Atlanta, GA 30308-2232
404-681-3190
ecorso18@yahoo.com

COSELLI, JOSEPH S.*
Baylor College of Medicine
Division of Cardiothoracic Surgery
One Baylor Plaza, Suite BCM 390
Houston, TX 77030
832-355-9910
jcoselli@bcm.edu

COSTANZA, MICHAEL J.
750 East Adams Street
Syracuse, NY 13210
315-464-6241
costanzm@upstate.edu

COX, MITCHELL W.
3308 Westover Road
Durham, NC 27707-5027
919-613-5239
mitchell.cox2@duke.edu

CRENSHAW, GREGORY D.
266 W. Robert E. Lee Boulevard
New Orleans, LA 70124
504-842-6829
grcrenshaw@gmail.com

CREPPS, JR., J. THOMAS*
3220 Orion Drive
Colorado Springs, CO 80906
719-776-7600
tomcrepps@outlook.com

*Senior Member

Active Membership Roster

CRIADO, ENRIQUE*
University of Michigan
Section of Vascular Surgery
CVC - 5463, SPC 5867
1500 E. Medical Center Drive
Ann Arbor, MI 48109-5867
734-763-0250
ecriado@umich.edu

CRUTCHLEY, TERESA A.
10117 SE Sunnyside Road, Suite F409
Clackamas, OR 97015
210-241-0095
renogrrrl@yahoo.com

CUFF, ROBERT F.
MMPC Vascular Surgery
4069 Lake Drive SE
Grand Rapids, MI 49546-8816
616-459-8700
robert.cuff@spectrum-health.org

CULL, DAVID L.*
Greenville Hopsital System
701 Grove Road
Greenville, SC 29605-4281
864-455-5599
dcull@ghs.org

CURCI, JOHN A.
Washington University School of Med.
Vascular Surgery
660 S. Euclid Avenue, Suite 5105
Campus Box 8109
St. Louis, MO 63110
314-362-7406
john@thecurcis.com

CURI, MICHAEL A.
Rutgers-New Jersey Medical School
Division of Vascular Surgery
150 Bergen Street, F-102
Newark, NJ 07103
973-972-6295
curi@njms.rutgers.edu

DAAB, LEO J.
1309 Madrona Way NW
Gig Harbor, WA 98332
253-968-2409
ldaab@hotmail.com

DALSING, MICHAEL C.*
Indiana University Medical Ctr.
1801 North Senate Blvd.
Suite 3500, MPC II
Indianapolis, IN 46202
317-630-7360
mdalsing@iupui.edu

DARDIK, ALAN
Yale University School of Medicine
Dept. of Surgery
10 Amistad Street, Room 437D
PO Box 208089
New Haven, CT 06520-8089
203-737-2213
alan.dardik@yale.edu

DARLING, III, R. CLEMENT*
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-8720
darlingc@albanyvascular.com

DATTILO, JEFFERY B.
The Surgical Clinic
4230 Harding Road, Suite 525
Nashville, TN 37205
615-385-1547
jdattilo@tsclinic.com

DAUTERIVE, JR., EDWARD*
1100 Andre Street, #101
New Iberia, LA 70563
318-369-9309
ndauter@bellsouth.net

DAVENPORT, PHYLLIS*
Peripheral Vascular Associates
111 Dallas Street, Suite 200-A
San Antonio, TX 78205
210-225-6508

DAVIES, MARK G.
Houston Methodist Hospital
6550 Fannin, Suite 1401
Houston, TX 77030
713-441-6201
mark.daviesmdphd@gmail.com

*Senior Member

Active Membership Roster

DAWSON, DAVID L.*
UC Davis Medical Center
Dept. of Surgery
UC Davis Vascular Center
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-8122
david.dawson@ucdmc.ucdavis.edu

D'AYALA, MARCUS
New York Methodist Hospital
Dept. of Surgery
506 Sixth Street
Brooklyn, NY 11215
718-780-3288
mdd9004@nyp.org

DE JESUS, GUSTAVO A.
PO Box 19554
San Juan 00910
Puerto Rico
787-726-0440
gusdejesus@hotmail.com

DE ROSE, GUY*
London Health Sciences Centre
800 Commissioners Road East
Room E2-123
London ON N6A 5W9
Canada
519-667-6644
guy.derose@lhsc.on.ca

DEATON, DAVID H.*
1593 Piscataway Road
Crownsville, MD 21032
202-444-2255
david@deaton.md

DEIPARINE, MICHAEL K.*
Liberty Medical Office Building
2521 Glenn Hendren Drive, #112
Liberty, MO 64068
816-781-5006
MDeiparine@planetkc.com

DEITCH, JONATHAN S.
Staten Island University Hospital
Vascular & Endovascular Surgery
256 Mason Avenue
Bldg. B, 2nd Floor
Staten Island, NY 10305
718-226-1278
jdeitch@siuh.edu

DELATORE, JASON R.
540 Parmalee Avenue
Youngstown, OH 44510
330-747-1106
jdelatore@pol.net

DEMARTINO, RANDALL R.
Mayo Clinic
Department of Surgery
200 First Street SW, Gonda 4S
Rochester, MN 55905
507-284-4652
demartino.randall@mayo.edu

DENNIS, JAMES W.*
University of Florida Health Sciences
653-2 West Eight Street
Jacksonville, FL 32209
904-244-3925
james.dennis@jax.ufl.edu

DERUBERTIS, BRIAN G.
13330 Chandler Blvd.
Sherman Oaks, CA 91401
619-543-6980
bderubertis@mednet.ucla.edu

DESAI, TINA R.
Stanford University
Division of Vascular Surgery
300 Pasteur Drive, H3600
San Francisco, CA 94305-5642
650-723-3639
tdesai2@stanford.edu

DESHMUKH, DEEPAK
313 Quarter Trks.
Yorktown, VA 23693-2330
757-470-5570
deepakdeshmukh@hotmail.com

DICKSON, CHRISTOPHER S.
2704 Henry Street
Greensboro, NC 27405
336-621-3777
cddolphin@aol.com

DIETZEK, ALAN M.*
41 Germantown Road, Suite 101
Danbury, CT 06810
203-794-5680
alan.dietzek@danhosp.org

*Senior Member

Active Membership Roster

DIMUZIO, PAUL J.
Thomas Jefferson University
111 S. Eleventh Street
Gibbon 6270
Philadelphia, PA 19107
215-955-8304
paul.dimuzio@jefferson.edu

DONAYRE, CARLOS E.*
2324 Colt Road
Rancho Palos Verdes, CA 90275
310-222-2704
cdonayre@cox.net

DOSCHER, WILLIAM*
2001 Marcus Avenue, Suite South 50
Lake Success, NY 11042
516-328-9800
DoscherMD@aol.com

DOSLUOGLU, HASAN H.
VA Western NY Healthcare Systems
3495 Bailey Avenue
Buffalo, NY 14215
716-862-8937
dosluoglu@yahoo.com

DOUGLAS, MICHAEL G.
4 Greenwood Place
Asheville, NC 28803
828-684-7470

DOVGAN, PETER S.
Space Coast Vascular Medicine
655 South Apollo Blvd., Suite 2
Melbourne, FL 32901-1485
321-751-2707

DOWNING, LAMIERE J.
2900 Lamb Circle, Suite 300
Christiansburg, VA 24073-6341

DUENSING, ROBERT A.
24411 Health Center Drive, Suite 350
Laguna Hills, CA 92653
949-457-7900
rduensing@thevasculargroup.com

DUNCAN, AUDRA A.
Mayo Clinic
Div. of Vascular and Endovasc. Surgery
200 First Street SW, Gonda 4S
Rochester, MN 55905
507-284-4751
duncan.audra@mayo.edu

DURHAM, JOSEPH R.*
10347 S. Longwood Drive
Chicago, IL 60643-2610
312-864-3190
drhoser@aol.com

DUWAYRI, YAZAN
Assistant Professor of Surgery
Div. of Vascular and Endovasc. Surgery
1365 Clifton Road NE
Building A, Suite A3205
Atlanta, GA 30322
404-694-8069
yduwayri@hotmail.com

EAGLETON, MATTHEW J.
Cleveland Clinic Foundation
Dept. of Vascular Surgery/H32
9500 Euclid Avenue
Cleveland, OH 44195
216-445-1167
eagletm@ccf.org

EARLY, TODD F.*
Vascular and Vein Specialists of
Greensboro
2704 Henry Street
Greensboro, NC 27405
336-621-3777

EDWARDS, MATTHEW S.
Wake Forest Univ. Baptist Medical Ctr.
Medical Center Blvd.
Winston-Salem, NC 27157-1095
336-716-3318
medwards@wfubmc.edu

EDWARDS, JR., WILLIAM*
The Surgical Clinic PLLC
4230 Harding Road, Suite 525
Nashville, TN 37205-2075
615-383-2674
wedwards@tsclinic.com

*Senior Member

Active Membership Roster

EGINTON, MARK T.
Pavilion Surgical Associates
920 E. First Street, Suite 302
Duluth, MN 55805-2225
218-249-6050
mteginton@gmail.com

EISENBERG, JOSHUA A.
11 Great Hills Road
New Hope, PA 18938-9283
215-955-8304
drjoshmd@gmail.com

ELIASON, JONATHAN L.
University of Michigan
Section of Vascular Surgery
1500 E. Medical Center Dr., SPC 5867
CVC 5463
Ann Arbor, MI 48109-5867
734-936-5786
jonaelia@med.umich.edu

ELLIS, JENNIFER
250 South Avenue, Apt. 400
Rochester, NY 14604
585-273-2048
ellis27@gmail.com

ELLISON, JR., ROBERT G.*
836 Prudential Drive
Pavilion, Suite 1405
Jacksonville, FL 32007
904-388-7521
dre@ellisonvein.com

ELMORE, JAMES R.*
Geisinger Medical Center
Vascular Surgery
100 N. Academy Avenue
Danville, PA 17822-2150
570-271-6369
jelmore@geisinger.edu

EL-SAYED, HOSAM F.
Ohio State University
Division of Vascular Surgery
376 W. 10th Street
701 Prior Hall
Columbus, OH 43210
614-293-8536
hosam.elsayed@osumc.edu

ENDEAN, ERIC D.*
Univ. of Kentucky Chandler Med. Ctr.
Div. of General Surgery
800 Rose Street, Room C-215
Lexington, KY 40536-0001
859-323-5273
edende0@uky.edu

ENGLE, JENNIFER S.
3290 W. Big Beaver Road, Suite 410
Troy, MI 48084
248-816-6300
jsuengle@yahoo.com

ERDOES, LUKE S.*
Mountain Medical Vascular Specialists
1486 East Skyline Drive
South Ogden, UT 84405
801-479-6687
erdoesls@gmail.com

ERICKSON, CURTIS A.
Cardiovascular Consultants
Vascular Surgery
3805 E. Bell Road, Suite 3100
Phoenix, AZ 85032
602-867-8644
caemd@cox.net

ESCOBAR, GUILLERMO A.
Univ. of Arkansas for Medical Sciences
Division of Vascular Surgery
4301 W. Markham Street, Slot 520-2
Little Rock, AK 72205-7199
gescobar@uams.edu

ESEMUEDE, NOWOKERE
8055 Spyglass Hill Road, Suite 102
Melbourne, FL 32940
321-255-8080
nesemuede@yahoo.com

ESKANDARI, MARK K.
Northwestern Medical Faculty Found.
Division of Vascular Surgery
676 N. Saint Clair Street, Suite 650
Chicago, IL 60611
312-695-2714
meskanda@nmh.org

*Senior Member

Active Membership Roster

EZE, AUGUSTINE R.
PO Box 550490
Gastonia, NC 28055
704-864-6500

FANCIULLO, DUSTIN J.
Rochester General Hospital
Vascular Surgery Associates
1445 Portland Avenue, Suite 108
Rochester, NY 14621
585-922-5550
dfanci1@gmail.com

FARBER, MARK A.
University of North Carolina
3025 Burnett Womack, Box 7212
Chapel Hill, NC 27599
919-966-3391
mark_farber@med.unc.edu

FARIES, PETER L.
Mount Sinai School of Medicine
5 E. 98th Street
PO Box 1273
New York, NY 10029-6501
212-241-5386
peter.faries@mountsinai.org

FAULK, JIMBOB
The Surgical Clinic, PLLC
4230 Harding Road, Suite 525
Nashville, TN 37205
615-385-1547
jfaulk@tsclinic.com

FEEZOR, ROBERT J.
University of Florida
Vascular and Endovascular Surgery
PO Box 100128
1600 SW Archer Road, Room NG-54
Gainesville, FL 32610
352-273-7020
feezor@surgery.ufl.edu

FEINBERG, RICHARD L.*
Johns Hopkins University School of Medicine
Dept. of Surgery
11065 Little Patuxent Pkwy., Suite 150
Columbia, MD 21044-2895
410-964-2306
rfeinbe4@jhmi.edu

FERRIS, BRIAN L.
Lake Washington Vascular Surgery
1135 116th Avenue NE, Suite 305
Bellevue, WA 98004
425-453-1772

FERRIS, EUGENE B.*
River Region Medical Center
2100 Hwy 61 N.
Vicksburg, MS 39183
601-883-6098

FISHMAN, ERIC
40 East 94th Street, 23F
New York, NY 10128
917-825-3250
efishman@westmedgroup.com

FLEMING, MARK D.
3554 75th Street NE
Rochester, MN 55906
507-284-1575
fleming.mark@mayo.edu

FOTEH, KOUSTA I.
4419 Parkwater Cove Ct.
Sugar Land, TX 77479-1583
281-446-6656
kfoteh@me.com

FOWL, RICHARD*
Mayo Clinic - Scottsdale
13400 E. Shea Blvd.
Scottsdale, AZ 85259-7157
480-301-7157
fowl.richard@mayo.edu

FOX, CHARLES J.
1190 S. York Street
Denver, CO 80210-1911
303-602-6798
charles.fox@dhha.org

FRANCO, CHARLES D.*
2 Research Way, Suite 206
Monroe Township, NJ 08831-6820
732-246-8266
doccutup@aol.com

*Senior Member

Active Membership Roster

FRANKINI, LARRY A.
Vascular Associates of Long Island
2001 Marcus Avenue, Suite S50
Lake Success, NY 11042-1039
516-328-9800
smartine10@nshs.edu

FRANKLIN, DAVID P.*
Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822-2150
717-271-6369

FRANZ, RANDALL W.
Central Ohio Vascular Services
285 E. State Street, Suite 260
Columbus, OH 43215
614-566-9035
RFRANZ2@ohiohealth.com

FREISCHLAG, JULIE A.*
Johns Hopkins Hospital
720 Rutland Avenue, Room 759
Baltimore, MD 21205-3500
443-287-3497
jfreisc1@jhmi.edu

FUJITANI, ROY M.*
Univ. of California Irvine Medical Ctr.
Div. of Vascular & Endovascular Surg.
333 City Blvd. West, Suite 1600
Orange, CA 92868
714-456-5453
rmfujita@uci.edu

GABLE, DENNIS R.
Texas Vascular Associates
621 North Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
Den1Beth@aol.com

GAGNE, PAUL J.*
Southern Connecticut Vascular Center
85 Old Kings Hwy N.
Darien, CT 06820
203-425-2790
paul.gagne@optonline.net

GAHTAN, VIVIAN*
Upstate Medical University
College of Medicine
750 E. Adams Street
Syracuse, NY 13210
315-464-6241

GALLAGHER, JAMES J.*
Hartford Clinical Associates
85 Seymour Street, Suite 409
Hartford, CT 06106
860-522-4158
jgallagher@hartfordspecialists.org

GALLAGHER, KATHERINE
17205 Crestbrook Drive
Northville, MI 48168
443-742-7872
kgallag@med.umich.edu

GARCIA-TOCA, MANUEL
85 Tipping Rock Drive
East Greenwich, RI 02818
401-228-0600
mgarciatoca@surg.org

GARG, KARAN
153 E. 32nd Street, Apt. 9G
New York, NY 10016
212-263-6378
karan.garg@nyumc.org

GARG, NITIN
333 N. Pine Valley Road
Winston Salem, NC 27104
843-876-4855
ngarg@wakehealth.edu

GARGIULO, III, NICHOLAS J.
21 Michael Drive
Old Bethpage, NY 11804-1522
516-780-5344
ngargiul@gmail.com

GEARY, KEVIN J.*
Vascular Surgery Associates
1445 Portland Avenue, #108
Rochester, NY 14621
585-922-5550
kevin.geary@viahealth.org

*Senior Member

Active Membership Roster

GELABERT, HUGH A.*
UCLA Division of Vascular Surgery
200 Medical Plaza, #526
Los Angeles, CA 90095-6958
310-825-3684
hgelabert@mednet.ucla.edu

GELFAND, DMITRI
Sutter Medical Group
Vascular Surgery
3 Medical Plaza Drive, Suite 130
Roseville, CA 95661
916-773-8750
GelfanD@sutterhealth.org

GENNARO, MARK*
North Shore Univ. Huntington Hospital
270 Pulaski Road
Greenlawn, NY 11740-1605
631-385-7258
mgvasdoc@aol.com

GEORGE, JR., SALEM M.*
Surgical Care Associates, PSC
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139

GERAGHTY, PATRICK J.
Washington University Medical School
660 S. Euclid, Box 8109
St. Louis, MO 63110
314-362-6490
geraghtyp@wustl.edu

GERDES, JODI
Swan Surgical
353 New Shackle Island Road
Suite 224B
Hendersonville, TN 37075
615-206-1700
jdgerdes@gmail.com

GEUDER, JAMES W.*
680 Kinderkamack Road
Gradell, NJ 07649
201-262-8346

GIANGOLA, GARY*
Lenox Hill Hospital
Dept. of Surgery
130 East 77th Street
New York, NY 10075
212-434-3400
ggiangola@nshs.edu

GIGLIA, JOSEPH S.
University of Cincinnati
231 Albert Sabin Way
ML 0513
Cincinnati, OH 45267-0058
513-558-5367
Joseph.Giglia@uc.edu

GILANI, RAMYAR
Baylor College of Medicine
Dept. of Surgery
One Baylor Plaza, MS: 390
Houston, TX 77030
713-873-2801
rgilani@bcm.edu

GILLESPIE, DAVID L.*
8 Mulberry Road
Bristol, RI 02809-1322
gillespied@southcoast.org

GINGERY, ROBERT O.*
13851 E. 14th Street, #202
San Leandro, CA 94578
510-247-4700

GLOCKER, ROAN
University of Rochester
1000 South Avenue, NE207
Rochester, NY 14620
585-275-6772
roan_glocker@urmc.rochester.edu

GO, MICHAEL R.
456 W. 10th Avenue
3018 Cramglett Hall
Columbus, OH 43210-1228
614-293-8536
michael.go@osumc.edu

GOFF, JR., JAMES M.
5409 Canyon Bluff Trail NE
Albuquerque, NM 87111
james.goff2@va.gov

*Senior Member

Active Membership Roster

GOLAN, JOHN F.*
Northshore Vascular Associates
495 Central Avenue, Suite 200
Northfield, IL 60093
847-441-9955

GOLDMAN, KENNETH A.*
Princeton Surgical Associates
5 Plainsboro Road, Suite 400
Plainsboro, NJ 08536-1915

GOLDSTEIN, LAWRENCE J.*
3663 Solano Avenue, Apt. 70
Napa, CA 94558-2771
707-226-2031

GOLDSTEIN, LEE J.
10 Brianna Lane
Easton, CT 06612
203-375-2861
leegoldstein@gmail.com

GONZALEZ, ALBERTO J.
17428 Varona Place
Lutz, FL 33548-4804
205-821-8734
ajgonzalezmd@gmail.com

GONZALEZ, LORENA
210 W. Division Street, Apt. 15
Syracuse, NY 13204
315-464-6241
gonzallo@upstate.edu

GONZE, MARK D.
Vascular Surgery Associates, LLC
520 Upper Chesapeake Drive, Suite 306
Bel Air, MD 21014
410-879-2006

GOODMAN, GREG R.*
5323 Woodrow Street, Suite 102
Salt Lake City, UT 84107-5853
801-408-1000

GOODNEY, PHILIP P.
Dartmouth-Hitchcock Medical Center
Section of Vascular Surgery
1 Medical Center Drive
Lebanon, NH 03756-1000
603-650-4682
philip.goodney@gmail.com

GOODREAU, JAMES J.*
1259 S. Cedar Crest
Allentown, PA 18103
215-437-0200

GOSIN, JEFFREY S.
442 Bethel Road
Somers Point, NJ 08244
609-927-3030
jsgosin@comcast.net

GRAHAM, ALAN M.*
UMDNJ RW Johnson Medical School
1 Robert Wood Johnson
Room 514 CN-19
New Brunswick, NJ 08901-1928
732-235-7816
grahamal@umdnj.edu

GREENBERG, JOSHUA I.
Mercy Health Physician Partners Grand River Vascular Surgery
Vascular and Endovascular Surgery
310 Lafayette Avenue, Suite 301
Grand Rapids, MI 49503
616-685-6900
jigreenbergmd@gmail.com

GREENSTEIN, STUART*
Albert Einstein College of Medicine
111 East 210th Street
Bronx, NY 10467-2401
718-920-6157
sgreenst@montefiore.org

GREENWALD, LORI L.*
1 Barnard Lane
Bloomfield, CT 06002-2413
860-761-6666

GRENON, MARLENE
University of CA San Francisco
4150 Clement Street
Mail Code 112G
San Francisco, CA 94121
415-221-4810
marlene.grenon@ucsfmedctr.org

GRIMSLEY, BRADLEY R.
Texas Vascular Associates
621 N. Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
bradgrimsley@gmail.com

*Senior Member

Active Membership Roster

GROEGER, EUGENE C.*
2645 Ocean Avenue, #307
San Francisco, CA 94132
415-239-2300

GROVE, MARK K.*
Cleveland Clinic - Florida
2950 Cleveland Clinic Blvd.
Weston, FL 33331
959-659-5232

GUIDRY, LONDON C.
Vascular Clinic
5425 Brittany Drive, Suite B
Baton Rouge, LA 70808
225-767-5479
londonguidry@yahoo.com

GUPTA, DEEPAK*
16700 Bayview Avenue
Newmarket ON L3X 1W1
Canada
905-953-0637

GUPTA, NAVYASH
North Shore University Health System
9977 Woods Drive, Suite 355
Skokie, IL 60077
847-663-8050

GUTHRIE, DAVID*
South Central Surgical Associates PC
757 Norland Avenue
Chambersburg, PA 17201-4230
717-263-1697

GUZZO, JAMES L.
6115 Whitetail Drive
Coopersburg, PA 18036
610-434-3466
jguzzo@mdmercy.com

HADCOCK, JR., WILLIAM*
Valley Vascular Surgical
1247 E. Allivial, Suite 101
Fresno, CA 93720
559-431-6226

HALANDRAS, PEGGE
Loyola University
Division of Vascular Surgery
2160 South First Avenue
Maywood, IL 60153
708-327-2686
phalandras@lumc.edu

HAMDAN, ALLEN D.
Beth Israel Deaconess M.C.
110 Francis Street, Suite 5B
Boston, MA 02215
617-632-9953
ahamdan@bidmc.harvard.edu

HAN, DAVID C.
Penn State Hershey Medical Center
Division of Vascular Surgery
500 University Drive, MCH053
Hershey, PA 17033-2360
717-531-8866
DHAN@hmc.psu.edu

HANSEN, KIMBERLEY J.*
Wake Forest School of Medicine
Vascular and Endovascular Surgery
Medical Center Boulevard
Winston-Salem, NC 27157-1095
336-713-5256
kjhansen@wfubmc.edu

HAQUE, SHAHID N.*
218 Common Way
Building B
Toms River, NJ 08755-6427
732-244-4448

HARLIN, STUART A.
Coastal Vascular and Interventional
5147 N. 9th Avenue, Suite 318
Pensacola, FL 32504
850-479-1805
harlin42k@cox.net

HARRINGTON, ELIZABETH*
Vascular Surgical Associates, PLLC
2 E. 93rd Street
New York, NY 10128
212-876-7400

*Senior Member

Active Membership Roster

HARRIS, KENNETH A.*
The Royal College of Physicians
774 Echo Drive
Ottawa ON K1S 5N8
Canada
kharris@royalcollege.ca

HARRIS, JR., E. JOHN*
Stanford University
Dept. of Surgery
300 Pasteur Drive, H-3641
Stanford, CA 94305-5642
650-725-6492
edjohn@stanford.edu

HART, JOSEPH P.
120 Laurel Circle
Bangor, ME 04401-3360
207-973-6670
josephphart@aol.com

HARTHUN, NANCY L.
WS Cardiothoracic Surgery-WMG
Apple Hill Medical Center
25 Monument Road, Suite 190
York, PA 17043
717-851-6454

HASER, PAUL B.
Moncton Vascular/Vasculaire
Vascular Surgery
105 - 100 Arden Street
Moncton NB E1C4B7
Canada
506-857-5809
surgerydad@gmail.com

HAURANI, MOUNIR J.
Ohio State University Medical Center
Vascular Diseases and Surgery
376 W. 10th Avenue
Prior Hall 702
Columbus, OH 43210
614-293-8536
jhaurani@hotmail.com

H'DOUBLER, JR., PETER B.*
Vascular Institute of Georgia
5673 Peachtree Dunwoody, NE
Suite 675
Atlanta, GA 30342
404-256-0404

HEALY, DEAN A.*
West Penn Allegheny Health System
Thoracic and Cardiovascular Surgery
320 East North Avenue
Pittsburgh, PA 15212
412-359- 3714
healydean@yahoo.com

HEDAYATI, NASIM
UC Davis
4860 Y Street, Suite 3400
Sacramento, CA 95817-2307
916-734-2022
nhedayati@ucdavis.edu

HEIDENREICH, MICHAEL J.
5325 Elliott Drive, Suite 104
Ypsilanti, MI 48197
734-712-8150
heiderm@trinity-health.org

HERNANDEZ, DIEGO A.
St. Joseph Mercy Oakland
44555 Woodward Avenue, Suite 501
Pontiac, MI 48341
248-338-7171
hernanda@trinity-health.org

HERRINGTON, JAMES W.
GFH Surgical Associates
718 Shore Road
Somers Point, NJ 08244
609-927-8550
JamHerr@comcast.net

HERSHBERGER, RICHARD C.
Loyola University Medical Center
Division of Vascular Surgery
2160 S. First Avenue
EMS Building 110 Rm 3216
Maywood, IL 60153
708-327-3431
rihershberger@lumc.edu

HILL, ANDREW B.*
Ottawa Hospital - Civic Campus
1053 Carling Avenue, A280
Ottawa ON K1Y 4E9
Canada
ahill@ottawahospital.on.ca

*Senior Member

Active Membership Roster

HINGORANI, ANIL
Lutheran Medical Center
960 50th Street
Brooklyn, NY 11219
718-438-3800
ahingorani67@gmail.com

HIRAMOTO, JADE
University of California San Francisco
Division of Vascular Surgery
400 Parnassus Avenue
Room A581, Box 0222
San Francisco, CA 94143-0222
415-353-4366
jade.hiramoto@ucsfmedctr.org

HIRKO, MARK K.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199
413-794-0900

HNATH, JEFFREY C.
Vascular Group
Vascular Surgery
117 Marys Avenue, Suite 202
Kingston, NY 12401
518-262-8720
hnathj@albanyvascular.com

HOBSON, JOHN R.*
Greenwood Surgery/Carolina Vasc. Lab
160 Academy Avenue
Greenwood, SC 29646
864-223-8090
rhobson@gwdsurgical.com

HOCH, JOHN R.*
University of Wisconsin
600 Highland Avenue
G5/321 Clinical Science Center
Madison, WI 53792-7375
608-263-1388
hoch@surgery.wisc.edu

HODGKISS-HARLOW, KELLEY D.
500 W Harbor Drive, Unit 705
San Diego, CA 92101
760-716-2962
khodgkis@gmail.com

HOEL, ANDREW W.
Northwestern University
Vascular Surgery
676 N. St. Clair Street, Suite 650
Chicago, IL 60611
312-695-2716
jmason@nmh.org

HOGAN, MICHAEL B.
1078 Courtney Lane
Biloxi, MS 39532-5324
423-778-7695
michael.hogan@universitysurgical.com

HOROWITZ, JOHN D.*
Surgical Specialists of Central FL
10000 West Colonial Drive, #495
Ocoee, FL 34761
407-293-5944

HOYNE, ROBERT F.*
4617 Forest Ridge Drive
Tallahassee, FL 32309
850-877-8539
rhoyne@VSAFL.com

HUANG, JOE
Rutgers - New Jersey Medical School
Division of Vascular Surgery
150 Bergen Street, F-102
Newark, NJ 07103
973-972-9371
joehuangmd@gmail.com

HUGHES, JOHN D.
University of Arizona Medical Center
PO Box 245072
Tucson, AZ 85724
520-626-6670
jhughes@email.arizona.edu

HUGHES, KAKRA
Howard University College of Medicine
Dept. of Surgery
2041 Georgia Avenue NW, 4B-34
Washington, DC 20060-0001
202-865-1281
kakra.hughes@howard.edu

*Senior Member

Active Membership Roster

HULTGREN, REBECKA
Karolinska University Hospital, Karolinska Institutet
Department of Vascular Surgery
A2:01, Karolinska University Hos
Stockholm 17176
Sweden
rebecka.hultgren@karolinska.se

HUMPHRIES, MISTY D.
Univeristy of California-Davis
Dept. of Surgery
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-8441
mdhumphries@ucdavis.edu

HURD, AARON M.
Augusta Vascular Center
603 13th Street
Augusta, GA 30901
706-724-2500
hurdmd@gmail.com

HURIE, JUSTIN
Wake Forest University
Dept. of Vascular Surgery
Medical Center Blvd
Winston-Salem, NC 27157
336-713-5256
justin.hurie@gmail.com

HURLBERT, SCOTT N.
Memorial Hospital
1400 E. Boulder Street, Suite 600
Colorado Springs, CO 80909
719-364-6487

HUSEYNOVA, KHUMAR
1712-16 Yonge Street
Toronto ON M5E2A1
Canada
khumarhuse@yahoo.ca

HUTCHINSON, STEVEN A.*
Wichita Surgical Specialists PA
551 N. Hillside, #550
Wichita, KS 67214
316-682-2911

HUTTO, JOHN D.
Prevea Health
1821 South Webster
Green Bay, WI 54301
920-436-1358
jd_hutto@yahoo.com

HUYNH, TAM T. T.
UT MD Anderson Cancer Center
Thoracic & Cardiovascular Surgery
1400 Pressler Street
FCT19.6000
Houston, TX 77030
713-794-1477
tamhuynh@mdanderson.org

IAFRATI, MARK D.
20 Hampshire Road
Wellesley, MA 02481
617-636-5019
miafrati@tuftsmedicalcenter.org

IERARDI, RALPH P.
Ierardi Vascular Clinic, LLC
1815 W. 13th Street, Suite 4
Wilmington, DE 19806
302-655-8272
RIerardi@christianacare.org

IHNAT, DANIEL M.
6905 Limerick Lane
Edina, MN 55439
520-429-1998
DIhnat@gmail.com

ILLIG, KARL A.
USF College of Medicine
Division of Vascular Surgery
2 Tampa General Circle
STC 7016
Tampa, FL 33606
813-259-0921
killig@health.usf.edu

INDES, JEFFREY
Yale University
Vascular Surgery
333 Cedar Street, BB 204
New Haven, CT 06510
203-785-6216
jeffrey.indes@yale.edu

*Senior Member

Active Membership Roster

IRWIN, CHANCE L.
3001 South Ong
Amarillo, TX 79109
806-212-6604
chance.irwin@suddenlink.net

IVARSSON, BENGT*
Doctors Pavilion
701 Ostrum Street, #601
Bethlehem, PA 18015
610-822-4111
bengtivarsson@prodigy.net

JACOB, DENNIS M.*
Community Heart and Vascular
1400 N Ritter Avenue, Suite 100
Indianapolis, IN 46219-3045
317-353-9338
jacobden1@gmail.com

JACOBOWITZ, GLENN R.
N.Y.U. Medical Center
530 First Avenue, #6-F
New York, NY 10016
212-263-7311
glenn.jacobowitz@nyumc.org

JAIN, KRISHNA M.*
Advanced Vascular Surgery
A Division of Paragon Health PC
1815 Henson Avenue
Kalamazoo, MI 49048-1510
616-226-5200
dockrishna@aol.com

JAXHEIMER, ERIC C.*
Reading Vascular Surgery Specialists
301 South 7th Avenue, Suite 1070
West Reading, PA 19611-1493
610-378-9667
mejax123@aol.com

JEPSEN, STEPHEN J.*
Adena Cardiothoracic Vascular Surgery
4439 State Route 159, Suite 130
Chillicothe, OH 45601
740-779-4360
stephenjep@aol.com

JEYABALAN, GEETHA
926 1/2 S. Aiken Avenue
Pittsburgh, PA 15232
412-802-3333
jeyabalang@upmc.edu

JIM, JEFFREY
Washington University
Vascular Surgery
660 S. Euclid Avenue
Campus Box 8109
St. Louis, MO 63110
314-362-7145
jimj@wudosis.wustl.edu

JIMENEZ, JUAN C.
UCLA
Vascular Surgery
200 Medical Plaza Ste 526
Los Angeles, CA 90095
310-206-1786
jcjimenez@mednet.ucla.edu

JOELS, CHARLES S.
592 South Crest Road
Chattanooga, TN 37404
423-267-0466
csjoels@gmail.com

JOGLAR, FERNANDO L.
UPR Medical Sciences
Dept. of Surgery, Suite A-923
San Juan 00936-5067
Puerto Rico
787-763-2440
fernando.joglar@upr.edu

JOHANNING, JASON M.
UNMC
Dept. of Surgery
983280 Nebraska Medical Center
Omaha, NE 68198-3280
402-559-4395
jjohanning@unmc.edu

JOHNNIDES, CHRISTOPHER G.
Colorado Permanente Medical Group
Vascular Therapy
2045 Franklin Street
Denver, CO 80205-5437
303-861-3688
christopher.g.johnnides@kp.org

JOHNSON, BRAD L.
USF Building
Vascular Surgery
2 Tampa General Circle, Suite 7002
Tampa, FL 33606
813-259-0921
bjohnson@hsc.usf.edu

*Senior Member

Active Membership Roster

JOHR, BERNARDO*
21110 Biscayne Blvd., #301
Aventura, FL 33180

JONES, III, WILMER T.
Mike O'Callaghan Federal Hospital
4700 N. Las Vegas Blvd.
Nellis AFB, NV 89191
702-653-3050
joneswt@hotmail.com

JORDAN, JR., WILLIAM D.*
University of Alabama at Birmingham
Vascular and Endovascular Surgery
1808 7th Avenue S., BDB 503
Birmingham, AL 35294-0012
205-934-2003
wdjordan@uab.edu

JUNG, MATTHEW T.
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139

KANSAL, NIKHIL
St. Elizabeth's Medical Center
Vascular and Endovascular Surgery
736 Cambridge Street, CCP 8010
Boston, MA 02135
858-229-4988
nkansalmd@gmail.com

KARANFILLIAN, RICHARD *
150 Lockwood Avenue
New Rochelle, NY 10801
914-636-1700
rkaranfilianmd@aol.com

KASHYAP, VIKRAM S.
University Hospitals - Case Medical Ctr.
Vascular & Endovascular Surgery
11100 Euclid Avenue, MS LKS 7060
Cleveland, OH 44106-7060
216-844-1631
Vikram.Kashyap@UHhospitals.org

KASIRAJAN, KARTHIK
NMT Corp.
223 SW 41st Street
Renton, WA 98057
kasi@naturalmolecular.com

KATZ, SHERMAN A.*
PO Box 277
Duncan Falls, OH 43734

KAUFMAN, JEFFREY L.*
Baystate Vascular Services
3500 Main Street, Suite 201
Springfield, MA 01107-1117
413-794-0900
kaufman@massmed.org

KAUVAR, DAVID
1106 Broad Street, Unit K
Augusta, GA 30901-1118
706-787-1145
davekauvar@gmail.com

KAZMERS, ANDRIS*
1721 East Mitchell Road
Petoskey, MI 49770
231-487-1900

KEEFER, ADAM J.
Coastal Surgical Vasc. & Vein Specialists
1327 Ashley River Road, Bldg. B
Charleston, SC 29407
843-553-5616
adamkeefer@gmail.com

KELDAHL, MARK L.
Northwestern Memorial Hospital
3000 N Halsted Street, Suite #703
Chicago, IL 60657
312-926-2000
Mark.Keldahl@advocatehealth.com

KELSO, REBECCA L.
Cleveland Clinic
Desk F30, 9500 Euclid Avenue
Cleveland, OH 44195
216-445-3527
kelsor@ccf.org

KERR, THOMAS M.*
2809 W. Waters Avenue
Tampa, FL 33614-1852
813-348-9088

*Senior Member

Active Membership Roster

KETTELER, ERIKA
NMVAHCS
Dept. of Surgery
1501 San Pedro SE (112)
Albuquerque, NM 87108
505-265-1711
erika.ketteler@va.gov

KEUSHKERIAN, SIMON*
1701 Cesar Chavez Avenue, #300
Los Angeles, CA 90033
213-264-2633

KIM, JASON K.
Rex Hospital
4414 Lake Boone Trail, Suite 108
Raleigh, NC 27607
919-784-2300
jason.kim@rexhealth.com

KIM, SUNG K.
Kaiser Foundation Hospital
Dept. of Surgery
10800 Magnolia Avenue
Riverside, CA 92505
909-353-3606
sung.k.kim@kp.org

KING, TERRY A.*
Cleveland Clinic Florida
Vascular Surgery
2950 Cleveland Clinic Blvd.
Weston, FL 33331
954-659-5230
KingT7@ccf.org

KLAMER, THOMAS W.*
Norton Vascular
3 Audubon Plaza Drive, Suite 220
Louisville, KY 40217
502-636-7242
tklamer@insightbb.com

KNIPP, BRIAN S.
3232 Conservancy Drive
Chesapeake, VA 23323
757-953-9741
brian.knipp@med.navy.mil

KOHN, JAMES S.
Doctors Hospital
9330 Poppy Drive, Suite 406
Dallas, TX 75218
214-321-1662
james-kohn@sbcglobal.net

KOKKOSIS, ANGELA A.
55 5th Street
Ronkonkoma, NY 11779
631-741-9392
aggeliki44@gmail.com

KOLLIPARA, VENKATA S.K.*
540 Parmalee Avenue, #410
Youngstown, OH 44510
216-747-6759
vkollipara@aol.com

KOSKAS, FABIEN F.*
Service de Chirurgie Vasculaire
Pavillon Husson Mourier
CHU Pitié-Salpêtrière
47 Bd De L'Hopital
Paris
France
fabien.koskas@psl.aphp.fr

KOUGIAS, PANOS
1709 Dryden, Suite 1500
Houston, TX 77030
713-798-8412
pkougias@bcm.tmc.edu

KRAISS, LARRY W.*
University of Utah
Division of Vascular Surgery
30 North 1900 East
Salt Lake City, UT 84132
801-581-8301
larry.kraiss@hsc.utah.edu

KREIENBERG, PAUL B.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
kreienbergp@albanyvascular.com

KREISHMAN, PETER
1111 116th Street Ct. NW
Gig Harbor, WA 98332
253-968-3104
pkreishman@gmail.com

*Senior Member

Active Membership Roster

KRONSON, JEFFREY W.
301 W. Huntington Drive, Suite 5
Arcadia, CA 91007
562-698-2291
drkronson@jeffkronsonmd.com

KULWICKI, AARON D.
9790 Allen Drive
Dublin, OH 43017
614-234-0444
aaronkulwicki@hotmail.com

KWOLEK, CHRISTOPHER J.*
Massachusetts General Hospital
Dept. of Vascular Surgery
15 Parkman Street, WAC-458
Boston, MA 02114
617-724-6101
ckwolek@partners.org

LAM, RUSSELL C.
Advanced Vascular & Vein Ctr. of Texas
8220 Walnut HIll Lane, Suite 615
Dallas, TX 75231
214-345-4160
rlamdesk@yahoo.com

LAMBERT, JR., GLENN E.*
Norton Vascular
3 Audubon Plaza Drive, Suite 220
Louisville, KY 40217
502-636-7242
teresa.watt@nortonhealthcare.org

LANDIS, GREGG S.
Long Island Jewish Medical Center
270-05 76th Avenue
New Hyde Park, NY 11004
718-470-4503
gregg.landis@rocketmail.com

LANE, III, JOHN S.
University of California San Diego
Division of Vascular Surgery
9434 Medical Center Drive, MC 7403
LaJolla, CA 92037
858-657-7404
j1lane@ucsd.edu

LANFORD, JEFFREY E.*
Greenwood Surgical Associates
160 Academy Avenue
Greenwood, SC 29646-3808
864-223-8090
thehamd@pol.net

LANGAN, III, EUGENE M.*
Greenville Hospital System
701 Grove Road
Greenville, SC 29605-5601
864-455-7886
elangan@ghs.org

LANGSFELD, MARK*
University of New Mexico Hospital
Vascular Surgery
1 University of New Mexico
MSC 10 5610
Albuquerque, NM 87131-0001
505-272-5850

LANTIS, II, JOHN C.
Mt. Sinai/St. Luke's & Roosevelt Hosp.
Vascular/Endovascular Surgery
1090 Amsterdam, Suite 7A
New York, NY 10025
212-523-4797
jlantis@chpnet.org

LAREDO, JAMES
2002 Carriage Court
Vienna, VA 22181
571-313-0349
jlaredo@mfa.gwu.edu

LARSON, ROBERT A.
VCU Medical Center
Vascular and Endovasc. Surgery
West Hospital, 16th Floor
1200 East Broad Street
Richmond, VA 23298
804-828-3511
rlarson@mac.com

LASKOWSKI, IGOR A.
Vascular Associates of Westchester
19 Bradhurst Avenue, Suite 700
Hawthorne, NY 10532-2171
914-593-1200
laskowski@ccwpc.com

*Senior Member

Active Membership Roster

LAUTERBACH, STEPHEN R.
1676 Sunset Avenue
Faxton 4th Floor
Utica, NY 13502
315-624-8110
SRLMD@hotmail.com

LAWRENCE, DAVID M.
Surgical Specialists Department
202 10th Street SE
Cedar Rapids, IA 52403
319-362-5118
dlawrence@pcofiowa.com

LEE, CHEONG J.
Medical College of Wisconsin
Dept. of Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
cjlee@mcw.edu

LEE, EUGENE S.
University of California, Davis
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-843-7174
eugenes.lee@ucdmc.ucdavis.edu

LEE, JASON T.
Stanford University Medical Center
Division of Vascular Surgery
300 Pasteur Drive, Suite H3600
Stanford, CA 94305
650-724-8292
jtlee@stanford.edu

LEPORE, JR., MICHAEL R.
Sarasota Vascular Specialists
600 North Cattlemen Road, Suite 220
Sarasota, FL 34232
941-371-6565
mlepore@veinsandarteries.com

LEVISON, JONATHAN A.
The Cardiovascular Care Group
433 Central Avenue
Westfield, NJ 07090
973-759-9000
jlevison@comcast.net

LEVY, MARK M.
1144 West Avenue
Richmond, VA 23220
804-828-3211
mmlevy@vcu.edu

LIN, JUDITH C.
Henry Ford Hospital
2799 W. Grand Blvd.
Detroit, MI 48202
313-916-3156
jlin1@hfhs.org

LIN, PETER H.
Baylor College of Medicine
2002 Holcombe Blvd.
HVAMC-112
Houston, TX 77030-4211
713-794-7895
plin@bcm.tmc.edu

LIN, STEPHANIE C.
1501 Trousdale Drive, 5th Floor
Burlingame, CA 94010
650-652-8787
lins3@pamf.org

LIPSCOMB, AMY L.
University of Kentucky
800 Rose Street, UKMC
Room C224
Lexington, KY 40536-0293
859-323-6346
amy.lipscomb@uky.edu

LIPSITZ, EVAN C.
Montefiore Medical Center
111 E. 210th Street
Bronx, NY 10467
718-920-2016
ELipsitz@aol.com

LITZENDORF, MARIA E.
Ohio State University Medical Center
Division of Vascular Diseases & Surgery
376 W. 10th Avenue
701 Prior Hall
Columbus, OH 43210
614-293-8536

*Senior Member

Active Membership Roster

LOFTUS, JOHN P.*
Surgical Group of Napa Valley
3443 Villa Lane 3
Napa, CA 94558
707-226-2031

LOH, SHANG A.
Stony Brook University Medical Center
Dept. of Surgery
HSC L19-090
Stony Brook, NY 11794-8191
631-444-8114
slohmd@gmail.com

LOHR, JOANN M.*
Lohr Surgical Specialists
6350 Glenway Avenue, Suite 208
Cincinnati, OH 45211
513-451-7400
geri_meister@trihealth.com

LONG, DAVID D.*
988 Oak Ridge Turnpike #350
Oak Ridge, TN 37830-6930
865-483-7030
LAkens@CovHlth.com

LONGO, GERNON M.
University of Nebraska Medical Center
Dept. of Surgery
985182 Nebraska Medical Center
Omaha, NE 68198-5182
402-559-9549
glongo@unmc.edu

LOSSING, ALAN G.*
184 Tansley Road
Thornhill ON L4J 4E7
Canada
416-972-7435
kellysteven.drlossingoffice@gmail.com

LUCAS, LAYLA C.
Saguaro Surgical
Vascular Surgery
6422 E. Speedway Blvd., Suite 150
Tucson, AZ 85710
520-318-3004
lucasvascular@gmail.com

LUCAS, PAUL R.
The Vascular Center at Mercy
301 St. Paul Place, 5th Floor
Baltimore, MD 21202
410-332-9404
prlucasmd@gmail.com

LUGO, JOANELLE
510 E 23rd Street, Apt. 9A
New York, NY 10010
212-562-3917
jzlugo@gmail.com

LUH, EDDY H.
Las Vegas Surgical Associates
8930 West Sunset Road, Suite 300
Las Vegas, NV 89148-5013
702-258-7788
ehluh@yahoo.com

LUM, YING WEI
Johns Hopkins Hospital
600 N Wolfe Street, Halsted 668
Baltimore, MD 21287
410-955-5020
ylum1@jhmi.edu

LUMSDEN, ALAN B.*
Methodist DeBakey Heart Center
Cardiovascular Surgery Department
6550 Fannin Street, Suite 1006
Houston, TX 77030-2700
713-441-6201
ablumsden@tmhs.org

LYDEN, SEAN P.
Cleveland Clinic Foundation
Vascular Surgery
9500 Euclid Avenue, H 32
Cleveland, OH 44195
216-444-3581
lydens@ccf.org

MA, HARRY
University of Oklahoma-Tulsa
Dept. of Surgery
1919 S. Wheeling Avenue, Suite 600
Tulsa, OK 74104
918-634-7523
harry-ma@ouhsc.edu

*Senior Member

Active Membership Roster

MACRIS, DEMETRIOS N.*
Peripheral Vascular Associates
111 Dallas Street, Suite 200
San Antonio, TX 78205
210-225-6508
dmacris@pvasatx.com

MAHARAJ, DALE A.
Caribbean Vascular & Vein Clinic
18 Elizabeth Street
St. Clair
Trinidad and Tobago
868-622-9665
dalemaharaj@hotmail.com

MALAS, MAHMOUD
Johns Hopkins Medical Center
4940 Eastern Avenue, A5
Baltimore, MD 21224
410-550-4335
bmalas1@jhmi.edu

MALDONADO, THOMAS
New York University
530 First Avenue, Suite 6F
New York, NY 10016
212-263-7311
thomas.maldonado@nyumc.org

MALGOR, RAFAEL D.
University of Oklahoma, Tulsa
Dept. of Vascular Surgery
1919 S. Wheeling Avenue, Suite 600
Tulsa, OK 74104
918-634-7523
rafael-malgor@ouhsc.edu

MANNAVA, KRISHNA
618 Pleasantville Road, Suite 302
Lancaster, OH 43130
krishnamannava@yahoo.com

MANORD, JEFFREY D.
255 Medical Drive, Suite 4
Winfield, AL 35594
205-487-7800
jeffrey.manord@lpnt.net

MANSOUR, M. A.*
PO Box 312
Ada, MI 49301
616-459-8700
Ashmans2@aol.com

MARCACCIO, EDWARD J.*
Rhode Island Hospital
2 Dudley Street, #470
Providence, RI 02905
401-553-8318

MAREK, JOHN M.
Vascular Surgery
1 University of New Mexico
MSC 10 5610
Albuquerque, NM 87131-0001
505-272-5850
jmarek@salud.unm.edu

MARICA, SILVIU C.
763 Queen Esther Drive
Sayre, PA 18840
570-882-2320
marsc92@hotmail.com

MARIN, MICHAEL L.*
Mt. Sinai Medical Center
Dept. of Surgery
5 East 98th Street, Box 1259
New York, NY 10029-6501
212-241-5392
michael.marin@mountsinai.org

MARROCCO, CHRISTOPHER J.
Harbor-UCLA Medical Center
Department of Surgery
1000 W. Carson Street
Torrance, CA 90502-2004
chris.marrocco@gmail.com

MARTIN, DANIEL
239 Byron Ridge Drive
Albany, GA 31721
229-312-7500
djm2221@yahoo.com

MARTINEZ, JORGE L.
Mansion Real 604
Calle Felipe II
Coto Laurel 00780
Puerto Rico

MARU, SANDIP T.
Mercy Medical Center
300 Staford Street, Suite 256
Springfield, MA 01104
413-748-9378

*Senior Member

Active Membership Roster

MASTRACCI, TARA M.
Cleveland Clinic Foundation
Dept. of Vascular Surgery
9500 Euclid Avenue, Desk H32
Cleveland, OH 44195
216-445-1338
mastrat@ccf.org

MATSUURA, JOHN H.
735 Edenwood Drive
Springfield, OH 45504-4641
937-208-2177
jhmatsuura@premierhealth.com

MATTESON, BRIAN
St Luke's Cardiothoracic & Vasc. Assoc.
333 N 1st Street, Suite 280
Boise, ID 83702
208-345-6545
bmatteson@slhs.org

MATTHEWS, THOMAS C.
927 28th Street S
Birmingham, AL 35205
205-934-2006
matthewstc@gmail.com

MCCREADY, ROBERT A.*
CorVasc MD's, PC
1801 N. Senate Blvd., Suite 3300
Indianapolis, IN 4620-1184
317-923-1787
RMCCGolrish@aol.com

MCCULLOUGH, JR., JAMES L.*
1259 S. Cedar Crest Blvd., #301
Allentown, PA 18103
215-439-0372

MCENANEY, RYAN M.
4274 Glen Lytle Road
Pittsburgh, PA 15217
412-864-0985
mcenaneyrm@upmc.edu

MCKINSEY, JAMES F.*
Columbia Presbyterian Medical Center
161 Ft. Washington Avenue, Suite 535
New York, NY 10032
212-342-3255
jfm2111@columbia.edu

MCLAUGHLIN, DANIEL J.*
18099 Lorain Avenue, #545
Cleveland, OH 44111
216-476-9669

MCNEIL, JAMES W.*
7777 Hennessy Blvd., Suite 1008
Baton Rouge, LA 70808
225-766-0416
jmcneil@cvtsc.com

MCNEILL, PAUL M.*
Maryland Surgical Care
77 Thomas Johnson Drive, Suite E
Fredrick, MD 21702
301-695-8346

MCPHILLIPS, FRANK*
Cardiothoracic & Vascular Surg. Assoc.
1855 Spring Hill Avenue
Mobile, AL 36607
251-471-3544

MEHTA, MANISH
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-5640
mehtam@albanyvascular.com

MELL, MATTHEW
Stanford University
Division of Vascular Surgery
300 Pasteur Drive, Room H3637
Stanford, CA 94305-5642
650-723-4322
mwmell@stanford.edu

MELTZER, ANDREW J.
136 East 64th Street, Apt 5E
New York, NY 10065
212-746-7311
andrewjmeltzer@gmail.com

MENA, JOSE*
240 Natchez Trace
Covington, LA 70433
504-837-4130
jmena@ochsner.org

*Senior Member

Active Membership Roster

MENDES, DONNA M.*
St. Luke's Roosevelt Hospital
10 W 66th Street
New York, NY 10023
212-636-4990
dmendes@chpnet.org

MENSINK, KAREN†
Mayo Clinic
200 First St. SW
Rochester, MN 55905
507-255-6658
mensink.karen@mayo.edu

METHODIUS-RAYFORD, WALAYA C.
5546 Gramercy Drive SW
Atlanta, GA 30349
404-350-9505
wmethodi@comcast.net

MILLER, JAY S.*
550 Peachtree Street NE, Suite 1085
Atlanta, GA 30308-2232
404-892-0137

MILLS, JOSEPH L.*
Baylor College of Medicine
One Baylor Plaza, MS 390
Houston, TX 77030
713-798-7851
joseph.mills@bcm.edu

MILNER, ROSS
Loyola University Medical Center
Dept. of Surgery
2160 South First Avenue
EMS Building 110, Room #3215
Maywood, IL 60153
708-327-3431
rmilner@lumc.edu

MINC, SAMANTHA
1624 W Division Street, Apt. 306
Chicago, IL 60622
312-563-2049
sminc00@gmail.com

MINION, DAVID J.
University of Kentucky Medical Ctr.
800 Rose Street, C-217
Lexington, KY 40536-0298
859-323-6346
djmini@email.uky.edu

MITCHELL, ERICA L.
Oregon Health & Science University
3181 SW Sam Jackson Park Road, OP11
Portland, OR 97239
503-4947593
mitcheer@ohsu.edu

MOHABBAT, WALID
Specialist Vascular Clinic
69 Christie Street, Suite 104
St. Leonards 02065
Australia
walid@specialistvascularclinic.com.au

MOINUDDEEN, KHAJA
727 Bunker Hill Road, Apt. 97
Houston, TX 77024-4448
304-588-0919
kmoinuddeen@hotmail.com

MOISE, MIREILLE A.
6112 Penfield Lane
Solon, OH 44139-5936
216-778-5904
astridmoise@gmail.com

MOLINA-HERNANDEZ, ALEJANDRO
Clinica del Coutry
Vascular y Endovascular
CRA 16 82 74 cons 704
Bogota
Colombia
amolinah@yahoo.com

MOLL, FRANS L.*
University Medical Center Utrecht
Heidelberglaan 100
GOU 12G
Utrecht 3584 CX
Netherlands
f.l.moll@umcutrecht.nl

MONAHAN, THOMAS S.
2102 Claremont Street
Baltimore, MD 21231
410-328-5840
t.monahan@hotmail.com

MOOMEY, JR., CHARLES B.
Gwinnett Surgical
631 Professional Drive, Suite 300
Lawrenceville, GA 30046
770-962-9977

Active Membership Roster

MOORE, ERIN M.
Cardiothoracic & Vascular Surg. Assoc.
836 Prudential Drive, Suite 1804
Jacksonville, FL 32207
904-398-3888
vascularmd@gmail.com

MORASCH, MARK D.
Billings Clinic
801 North 29th Street
PO Box 37000
Billings, MT 59107-7000
406-435-8272
mdmorasch@gmail.com

MORCOS, OMAR C.
Northshore University Health Systems
Dept. of Surgery
9650 Gross Point Road
Skokie, IL 60076
847-663-8050
omorcos@northshore.org

MORGAN, III, JOE H.
Albany Vascular
2300 Dawson Road, Suite 101
Albany, GA 31707
229-436-8535
lcox@albanyvsc.com

MORRIS, MARVIN E.
19 Eunice Drive
Longmeadow, MA 01106-1222
413-794-0900
dcmorris12@hotmail.com

MORRISON, EDWARD C.*
1327 Ashley River Road, Bldg. B
Charleston, SC 29407
803-577-4551

MORRISSEY, NICHOLAS J.
Columbia/Weill Cornell
Division of Vascular Surgery
161 Ft. Washington Avenue, Suite 639
New York, NY 10032
212-342-2929
njm2106@columbia.edu

MOTAGANAHALLI, RAGHUNANDAN
13988 Wilmuth Drive
Carmel, IN 46074-3103
317-962-0282
raghunandanml@yahoo.com

MOUAWAD, NICOLAS J.
4802 Claremont Street, #2
Midland, MI 48642
989-894-3278
nmouawad@gmail.com

MUBARAK, OMAR
Vascular Institute of the Rockies
1601 E. 19th Avenue, Suite 3950
Denver, CO 80218
303-539-0736
docotoromubarak@yahoo.com

MUCK, PATRICK E.
10506 Montgomery Road, Suite 302
Cincinnati, OH 45242
513-232-8181
patrick_muck@trihealth.com

MULUK, SATISH C.*
Allegheny General Hospital
320 E. North Avenue, 14th Floor
Pittsburgh, PA 15212
412-359-3714
muluk@.net

MUNN, JOHN S.*
1815 Henson
Kalamazoo, MI 49048-1510
616-226-5200

MUREEBE, LEILA
Duke University Medical Center
Box 3467
Durham, NC 27710
919-681-2800
leila.mureebe@duke.edu

MUSSA, FIRAS F.
525 E 80th Street, 7D
New York, NY 10075-0789
212-263-7311
firas.mussa@nyumc.org

MUTO, PAULA M.
Muto Surgical
100 Amesbury Street
Lawrence, MA 01840
978-685-5474
icastillo@mutosurgical.com

*Senior Member

Active Membership Roster

NALBANDIAN, MATTHEW M.
247 Third Avenue, Suite 504
New York, NY 10010
212-254-6882
matthew.nalbandian@med.nyu.edu

NAOUM, JOSEPH J.
The Methodist Hospital
6550 Fannin Street, Suite 1401
Houston, TX 77030
713-441-5200
jjnaoum@tmhs.org

NASLUND, THOMAS C.*
Vanderbilt University Medical Center
1161 22nd Avenue S, D-5237 MCN
Nashville, TN 37232-2735
615-322-2343
thomas.naslund@vanderbilt.edu

NAZZAL, MUNIER
University of Toledo Medical Center
Dept. of Surgery
3064 Arlington Avenue
Dowling Hall
Toledo, OH 43614-2595
419-383-3588
nazzal.munier@utoledo.edu

NELSON, PETER R.
USF Morsani College of Medicine
Vascular and Endovasc. Surgery
STC 7016 Com
2Tampa General Circle
Tampa, FL 33606-3603
813-259-0921
pnelson1@health.usf.edu

NESCHIS, DAVID G.
Baltimore Washington Medical Center
Maryland Vascular Center
301 Hospital Drive
Glen Burnie, MD 21061-5803
410-553-8300
dneschis@bwmc.umms.org

NEVILLE, PATRICK M. S.
1491 Pasteur Lane
Swansea, IL 62226
618-222-1020
pneville712@gmail.com

NEWTON, WM. D.*
United Surgical Associates
1401 Harrodsburg Road, #C-100
Lexington, KY 40504-3766
859-278-2334
dnewton553@aol.com

NGUYEN, LOUIS L.
Brigham & Women's Hospital
Division of Vascular Surgery
75 Francis Street
Boston, MA 02115
857-307-1920
llnguyen@partners.org

NICHOLSON, RACHAEL
University of Iowa Hospitals & Clinics
Vascular Surgery
200 Hawkins Drive
Iowa City, IA 52242
319-356-8242
rachael-nicholson@uiowa.edu

NOLAN, BRIAN W.*
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-1000
603-650-8670
brian.w.nolan@hitchcock.org

NOLAN, KEVIN D.
22250 Providence Drive, #555
Southfield, MI 48075-6512
248-424-5748

NOLL, JR., ROBERT E.
3255 Conquistador Way
Davis, CA 95618
916-843-9388
robert.noll@va.gov

OBMANN, MELISSA A.
Geisinger Wyoming Valley Medical Ctr.
Pearsall Heart Hospital
1000 E. Mountain Drive
Wilkes-Barre, PA 18711
570-808-6125
maobmann@geisinger.edu

O'BRIEN, PATRICK J.
52 Rock Creek Road
Clinton, MT 59825-9629
406-543-7271
obrien2004@gmail.com

*Senior Member

Active Membership Roster

OCHOA, CHRISTIAN J.
USC
Vascular Surgery
1520 San Pablo, Suite 4300
Los Angeles, CA 90033
323-442-5899
dr8amd@gmail.com

OCHOA CHAAR, CASSIUS IYAD
Yale School of Medicine
Vascular Surgery
330 Cedar Street, Box 208062
Boardman Building 204
New Haven, CT 06510-3218
203-785-2561
cassius.chaar@yale.edu

O'CONNELL, JESSICA B.
2915 Tiffany Circle
Los Angeles, CA 90077-1720
310-825-5275
jbocjboc@hotmail.com

O'CONNOR, DAVID J.
792 Columbus Avenue, 17F
New York, NY 10025
646-379-1200
djo5853@hotmail.com

ODERICH, GUSTAVO S.
Mayo Clinic
200 First Street SW
Rochester, MN 55905
507-284-1575
oderich.gustavo@mayo.edu

O'DONNELL, SEAN D.*
4310 Bayview Drive
Ft. Lauderdale, FL 33308-5327
202-782-9184

OLINDE, ANDREW J.*
Vascular Surgery Associates
8888 Summa Avenue, 3rd Floor
Baton Rouge, LA 70809
225-769-4493

O'MARA, CHARLES S.*
501 Marshall Street, #100
Jackson, MS 39202
601-948-1416

OMBRELLINO, MICHAEL
Vein Institute of New Jersey
95 Madison Avenue, Suite 109
Morristown, NJ 07960
973-539-6900
omby@aol.com

O'NEILL, ALISSA B.
23 Stratton Drive
Trenton, NJ 08690-2413
asbrotman@yahoo.com

ORECCHIA, PAUL M.*
The Heart Doctors Cardiology Assoc.
4150 Fifth Street
Rapid City, SD 57701
605-399-4300

ORTEGA, RAUL E.
North Texas Vascular Specialists
2900 N. I-35, Suite 105
Denton, TX 76201
940-591-0500
reomd@yahoo.com

OSBORNE, NICHOLAS*
University of Michigan
Vascular Surgery
1500 E. Medical Ctr. Drive, 5168 CVC
Ann Arbor, MI 48109
734-936-5790
nichosbo@med.umich.edu

OSBORNE, JR., ROBERT
3201 17th Street, PL SE
Puyallup, WA 98374
253-268-3400

OWENS, ERIK L.
VA Medical Center - San Diego
3350 La Jolla Village Drive
Surgical Service (112)
San Diego, CA 92161
858-642-3621
eowens@ucsd.edu

OZSVATH, KATHLEEN J.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
ozsvathk@albanyvascular.com

*Senior Member

Active Membership Roster

PADBERG, JR., FRANK T.*
Rutgers-New Jersey Medical School
Division of Surgery
Doctors Office Center
90 Bergen Street, Suite 7200
Newark, NJ 07103
973-972-9371
padbergjr@aol.com

PAINTER, THOMAS A.*
1614 W. Central Road, Suite 100
Arlington Heights, IL 60005-2452
847-577-5814
tapain41@aol.com

PALADUGU, RAMESH
6812 Sawgrass Drive
Fort Worth, TX 76132
817-332-8346
rameshpal@pol.net

PALIT, TAPASH
LSU Health Sciences Ctr. - New Orleans
Vascular Surgery
4500 10th Street
Marrero, LA 70072
504-412-1960
tpalit@gmail.com

PANETTA, THOMAS*
600 Northern Blvd., Suite 115
Great Neck, NY 11021
516-482-8220

PAOLINI, DAVID J.
8560 Pilliod Road
Holland, OH 43528-8666
419-291-2003
punch25@aol.com

PARENT, III, F. NOEL*
Sentara Vascular Specialists
300 S. Building
397 Little Neck Road, Suite 100
Virginia Beach, VA 23452
757-470-5570
fnp3md@aol.com

PARK, WOOSUP M.
Cleveland Clinic Foundation
9500 Euclid Avenue, H32
Cleveland, OH 44195
216-444-6268
parkm3@ccf.org

PARMER, SHANE S.
Marietta Memorial Hospital
Vascular Surgery
400 Matthew Street, Suite 208
Marietta, OH 45750-1656
740-568-5466
SParmer@mhsystem.org

PARRA, JOSE R.
9 Long Bow Ct.
Cockeysville, MD 21030
443-287-2312
mjstrooper@gmail.com

PASSMAN, MARC A.
University of Alabama at Birmingham
Section of Vascular Surgery
1808 7th Avenue S, BDB 503
Birmingham, AL 35294-0012
205-934-2003
Marc.Passman@ccc.uab.edu

PATTERSON, DONALD E.
5600 Winthrop Ct.
Evansville, IN 47715-4284
812-424-8231
Donald.Patterson@EvansvilleSurgical.com

PATTERSON, MARK A.
Univ. of Alabama at Birmingham
1808 7th Avenue S, BDB 503
Birmingham, AL 35294-0012
205-934-7279
mark.patterson@ccc.uab.edu

PATY, PHILIP S.K.*
27 Birkdale Court
Slingerlands, NY 12159
518-262-5640
patyp@nycap.rr.com

PEARCE, BENJAMIN J.
University of Alabama at Birmingham
Division of Vascular Surgery
1801 7th Avenue S, 503 BDB
Birmingham, AL 35294
205-934-2003
bjpearce@uabmc.edu

*Senior Member

Active Membership Roster

PEARCE, JEFFREY D.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606-6736
706-549-8306
jpearce@athensvascular.com

PECK, MICHAEL A.
18522 Rogers Place
San Antonio, TX 78258
210-614-7414
mpeck@pvasatx.com

PEDEN, ERIC K.
Methodist CardioVascular Surg. Assoc.
Heart and Vascular Center
6550 Fannin Street, Suite 1401
Houston, TX 77030-2738
731-441-5200

PENNELL, RICHARD C.*
St. Louis Vascular Center
625 S. New Ballas Road, Suite 7063
St. Louis, MO 63141
314-251-4200
Richard.Pennell@Mercy.net

PEREDA, JUAN C.
Miami Vascular Surgery
6200 Sunset Drive, Suite 505
South Miami, FL 33143
305-598-0888
juancarlospereda@yahoo.com

PERKOWSKI, PAUL E.
Vascular Clinic
8585 Picardy Avenue, Suite 310
Baton Rouge, LA 70809-3679
225-767-5479
pperkowski@cox.net

PETERSON, BRIAN G.
The Heart Specialty Associates, LLC
Dept of Surgery
10012 Kennerly Road, Suite 300
St. Louis, MO 63128
314-525-4325
bpeters1@slu.edu

PETRIK, PAVEL
1331 West Avenue, J 203
Lancaster, CA 93534
661-945-4433
p.petrikmd@gmail.com

PEVEC, WILLIAM C.*
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-4738
william.pevec@ucdmc.ucdavis.edu

PFEIFFER, III, RALPH B.
Wiregrass Surgical Associates
4300 W. Main Street, Suite 24
Dothan, AL 36305-1312
344-793-1534

PHADE, SACHIN V.
3091 Enclave Bay Drive
Chattanooga, TN 37415
423-267-0466
saphade@aol.com

PHILLIPS, VICTOR M.
VP Medical, LLC
3308 W Edgewood, Suite D
Jefferson City, MO 65109
573-632-0010
tracivictor@earthlink.net

PIERCY, KENNETH T.
6183 Plantation Pointe Drive
Granite Falls, NC 28630
828-322-2005
t.piercy@mailcity.com

PIETROPAOLI, JOHN A.
Southern CT Vascular Center
495 Hawley Lane, Suite 2A
Stratford, CT 06614
203-375-2861

PIGOTT, JOHN P.*
2109 Hughes Drive #450
Toledo, OH 43606-3845
419-471-2003

PIN, RICHARD
Southcoast Physician Group
300A Faunce Corner Road
Dartmouth, MA 02747
508-973-2213
rhpin@hotmail.com

POI, MUN JYE J.
4223 West Alabama Street
Houston, TX 77027
713-798-5700
poimunjye@gmail.com

*Senior Member

Active Membership Roster

POINDEXTER, JR., JAMES M.*
Georgia Vascular Specialists
1718 Peachtree Street NW, Suite 360
Atlanta, GA 30309-2453
404-350-9505
trenton.shy@gvsatl.com

POLIQUIN, JAMES R.*
7985 Darby's Run
Chagrin Falls, OH 44023-4840
216-390-7708
poliquj@ccf.org

PROCTER, SR., CHARLES D.*
Vascular & Vein Specialists
705 Jesse Jewel Pkwy SE, Suite 125
Gainesville, GA 30501-3824
770-534-0110
cdprocter@gmail.com

PROPPER, BRANDON
18506 Canoe Brook
San Antonio, TX 78258
210-916-1174
bpropper@mac.com

PUCKRIDGE, PHILLIP J.
Flinders Medical Centre
Vascular Surgery
Flinders Drive
Bedford Park 05042
Australia
phillip.puckridge@health.sa.gov.au

PULLIAM, CARY W.*
Middle Tennessee Vascular
4601 Carothers Pkwy., Suite 375
Franklin, TN 37067
615-791-4790

PURCELL, PETER N.
Horizon Surgical Specialists
401 Mulberry Street, Suite 101
Lenoir, NC 28645
828-758-5501
peterpurcell@charter.net

PURTILL, WILLIAM A.
900 Northern Blvd., Suite 140
Great Neck, NY 11021
516-466-0485

QUAN, REAGAN W.
Wellstan Health Network
25 Monument Road, Suite 190
York, PA 17403
717-851-1607
rwquan@icloud.com

QUICK, RHONDA C.
Carondelet Heart & Vascular Institute Physicians
1815 W. St. Mary's Road
Tucson, AZ 85745
520-628-1400
rqbypass@comcast.net

QUIGLEY, TERENCE M.*
Northwest Surgical Specialists
1560 N. 115th Street, Suite 102
Seattle, WA 98133
206-363-2882

QUINNEY, BRENT E.
The Vascular Institute of Birmingham
2660 10th Avenue South
Prof. Office Bldg 1, Suite 608
Birmingham, AL 35201-0001
205-939-3495
vascularinstitutebham@yahoo.com

QUINONES-BALDRICH, WILLIAM J.*
UCLA Medical Center
200 UCLA Medical Plaza, #526
Los Angeles, CA 90095-6904
310-825-7032
wquinones@mednet.ucla.edu

QUIROGA, ELINA
University of Washington
Dept. of Surgery
325 9th Avenue, Box 359908
Seattle, WA 98104
206-744-3538
elinaq@uw.edu

RACHEL, ELIZABETH S.
Surgical Care Associates, PSC
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139
erachel@surgicalcare.com

*Senior Member

Active Membership Roster

RAJANI, RAVI
1507 Wesley Parkway
Atlanta, GA 30327
404-251-8916
r.rajani@emory.edu

RAMADAN, FUAD M.*
Melbourne Vascular Center
1250 S. Harbor City Blvd., Suite A
Melbourne, FL 32901
321-725-8919
flyerdoc@melbournevascular.com

RAMAN, KATHLEEN G.
8000 Gannon Avenue
St. Louis, MO 63130
314-362-6460
kathleen.raman@gmail.com

RAMMOHAN, SURIANARAYANAN
106-4256 Portage Road
Niagra Falls ON L2E 6A4
Canada
905-357-3336
drvascular@hotmail.com

RAMOS, TAMMY K.*
Midwest Vascular & Endovasc. Surgery
9202 West Dodge Road, Suite 305
Omaha, NE 68114
402-390-6601

RANDEL, MARK A.
3034 Raguet
Nacogdoches, TX 75965
936-554-3795
marmd@markrandelmd.com

RAO, ATUL S.*
Maimonides Medical Center
Division of Vascular Surgery
947 49th Street, Room 102
Brooklyn, NY 11219
718-283-7957
atulsrao@gmail.com

RAO, NIRANJAN V.
78 Easton Avenue
New Brunswick, NJ 08901-1838
908-249-0360
nvrao789@gmail.com

RASMUSSEN, TODD E.
Uniformed Services University
4301 Jones Bridge Road
Bethesda, MD 20814-4799
301-619-7591
todd.e.rasmussen.mil@mail.mil

RAYAN, SUNIL S.
9850 Genesse Avenue, Suite 560
La Jolla, CA 92037
858-452-0306

RAZZINO, RICHARD A.*
2433 Malvern Circle
Harrisburg, PA 17112
717-763-0510
poncho2433@verizon.net

RECTENWALD, JOHN E.
UT Southwestern Medical Center
Vascular Surgery
5323 Harry Hines Blvd., MC9157
Dallas, TX 75390-9157
214-645-2040
john.rectenwald@utsouthwestern.edu

REED, AMY B.
Penn State Heart & Vascular Institute
Vascular Surgery Training
500 University Drive, H053
Hershey, PA 17033
717-673-3616
areed3@hmc.psu.edu

REEVES, JAMES G.
4585 Montclair Circle
Gainesville, GA 30506-5134
770-219-4000
iron140.6@gmail.com

REHRING, THOMAS F.
Colorado Permanente Medical Group
Vascular Therapy
2045 Franklin Street, 3rd Floor
20th Avenue Medical Center
Denver, CO 80205
303-861-3688
thomas.f.rehring@kp.org

REISSER, JOHN*
266 Joule Street
Alcoa, TN 37701

*Senior Member

Active Membership Roster

RHEE, ROBERT Y.*
227 Edelweiss Drive
Wexford, PA 15090
rrhee@maimonidesmed.org

RHEE, SAN WON*
Vascular Services of Western
New England
3500 Main Street, Suite 201
Springfield, MA 01107-0126
413-784-0900

RHEUDASIL, J. MARK*
Vascular Institute of Georgia
5673 Peachtree Dunwoody Road
Suite 675
Atlanta, GA 30342
404-256-0404
jmr56@comcast.net

RHODES, JEFFREY M.
8065 Barony Woods
Pittsford, NY 14534-4164
585-922-5550
jeffrey.rhodes@rochestergeneral.org

RICHARDSON, JR., JAMES W.*
1222 Trotwood Avenue, #211
Columbia, TN 38401
931-380-3033

RICOTTA, II, JOSEPH J.
Northside Heart & Vascular Institute
980 Johnson Ferry Road, NE, Suite 1040
Atlanta, GA 30342
404-303-3615
joseph.ricotta@northside.com

RIESENMAN, PAUL J.
University Hospital Vascular Specialists
1350 Walton Way
Augusta, GA 30901
706-774-7022
paulriesenman@uh.org

RIFKIN, KERRY V.*
Vasc. Surgery Assoc. of N. FL, P.A.
2140 Kingsley Avenue, Suite 14
Orange Park, FL 32073-5129
904-276-7997
terrifkin@aol.com

RIGBERG, DAVID A.
532 11th Street
Santa Monica, CA 90402
310-206-5594
drigberg@mednet.ucla.edu

RIGGS, PATRICK N.*
Vascular Surgery Associates
1445 Portland Avenue, #108
Rochester, NY 14621
585-922-5550

RITS, YEVGENIY
Wayne State University
3990 John R
Detroit, MI 48201
313-745-8637
yrits@dmc.org

RIZVI, ADNAN Z.
Providence Vascular Institute &
Vein Center
Vascular and Endovascular Surgery
122 West 7th Avenue, Suite 420
Spokane, WA 99204
509-626-9440
adnan.rizvi@providence.org

RIZZO, ANTHONY
Cleveland Clinic Foundation
Vascular Surgery
6801 Mayfield Road, Bldg. 2, Suite 146
Mayfield Heights, OH 44124
440-461-1150
rizzoa@ccf.org

ROBERTS, RICK M.*
Vascular Surgery Associates, PC
201 Sivley Road, Suite 305
Huntsville, AL 35801
256-536-9000
rmrobertsal@yahoo.com

ROBINSON, III, WILLIAM P.
UMass Memorial Medical Center
Vascular and Endovascular Surgery
55 Lake Ave North Drive, Room S3819
Worcester, MA 01655
508-856-5599
william.robinson@umassmemorial.org

*Senior Member

Active Membership Roster

ROCKMAN, CARON B.
NYU University Medical School
530 First Avenue #6F
New York, NY 10016-6402
212-263-7311
caron.rockman@nyumc.org

RODDY, SEAN P.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3412
518-262-8720
roddys@albanyvascular.com

RODRIGUEZ, CHRISTIAN C.
Foundation Vascular Surgery
8 Prospect Street, North II Specialty
PO Box 1184
Nashua, NH 03061
603-577-3070
crodrigueznh@gmail.com

RODRIGUEZ, HERON E.
Northwestern Medical Faculty Found.
676 N. Saint Clair Street, Suite 650
Chicago, IL 60611
312-695-4857
herodrig@nmh.org

ROLLINS, DAVID L.*
36060 Euclid Avenue, #107
Willoughby, OH 44094-4661
440-269-8346
drollins@neo-vascular.com

ROSA, PATRICIO
5908 NW 54th Circle
Coral Springs, FL 33067-3523
954-436-5000
patriciorosa@aol.com

ROSCA, MIHAI
22 Acorn Ponds Drive
Roslyn, NY 11576
516-233-3701
mihairosca@optonline.net

ROSENFELD, JOEL C.*
St. Luke's Hospital
801 Ostrum Street
Bethlehem, PA 18015
rosenfj@slhn.org

ROSSI, PETER J.
Medical College of Wisconsin
Division of Vascular Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
prossi@mcw.edu

ROULHAC, MAURICE R.*
Carolina Vascular
1251 Oliver Street
Fayettville, NC 28304
910-822-6587
vasmd@aol.com

ROUSH, TIMOTHY S.
Carolinas Heart Institute
1001 Blythe Blvd., Suite 300
Charlotte, NC 28203
704-355-9430
timothy.roush@carolinas.org

ROWE, VINCENT L.
Keck USC School of Medicine
LAC + USC Medical Center
1200 North State Street, Room 9442
Los Angeles, CA 90033
323-226-5818
vrowe@surgery.usc.edu

RUBIN, JEFFREY R.*
Detroit Medical Center/Harper
University Hospital
Vascular Surgery
3990 John R
Detroit, MI 48201-2022
313-745-8637
jrubin@med.wayne.edu

RUBINSTEIN, CHEN
Hadassah Hebrew University Med. Ctr.
Vascular Surgery
PO Box 12000
Jerusalem, 9112001
Israel
chenr@hadassah.org.il

*Senior Member

Active Membership Roster

RUDDY, JEAN MARIE
Medical University of South Carolina
Surgery, Division of Vascular Surgery
25 Courtenay Drive, Suite 7018
MSC 295
Charleston, SC 29425
843-876-4855
jeanieruddy@gmail.com

RUDO, NEIL D.*
236 San Jose Street
Salinas, CA 93901-3901

RUEDA, CARLOS A.
5925 Las Cadenas Road NW
Albuquerque, NM 87120
720-949-5057
carlosruedamd@gmail.com

RUSHTON, JR., FRED W.*
University of Mississippi Medical Ctr.
Dept. of Surgery
2500 N. State Street
Suite L228-4
Jackson, MS 39216
601-984-2680
frushton@umc.edu

RUSSELL, TODD E.
2109 Hughes 450
Toledo, OH 43606
419-471-2003
ter1965@aol.com

RYAN, TIMOTHY
417 W. 39th Street
San Pedro, CA 90731
310-222-2704
tjryanmd@gmail.com

SAILORS, DAVID M.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606
706-549-8306
dsailors@bellsouth.net

SALANDER, JAMES M.*
11119 Rockville Pike #204
Rockville, MD 20852
301-881-5503
marysalander@hotmail.com

SALES, CLIFFORD M.*
The Cardiovascular Care Group
45 Farbrook Drive
Short Hills, NJ 07078-3008
973-759-9000
csales@tcvcg.com

SALTZBERG, STEPHANIE
The Vascular Group, PLLC
117 Marys Avenue, Suite 202
Kingston, NY 12401
845-338-1992
saltzbergs@albanyvascular.com

SAMPSON, JAMES B.
3904 Arroyo Avenue
Davis, CA 95618
707-423-2300
jambsam@gmail.com

SAMPSON, LAWRENCE N.*
Guthrie Clinic
One Guthrie Square
Sayre, PA 18840
570-882-2428
sampson_lawrence@guthrie.org

SANCHEZ, LUIS A.*
Washington Univ. School of Medicine
660 South Euclid Avenue
Campus Box 8109
St. Louis, MO 63110

SANTILLI, STEVEN M.*
University of Minnesota
Vascular Surgery
420 Delaware Street SE, MMC195
Minneapolis, MN 55455
612-625-1485
santi002@umn.edu

SAWCHUK, ALAN P.*
Indiana University Vascular Surgery
1801 N. Senate Blvd.
MPC 2 #D3500
Indianapolis, IN 46202
317-630-8854

*Senior Member

Active Membership Roster

SCHELLACK, JON V.*
Vascular Clinic
8585 Picardy Avenue, Suite 310
Baton Rouge, LA 70809-3679
225-767-5479
jschellack@vasclin.com

SCHERMERHORN, MARC L.
Beth Israel Deaconess Medical Center
110 Francis Street, Suite 5B
Boston, MA 02215
617-632-9971
mscherme@bidmc.harvard.edu

SCHMITT, DAVID D.*
1111 Delafield Street #209
Wauhesha, WI 53188-3403
262-542-0444
dds509@aol.com

SCHMITTLING, ZACHARY C.
4306 E Bogey Ct.
Springfield, MO 65809
417-875-3755
marsha.maggi@coxhealth.com

SCHNEIDER, DARREN B.
Weill Cornell Medical College
Vascular and Endovascular Surgery
525 E. 68th Street, P-707
New York, NY 10065
212-746-5192
dschneider@med.cornell.edu

SCHOR, JONATHAN A.
Staten Island University Hospital
Vascular Surgery
256 Mason Avenue, Bldg B, 2nd Floor
Staten Island, NY 10305
718-226-6800
jschor@siuh.edu

SCHRODER, WILLIAM B.*
Cardio & Vascular Surgical Associates
688 Walnut Street, Suite 200
Macon, GA 31201
478-742-7566
bill@kcdoc.com

SCHWARTZ, LEWIS B.*
Abbott Laboratories
200 Abbott Park Road, AP52-2, AV2R
Abbott Park, IL 60064-6229
847-936-3104
lewis.schwartz@abbott.com

SCHWARTZ, MARK A.
North Shore Vein Center
1 Hollow Lane, Suite 210
Lake Success, NY 11042
516-869-8346
mschwartz@veincenters.com

SCRIBNER, ROBERT G.*
1800 Sullivan Avenue, #308
Daly City, CA 94015
650-755-1132
rscrib@sbcglobal.net

SEABROOK, GARY*
Medical College of Wisconsin
Division of Vascular Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
gseabroo@mcw.edu

SEDWITZ, MARC M.*
Pacific Coast Vascular & General Surg.
9850 Genesse Avenue, #560
La Jolla, CA 92037
619-452-0306

SEIDEL, SCOTT A.
Cardiothoracic & Vascular Surgeons
1010 West 40th
Austin, TX 78756
512-459-8753
saseidel@ctvstexas.com

SEIWERT, ANDREW J.*
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*Senior Member

Active Membership Roster

SENKOWSKY, F. JON*
1001 N. Waldrop Street, Suite 612
Arlington, TX 76012
817-267-1166

SHAFII, SN M.
10318 Orange Grove Drive
Tampa, FL 33618
404-251-8916
shafiis99@gmail.com

SHAFIQUE, SHOAIB
St. Vincent Medical Group
8433 Harcourt Road, Suite 100
Indianapolis, IN 46260-2193
317-583-7600
endovsolutions@aol.com

SHAH, HEMAL
Hemal J. Shah, MD PC
Vascular Surgery
20 East 46th Street, 9th Floor
New York, NY 10017
646-490-5475
hjshahmd@gmail.com

SHAH, MELISSA
The Vascular Group, PLLC
71 Prospect Avenue, Suite 190
Hudson, NY 12534
518-262-8720
shahm@albanyvascular.com

SHALHUB, SHERENE
2802 33rd Avenue S
Seattle, WA 98144
206-226-7042
shereneshalhub@gmail.com

SHAMES, MURRAY L.
USF Health South-UMSA
Vascular & Endovascular Surgery
2 Tampa General Circle, Room 7006
Tampa, FL 33606
813-259-0958
mshames@health.usf.edu

SHANLEY, CHARLES J.
William Beaumont Hospital
Hospital Admin
3601 West 13 Mile Road
Royal Oak, MI 48073
313-745-8637
etaylor@beaumont.edu

SHARAFUDDIN, MEL J.
University of Iowa College of Medicine
Dept. of Surgery, 1JPP
200 Hawkins Drive
Iowa City, IA 52242
319-356-4791
Mel-sharafuddin@uiowa.edu

SHARP, WILLIAM J.*
University of Iowa Hospital & Clinics
Dept. of Surgery
200 Hawkins Drive
Iowa City, IA 52242-1009
319-356-1907
william-sharp@uiowa.edu

SHEAHAN, CLAUDIE
1314 Napoleon Avenue, Unit 19
New Orleans, LA 70115
504-412-1960
claudiesheahan@yahoo.com

SHEAHAN, III, MALACHI
1314 Napoleon Avenue, Unit 19
New Orleans, LA 70115
504-412-1960
msheah@lsuhsc.edu

SHEEHAN, MAUREEN K.
University of TX Health Science Center
Dept. of Surgery HSC
7703 Floyd Curl Drive, MC 7741
San Antonio, TX 78229-3900
210-567-5715
sheehanm@uthscsa.edu

SHENG, NEHA
Loma Linda University Medical Center
Vascular Surgery
11175 Campus Street, Suite 21123
Loma Linda, CA 92350
909-558-4534
neha.sheng@gmail.com

SHERWOOD, ANDREW J.
Eastern Maine Medical Center
Vascular Care of Maine
489 State Street
Bangor, ME 04402-0404
207-973-6670
ajsherwood@emh.org

*Senior Member

Active Membership Roster

SHIN, SNNA
Georgetown University Hospital
3800 Reservoir Road, NW
4th Floor PHC
Washington, DC 20007
202-444-2255
snna.h.shin@medstar.net

SHORTELL, CYNTHIA K.*
Duke University Medical Center
DUMC, Box 3538
Durham, NC 27710
919-681-2223
cynthia.shortell@duke.edu

SHUSTER, THOMAS A.
3485 Ambleside Drive
Flushing, MI 48433
810-606-1660
ttshuster@comcast.net

SHUTZE, WILLIAM P.*
Texas Vascular Associates
621 North Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
willshut@sbcglobal.net

SIMONI, EUGENE J.*
116 Meadow Flower Circle
Bellefonte, PA 16823
ejca@aol.com

SIMONIAN, GREGORY T.
211 Essex Street, Suite 102
Hackensack, NJ 07601
201-487-8882
GSimonian@aol.com

SIMOSA, HECTOR F.
MetroWest Medical Center
Vascular and Endovascular Surgery
85 Lincoln Street, 6th Floor
Framingham, MA 01702
508-383-1078

SINGH, MICHAEL J.
Univ. of Pittsburgh Med. Ctr. Shadyside
5200 Centre Avenue, Suite 313
Gibsonia, PA 15044
412-802-3333
singhmj@upmc.edu

SINGH, NITEN
University of Washington
Vascular Surgery
325 9th Avenue, Box 359908
Seattle, WA 98104
206-744-8025
singhn2@uw.edu

SIRACUSE, JEFFREY J.
Boston University
Dept. of Surgery
88 East Newton Street, C520
Boston, MA 02218
617-638-8488
jeffrey.siracuse@bmc.org

SLAIBY, JEFFREY M.
2 Dudley Street, Suite 470
Providence, RI 02905
401-553-8333
jslaiby@surg.org

SMEDS, MATTHEW R.
Univ. of Arkansas for Medical Sciences
Vascular Surgery
4301 W. Markham Street, 520-2
Little Rock, AR 72205-7199
501-686-6176
mrsmeds@uams.edu

SMILANICH, ROBERT
Utah Vascular Center
1055 N. 300 W, Suite 205
Provo, UT 84604-3374
801-374-9100
UVC@comcast.net

SMITH, DENISE A.B.
833 Auto Center Drive, Suite D
Palmdale, CA 93551
661-526-4260
denise.smith@uc.edu

SMITH, SUMONA
University of Mississippi Medical Ctr.
Vascular Surgery
2500 North State Street Jackson
Jackson, MS 39216
601-984-2680
svsmith3@umc.edu

*Senior Member

Active Membership Roster

SMITH, TAYLOR A.
Ochsner Medical Center
Vascular and Endovascular Surgery
1514 Jefferson Highway
New Orleans, LA 70121
504-842-4053
taysmith@ochsner.org

SOHN, MICHELLE E.
St. Joseph Hospital
2950 Squalicum Pkwy., Suite B
Bellingham, WA 98225
360-788-6063
msohnmd@gmail.com

SORIAL, EHAB E.
3003 Olin Avenue, Unit 312
San Jose, CA 95128-2434
859-327-1391
esorial@stanford.edu

SOUNDARARAJAN, KRISH
endovas@hotmail.com

SPROUSE, II, LARRY R.
UT College of Medicine
Vascular Surgery
979 E. Third Street, Suite 401
Chattanooga, TN 37403
423-778-7695
LRSii@msn.com

SRIVASTAVA, SUNITA D.
The Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44195
216-445-6939
srivass@ccf.org

STANZIALE, STEPHEN F.
Vascular & Endovascular Surgery
Cardiology Associates
2002 Medical Parkway, Suite 500
Annapolis, MD 21401
stephen_stanziale@hotmail.com

STARNES, BENJAMIN W.
Harborview Medical Center
Vascular Surgery
325 Ninth Avenue, Box 359796
Seattle, WA 98104
206-744-3033
starnes@u.washington.edu

STEPHANIAN, EDIC*
700 Walter Reed Blvd., Suite 311
Garland, TX 75042
972-487-6400
drstephanian@ndallassurg.com

STERNBACH, YARON
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
sternbachy@albanyvascular.com

STERNBERGH, III, W. CHARLES
Ochsner Clinic
1514 Jefferson Highway
New Orleans, LA 70121
504-842-4053
csternbergh@ochsner.org

STEWART, MARK T.*
Cardiothoracic and Vascular Surgeons
1010 W. 40th Street
Austin, TX 78756
512-459-8753
mstewart@ctvstexas.com

STEWART, II, JOHN D.*
Fayette Surgical Associates
1401 Harrodsburg Road, Suite C100
Lexington, KY 40504-3766
859-278-4960

STONE, PATRICK A.
PO Box 4555
Charleston, WV 25364
304-388-3884
pstone0627@yahoo.com

STONER, MICHAEL C.
University of Rochester Medical Center
Division of Vascular Surgery
601 Elmwood Avenue, Box 652
Rochester, NY 14642
585-275-6772
michael_stoner@urmc.rochester.edu

STONEROCK, CHARLES E.
SC Cardiovascular Surgery
805 Pamplico Hwy.
Medical Mall, Suite 300
Florence, SC 29505
843-676-2760

*Senior Member

Active Membership Roster

SUGGS, WILLIAM D.*
Montefiore Medical Center
4 Lyons Place
White Plains, NY 10601
718-920-4108

SULLIVAN, THEODORE R.
Abington Health
Dept. of Surgery
1245 Highland Avenue, Suite 600
Abington, PA 19001
215-887-3990
tsullivan@amh.org

SULLIVAN, TIMOTHY M.*
Minneapolis Heart Institute
Vascular Surgery Dept.
920 E. 28th Street, #300
Minneapolis, MN 55407
612-863-6800
timothy.sullivan@allina.com

SULTAN, SHERIF
Stoneyacre, Corcullen
Bushy Park
Galway
Ireland
sherif.sultan@hse.ie

SUN, LUCY
1805 Crockett Circle
Irving, TX 75038
800-660-8346
lucysun8@gmail.com

SUNDARAM, SHANKAR M.
2707 Cole Avenue, Apt. 615
Dallas, TX 75204-1076
972-888-4500
sms5217@yahoo.com

SUROWIEC, SCOTT M.
4507A Medical Center Drive
Fayetteville, NY 13066
315-663-0508
ssurowi@vascare.com

SYKES, MELLICK T.*
4330 Medical Drive, Suite 120
San Antonio, TX 78229-3920
210-692-9700
mellicksykes@aol.com

TADROS, RAMI O.
22 E 105th Street, Apt. 4D
New York, NY 10029
708-878-2002
rami.tadros@mountsinai.org

TAGGERT, JOHN B.
The Vascular Group, PLLC
43 New Scotland Ave (MC157)
Albany, NY 12208
518-262-8720
taggertj@albanyvascular.com

TAMEZ, JR., DANIEL D.*
Peripheral Vascular Assoc.
111 Dallas Street, Suite 200-A
San Antonio, TX 78205-1201
210-225-6508

TAN, TZE-WOEI
9395 Milbank Drive
Shreveport, LA 71115
401-626-9558
tzewoei@gmail.com

TANG, GALE L.
VA Puget Sound Health Care System
University of Washington
Dept. of Surgery
Surgical Services 112
1660 S. Columbian Way
Seattle, WA 98108
206-764-2245
gtang@uw.edu

TAORMINA, MARTIN V.
Carolina Vascular Surgery
1721 Ebenezer Road, Suite 115
Rock Hill, SC 29732
803-985-4000

TASSIOPOULOS, APOSTOLOS K.
SUNY
Division of Vascular Surgery
HSC T19-090
Stony Brook, NY 11794-8191
631-444-2037
apostolos.tassiopoulos@stonybrook.edu

*Senior Member

Active Membership Roster

TAYLOR, STEVEN M.
Baptist Health Center
1004 1st North, Suite 150
Alabaster, AL 35007
205-664-2420
stevetaylor@bhsala.com

TEFERA, GIRMA
University of Wisconsin Medical School
600 Highland Avenue, Suite G5/319
Madison, WI 53792-3236
608-265-4420
tefera@surgery.wisc.edu

TERUYA, THEODORE H.
11201 Benton Street, #112
Loma Linda, CA 92357
tteruya@hawaii-vascular.com

TESO, DESAROM
PeaceHealth Southwest Medical Ctr.
Vascular Surgery
505 NE 87th Avenue, Bldg. B, Suite 301
Vancouver, WA 98664
360-514-1852
dteso@swmedicalcenter.org

THOMAS, BRADLEY G.
Surgical Care Associates
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139
BThomas76@gmail.com

THOMASON, III, ROBERT B.*
Salem Vascular Specialists
2827 Lyndhurst Avenue, Suite 203
Winston-Salem, NC 27103
336-794-8624
rbthomason@novanthealth.org

THOMPSON, J. KEITH
Hattiesburg Clinic
415 S. 28th Avenue
Hattiesburg, MS 39401
601-264-6000
keiththompson23@hotmail.com

TONNESSEN, BRITT H.
316 Calhoun Street
Charleston, SC 29401
843-720-5665
britttonnessen@gmail.com

TORRES, GUSTAVO A.
Los Angeles Vascular Services
120 S. Montebello Blvd.
Montebello, CA 90640
323-869-0871
gatgus@hotmail.com

TRACCI, MARGARET C.
University of Virginia
Dept. of Surgery
PO Box 800679
Charlottesville, VA 22908-0679
434-243-9493
msc7s@virginia.edu

TRACHTENBERG, JEFFREY D.
Surgical Specialists of Central Illinois
1750 E. Lake Shore Drive, Suite 200
Decatur, IL 62521-3805
217-876-2740
jefftrach@aol.com

TRINIDAD, MAGDIEL
Penrose/St. Francis Medical Center
Vascular Surgery
719-776-6700
dr_magdiel@yahoo.com

TULLIS, MICHAEL J.
St. Luke's Clinic - VeinCare
3277 E. Louise Drive, Suite 150
Boise, ID 83642
208-706-8346
mjtullis@slhs.org

TWENA, MORDECHAI F.
6508 E. Carondelet Drive
Tucson, AZ 85710-2117
520-885-6717

UPTON, BRANDI
Mercy Clinic
Vascular Surgery
2115 S. Fremont, Suite 5000
Springfield, MO 65804
417-820-3960
brandi.upton@mercy.net

*Senior Member

Active Membership Roster

VADDINENI, SARAT K.
Health Care Midwest
Vascular and Endovascular Surgery
601 John Street, Suite 283
Kalamazoo, MI 49007
269-349-7696
vaddineni@msn.com

VALENTIN, MARLENE D.
2809 W. Waters Avenue
Tampa, FL 33614
813-348-9088

VALLABHANENI, RAGHUVEER
University of North Carolina
Division of Vascular Surgery
3024 Burnett-Womack Building
CB 7212
Chapel Hill, NC 27599
919-966-3391
raghuveer_vallabhaneni@med.unc.edu

VARNAGY, DAVID
2501 North Orange Avenue, Suite 402
Orlando, FL 32804
407-303-7250
davidvarnagy@hotmail.com

VEERASWAMY, RAVI K.
101 Woodruff Circle
W5015 WMB
Atlanta, GA 30322
404-727-8413
ravi.veeraswamy@emoryhealthcare.org

VERTA, JR., MICHAEL J.*
Vascular and Interventional Program
25 North Winfield Road, Suite 202
Winfield, IL 60190
630-933-4487
michael.verta@cadencehealth.org

VOGEL, TODD R.
UMDNJ-Robert Wood Johnson Medical School
One Robert Wood Johnson Place
MEB 541
New Brunswick, NJ 08901-1928
732-235-7816

VOGT, PHILIP A.*
1818 N. Meade Street, 240-W
Appleton, WI 54911-3496
920-731-8131
philip.vogt@thedacare.org

WAGMEISTER, ROBERT*
2001 Santa Monica Blvd., Suite 690W
Santa Monica, CA 90404-2124
310-828-5626
rwagmd@aol.com

WAGNER, WILLIS H.*
Willis Wagner
8631 West Third Street, #615-E
Los Angeles, CA 90048
310-652-8132
willis.wagner@cshs.org

WAHLGREN, CARL-MAGNUS
Observatoriegatan 12, 4TR
Stockholm 113 29
Sweden
carl.wahlgren@karolinska.se

WAIN, REESE A.
Thoracic and Cardiovascular Surgery
120 Mineola Blvd., Suite 300
Mineolo, NY 11501
516-633-4400
Rawain@optonline.net

WALTKE, EUGENE A.*
Omaha Vascular Surgery LLC
515 N. 162nd Avenue, Suite 300
Omaha, NE 68118-2540
402-393-6624
ewaltke@radiks.net

WANG, GRACE J.
Hospital of the University of PA
Vascular Surgery
3400 Spruce Street
4 Silverstein Pavilion
Philadelphia, PA 19104
215-662-2069
grace.wang@uphs.upenn.edu

WARREN, II, THOMAS R.
2026 Running Creek Drive
Belton, TX 76513-8240
254-724-2232
tcwarren97@aol.com

*Senior Member

Active Membership Roster

WATERS, HARRIS J.*
Silverton Surgical LLC
450 Welch Street
Silverton, OR 97381
503-932-7164
skibum5050@hotmail.com

WATTENHOFER, SCOTT P.*
Omaha Vascular Specialists
515 N. 162nd Avenue, Suite 300
Omaha, NE 68118-2540
402-393-6624

WEINGARTEN, MICHAEL S.*
Drexel University College of Medicine
245 N 15th Street, M/S 413
Philadelphia, PA 19102
215-762-4005
michael.weingarten@drexelmed.edu

WEISWASSER, JONATHAN M.
Vascular Associates of New Jersey
68 Melrose Place
Montclair, NJ 07042
973-322-7233

WELKIE, JOHN F.*
1259 S. Cedar Crest Blvd. #301
Allentown, PA 18103
610-439-0372

WELLONS, ERIC
Atlanta Vascular Specialists
775 Poplar Road, Suite 260
Newnan, GA 30265
404-524-0095
ewellons@gmail.com

WESTERBAND, ALEX
Northwest Allied Physicians
6060 N. Fountain Plaza, Suite 270
Tucson, AZ 85704
520-229-2578
alexwesterband01@gmail.com

WHITLEY, W. D.
2660 10th Avenue S, Suite 608
Birmingham, AL 35205
205-939-3495
dw6931@yahoo.com

WHITTEN, MATTHEW G.
Mountain Medical Vascular Specialists
5323 S. Woodrow Street, Suite 102
Murray, UT 84107
801-313-4101
matthew.whitten@gmail.com

WIDMEYER, JEFFREY H.
Vein and Cosmetic Solutions
7626 Timberlake Road
Lynchburg, VA 24502
434-847-5347
jhwid@aol.com

WILDERMAN, MICHAEL J.
14 Peter Lynas Ct.
Tenafly, NJ 07670-1115
201-343-0040
michael.wilderman@gmail.com

WILKENS, TODD H.
131 Hospital Road
Jellico, TN 37762
423-784-7269
wilkensth@yahoo.com

WILLIAMS, LARRY R.*
995 16th Street N
St. Petersburg, FL 33705
727-894-4738
drwilliams_630@hotmail.com

WILLIAMS, TIMOTHY K.
1807 Tahoe Place
Davis, CA 95616
707-423-5208
timothykeithwilliams@gmail.com

WILSON, JEFFREY S.
13604 Chapman Reserve Ct.
Tampa, FL 33613-2096
813-977-3607
jwcwilson11@hotmail.com

WINKLER, GABOR A.
3312 Trenton Street
Florence, SC 29501
843-777-7043
gawinkler@mac.com

*Senior Member

Active Membership Roster

WINTER, ROBERT P.*
Florida Vascular Consultants, PA
400 S. Maitland Avenue
Maitland, FL 32751
407-539-2100
Runningdog57@aol.com

WIRTHLIN, DOUGLAS J.
Mountain Medical
5323 S. Woodrow Street, Suite 102
Murray, UT 84107
801-713-1010
douglas_wirthlin@yahoo.com

WITTGEN, CATHERINE M.
St. Louis University Hospital
3635 Vista Avenue
PO Box 15250
St. Louis, MO 63110-0259
314-577-8310
wittgenc@slu.edu

WOO, KAREN
1520 San Pablo Street, Suite 4380
Los Angeles, CA 90033
kwoo@mednet.ucla.edu

WOODY, JONATHAN D.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606-5902
706-549-8306
woody@athensvascular.com

WRIGHT, J. GORDON*
Midwest Vein Center
2001 Butterfield Road, Suite 100
Downers Grove, IL 60515-1590
630-322-9126

WU, TIMOTHY
University of Pittsburgh
Vascular Surgery
200 Lothrop Street, Suite A1011
Pittsburgh, PA 15213
412-802-3333
wut@upmc.edu

WYBLE, JR., CHARLES W.
Vascular Surgical Associates, PC
61 Whitcher Street, Suite 2100
Marietta, GA 30060
770-423-0595
cwyble@vascularsurgical.com

XENOS, ELEFTHERIOS
University of Kentucky
Div. of General Surgery
800 Rose Street, Room C-225
Lexington, KY 40536-0293
859-323-6346
lxenos@yahoo.com

YANCEY, ANDREA E.
University Surgical Associates
Vascular and Endovasc. Therapeutics
401 East Chestnut Street, Suite 710
Louisville, KY 40202
502-583-8303
yanceybates@yahoo.com

YANG, PAUL M.*
North Shore LIJ
130 East 77th Street
Blackhole, 13th Floor
New York, NY 10075
212-434-3420
pyang@nshs.edu

YAVORSKI, CHESTER C.
Surgical Specialists of Wyoming Valley
200 S. River Street
Plains, PA 18705-1143
570-821-1100

YEARY, II, EDWIN C.*
1725 E. 19th Street, 800
Tulsa, OK 74104
918-748-7676

YOLYAPAN, AYKUT
Mugla Devlet Hastanesi
Kalp Ve Damar Cerr
Muslihittin Mah
Mugla 48000
Turkey
op.draykut@hotmail.com

YORK, JOHN W.
SC Associates for Cardiac & Vascular Disease
890 W. Faris Road, Suite 320
Greenville, SC 29605-4281
864-455-6800
jyork@ghs.org

*Senior Member

Active Membership Roster

ZAKHARY, EMAD M.. A.
St. Louis University
3635 Vista Avenue
St. Louis, MO 63110
314-577-8310
zakhare@gmail.com

ZATINA, MICHAEL A.*
Maryland Vascular Associates, LLC
3350 Wilkins Street, #100
BMD 21229
Baltimore, MD 21229
410-646-4888
mzatina@marylandvascular.com

ZAYED, MOHAMED A.
Washington University School of Med.
Division of Vascular Surgery
660 S. Euclid Avenue, Box 8109
St. Louis, MO 63110
314-362-5648
zayedm@wudosis.wustl.edu

ZENNI, GREGORY C.*
Cardiac, Vascular & Thoracic Surgeons
4030 Smith Road, Suite 300
Cincinnati, OH 45209-1974
513-241-3494

ZHOU, WEI
Stanford University
Vascular Surgery
300 Pasteur Drive, H3640
Stanford, CA 94305
650-849-0507
weizhou@stanford.edu

ZIPORIN, SCOTT J.
5719 S. Grant Street
Hinsdale, IL 60521
312-996-8459
ziporins@gmail.com

ZUNIGA, CARLOS
Av. Brigida Silva de Ochoa
181 F-801 San Miguel
Lima L-32
Peru
czl28@hotmail.com

*Senior Member

Geographical Listing of Active Members

ALABAMA
Alabaster
Taylor, Steven

Birmingham
Jordan, Jr., William
Matthews, Thomas
Passman, Marc
Patterson, Mark
Pearce, Benjamin
Quinney, Brent
Whitley, W.

Dothan
Pfeiffer, III, Ralph

Huntsville
Collins, David
Roberts, Rick

Mobile
McPhillips, Frank

Winfield
Manord, Jeffrey

ARKANSAS
Little Rock
Ali, Ahsan
Escobar, Guillermo
Smeds, Matthew

ARIZONA
Flaggstaff
Caparrelli, David

Phoenix
Erickson, Curtis

Scottsdale
Fowl, Richard

Sun City West
Carlon, Douglas

Tucson
Berman, Scott
Hughes, John
Lucas, Layla
Quick, Rhonda
Twena, Mordechai
Westerband, Alex

CALIFORNIA
Arcadia
Kronson, Jeffrey

Belmont
Chandra, Venita

Burlingame
Lin, Stephanie

Daly City
Scribner, Robert

Davis
Noll, Jr., Robert
Sampson, James
Williams, Timothy

Fresno
Hadcock, Jr., William

Glendale
Acosta, Ignacio

La Jolla
Barleben, Andrew
Chandra, Ankur
Lane, III, John
Rayan, Sunil
Sedwitz, Marc

Laguna Hills
Duensing, Robert

Lancaster
Petrik, Pavel

Loma Linda
Abou-Zamzam, Jr., Ahmed
Chiriano, Jason
Sheng, Neha
Teruya, Theodore

Los Angeles
Gelabert, Hugh
Jimenez, Juan
Keushkerian, Simon
Ochoa, Christian
O'Connell, Jessica
Quinones-Baldrich, William
Rowe, Vincent
Wagner, Willis
Woo, Karen

*Senior Member

Geographical Listing of Active Members

Montebello
Torres, Gustavo

Napa
Goldstein, Lawrence
Loftus, John

Orange
Ballard, Jeffrey
Charney, Kim
Fujitani, Roy

Palmdale
Smith, Denise

Rancho Palos Verdes
Donayre, Carlos

Riverside
Kim, Sung

Roseville
Gelfand, Dmitri
Sacramento
Carson, John
Dawson, David
Hedayati, Nasim
Humphries, Misty
Lee, Eugene
Pevec, William

Salinas
Rudo, Neil

San Diego
Angle, Niren
Casey, Kevin
Hodgkiss-Harlow, Kelley
Owens, Erik

San Francisco
Conte, Michael
Desai, Tina
Grenon, Marlene
Groeger, Eugene
Hiramoto, Jade

San Jose
Sorial, Ehab

San Leandro
Gingery, Robert

San Pedro
Ryan, Timothy

Santa Monica
Rigberg, David
Wagmeister, Robert

Sherman Oaks
DeRubertis, Brian

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

Torrance
Marrocco, Christopher

Victorville
Chauvapun, Joe

Woodland
Al-Khatib, Weesam

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

Denver
Annest, Stephen
Fox, Charles
Johnnides, Christopher
Mubarak, Omar
Rehring, Thomas

CONNECTICUT
Bloomfield
Greenwald, Lori

Danbury
Dietzek, Alan

Darien
Gagne, Paul

Easton
Goldstein, Lee

Glastonbury
Bulger, Christopher

Geographical Listing of Active Members

Hartford
Gallagher, James

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

Stratford
Pietropaoli, John

DELEWARE
Wilmington
Ierardi, Ralph

DISTRICT OF COLUMBIA
Washington
Beavers, Frederick
Hughes, Kakra
Shin, Susanna

FLORIDA
Aventura
Johr, Bernardo
Coral Springs
Rosa, Patricio

Ft. Lauderdale
O'Donnell, Sean

Gainesville
Feezor, Robert

Jacksonville
Dennis, James
Ellison, Jr., Robert
Moore, Erin

Jupiter
Cires, Giancarlo

Lutz
Gonzalez, Alberto

Maitland
Adcock, G.
Winter, Robert

Melbourne
Dovgan, Peter
Esemuede, Nowokere
Ramadan, Fuad

Ocoee
Horowitz, John

Orange Park
Rifkin, Kerry

Orlando
Varnagy, David

Pensacola
Harlin, Stuart

Sarasota
Lepore, Jr., Michael

South Miami
Pereda, Juan

St. Petersburg
Almond, Brett
Collins, P.
Williams, Larry

Tallahassee
Brumberg, Robert
Hoyne, Robert

Tampa
Back, Martin
Illig, Karl
Johnson, Brad
Kerr, Thomas
Nelson, Peter
Shafii, Susan
Shames, Murray
Valentin, Marlene
Wilson, Jeffrey

Weston
Grove, Mark
King, Terry

GEORGIA
Albany
Martin, Daniel
Morgan, III, Joe

Athens
Pearce, Jeffrey
Sailors, David
Woody, Jonathan

Geographical Listing of Active Members

Atlanta
Austin, Joseph
Best, Irwin
Corso, J. Eduardo
Duwayri, Yazan
H'Doubler, Jr., Peter
Methodius-Rayford, Walaya
Miller, Jay
Poindexter, Jr., James
Rajani, Ravi
Rheudasil, J. Mark
Ricotta, II, Joseph
Veeraswamy, Ravi

Augusta
Hurd, Aaron
Kauvar, David
Riesenman, Paul

Decatur
Brewster, Luke

Gainesville
Procter, Sr., Charles
Reeves, James

Lawrenceville
Moomey, Jr., Charles

Macon
Schroder, William

Marietta
Wyble, Jr., Charles

Newnan
Wellons, Eric

Savannah
Cohn, Jr., Edward

Tucker
Adeduntan, Azeez

IDAHO
Boise
Matteson, Brian
Tullis, Michael

ILLINOIS
Abbott Park
Schwartz, Lewis

Arlington Heights
Painter, Thomas

Buffalo Grove
Clark, Elizabeth

Chicago
Brown, Katherine
Durham, Joseph
Eskandari, Mark
Hoel, Andrew
Keldahl, Mark
Minc, Samantha
Rodriguez, Heron

Decatur
Trachtenberg, Jeffrey

Downers Grove
Wright, J. Gordon

Hinsdale
Ziporin, Scott

Maywood
Aulivola, Bernadette
Halandras, Pegge
Hershberger, Richard
Milner, Ross

Northfield
Golan, John

Skokie
Gupta, Navyash
Morcos, Omar

Swansea
Neville, Patrick

Winfield
Verta, Jr., Michael

INDIANA
Carmel
Motaganahalli, Raghunandan

Evansville
Patterson, Donald

Geographical Listing of Active Members

Indianapolis
Cikrit, Dolores
Dalsing, Michael
Jacob, Dennis
McCready, Robert
Sawchuk, Alan
Shafique, Shoaib

IOWA
Cedar Rapids
Lawrence, David

Iowa City
Nicholson, Rachael
Sharafuddin, Mel
Sharp, William

West Des Moines
Borromeo, Jose

KANSAS
Wichita
Hutchinson, Steven

KENTUCKY
Lexington
Endean, Eric
Lipscomb, Amy
Minion, David
Newton, Wm.
Stewart, II, John
Xenos, Eleftherios

Louisville
Bergamini, Thomas
George, Jr., Salem
Jung, Matthew
Klamer, Thomas
Lambert, Jr., Glenn
Rachel, Elizabeth
Thomas, Bradley
Yancey, Andrea

LOUSIANA
Baton Rouge
Conners, III, Michael
Guidry, London
McNeil, James
Olinde, Andrew
Perkowski, Paul
Schellack, Jon

Covington
Mena, Jose

Marrero
Batson, Robert
Palit, Tapash

New Iberia
Dauterive, Jr., Edward

New Orleans
Adinolfi, Michael
Bazan, Hernan
Crenshaw, Gregory
Sheahan, Claudie
Sheahan, III, Malachi
Smith, Taylor
Sternbergh, III, W. Charles

Shreveport
Tan, Tze-Woei

MAINE
Bangor
Cambria, Robert
Hart, Joseph
Sherwood, Andrew

Portland
Blazick, Elizabeth

MARYLAND
Annapolis
Stanziale, Stephen

Baltimore
Arnold, Margaret
Black, III, James
Buchbinder, Dale
Freischlag, Julie
Lucas, Paul
Lum, Ying Wei
Malas, Mahmoud
Monahan, Thomas
Zatina, Michael

Bel Air
Gonze, Mark

Bethesda
Rasmussen, Todd

Cockeysville
Parra, Jose
Columbia
Feinberg, Richard

Geographical Listing of Active Members

Crownsville
Deaton, David

Fredrick
McNeill, Paul

Glen Burnie
Neschis, David

Rockville
Salander, James

Sparks
Coll, David

MASSACHUSETTS
Boston
Chaikof, Elliot
Clouse, W. Darrin
Conrad, Mark
Hamdan, Allen
Kansal, Nikhil
Kwolek, Christopher
Nguyen, Louis
Schermerhorn, Marc
Siracuse, Jeffrey

Boylston
Aiello, Francesco

Dartmouth
Pin, Richard

Framingham
Simosa, Hector

Lawrence
Muto, Paula

Long Meadow
Morris, Marvin

North Chelmsford
Burke, Jr., Paul

Springfield
Hirko, Mark
Kaufman, Jeffrey
Maru, Sandip
Rhee, San Won

Wellesley
Iafrati, Mark

Winchester
Breckwoldt, William

Worcester
Robinson, III, William

MICHIGAN
Ada
Mansour, M.

Ann Arbor
Criado, Enrique
Eliason, Jonathan
Osborne, Nicholas

Bingham Farms
Brown, O. William

Detroit
Lin, Judith
Rits, Yevgeniy
Rubin, Jeffrey

Dexter
Coleman, Dawn

Flushing
Shuster, Thomas

Grand Rapids
Chambers, Christopher
Cuff, Robert
Greenberg, Joshua

Kalamazoo
Jain, Krishna
Munn, John
Vaddineni, Sarat

Midland
Mouawad, Nicolas

Northville
Gallagher, Katherine

Petoskey
Kazmers, Andris

Pontiac
Hernandez, Diego

Royal Oak
Shanley, Charles

Geographical Listing of Active Members

Southfield
Nolan, Kevin

Troy
Engle, Jennifer

Ypsilanti
Heidenreich, Michael

MINNESOTA
Duluth
Bunch, Christopher
Eginton, Mark

Edina
Ihnat, Daniel

Minneapolis
Alexander, Jason
Santilli, Steven
Sullivan, Timothy

Rochester
Ballinger, Beth Ann
Bjellum, Karl
Bower, Thomas
DeMartino, Randall
Duncan, Audra
Fleming, Mark
Mensink, Karen
Oderich, Gustavo

MISSISSIPPI
Biloxi
Hogan, Michael

Hattiesburg
Thompson, J. Keith

Jackson
Baldwin, Zachary
O'Mara, Charles
Rushton, Jr., Fred
Smith, Sumona

Vicksburg
Ferris, Eugene

MISSOURI
Jefferson City
Phillips, Victor

Liberty
Deiparine, Michael

Springfield
Schmittling, Zachary
Upton, Brandi

St. Louis
Zayed, Mohamed
Curci, John
Geraghty, Patrick
Jim, Jeffrey
Pennell, Richard
Peterson, Brian
Raman, Kathleen
Sanchez, Luis
Wittgen, Catherine
Zakhary, Emad

MONTANA
Billings
Morasch, Mark

Clinton
O'Brien, Patrick

NEBRASKA
Moncton
Haser, Paul

Omaha
Baxter, B. Timothy
Johanning, Jason
Longo, Gernon
Ramos, Tammy
Waltke, Eugene
Wattenhofer, Scott

Port Elgin
Cole, C. William

NEW HAMPSHIRE
Lebanon
Goodney, Philip
Nolan, Brian

Nashua
Rodriguez, Christian

NEW JERSEY
Camden
Caputo, Francis

Gradell
Geuder, James

Geographical Listing of Active Members

Hackensack
Simonian, Gregory

Monroe Township
Franco, Charles

Montclair
Weiswasser, Jonathan

Morristown
Ombrellino, Michael

New Brunswick
Graham, Alan
Rao, Niranjan
Vogel, Todd

Newark
Curi, Michael
Huang, Joe
Padberg, Jr., Frank

Plainsboro
Goldman, Kenneth

Short Hills
Sales, Clifford

Somers Point
Gosin, Jeffrey
Herrington, James

Tenafly
Wilderman, Michael

Toms River
Haque, Shahid

Trenton
O'Neill, Alissa

Westfield
Levison, Jonathan

NEVADA
Las Vegas
Luh, Eddy

Nellis AFB
Jones, III, Wilmer

NEW MEXICO
Albuquerque
Goff, Jr., James
Ketteler, Erika
Langsfeld, Mark
Marek, John
Rueda, Carlos

NEW YORK
Albany
Chang, Benjamin
Darling, III, R. Clement
Kreienberg, Paul
Mehta, Manish
Ozsvath, Kathleen
Roddy, Sean
Sternbach, Yaron
Taggert, John

Bronx
Greenstein, Stuart
Lipsitz, Evan
Brooklyn
D'Ayala, Marcus
Hingorani, Anil
Rao, Atul

Buffalo
Cherr, Gregory
Dosluoglu, Hasan

Cooperstown
Cooper, Shelby

Fayetteville
Surowiec, Scott

Great Neck
Panetta, Thomas
Purtill, William

Greenlawn
Gennaro, Mark

Hawthorne
Laskowski, Igor

Hudson
Shah, Melissa

Kingston
Hnath, Jeffrey
Saltzberg, Stephanie

Geographical Listing of Active Members

Lake Success
Doscher, William
Frankini, Larry
Schwartz, Mark

Mineolo
Wain, Reese

New Hyde Park
Landis, Gregg

New Rochelle
Karanfillian, Richard

New York
Adelman, Mark
Benvenisty, Alan
Berland, Todd
Bernik, Thomas
Cayne, Neal
Connolly, Peter
Faries, Peter
Fishman, Eric
Garg, Karan
Giangola, Gary
Harrington, Elizabeth
Jacobowitz, Glenn
Lantis, II, John
Lugo, Joanelle
Maldonado, Thomas
Marin, Michael
McKinsey, James
Meltzer, Andrew
Mendes, Donna
Morrissey, Nicholas
Mussa, Firas
Nalbandian, Matthew
O'Connor, David
Rockman, Caron
Schneider, Darren
Shah, Hemal
Tadros, Rami
Yang, Paul

Old Bethpage
Gargiulo, III, Nicholas

Pittsford
Rhodes, Jeffrey

Rochester
Ellis, Jennifer
Fanciullo, Dustin
Geary, Kevin
Glocker, Roan
Riggs, Patrick
Stoner, Michael

Ronkonkoma
Kokkosis, Angela

Roslyn
Rosca, Mihai

Slingerlands
Paty, Philip

Staten Island
Deitch, Jonathan
Schor, Jonathan

Stony Brook
Loh, Shang
Tassiopoulos, Apostolos

Syracuse
Amankwah, Kwame
Costanza, Michael
Gahtan, Vivian
Gonzalez, Lorena

Utica
Lauterbach, Stephen

White Plains
Suggs, William

NORTH CAROLINA
Asheville
Douglas, Michael

Chapel Hill
Farber, Mark
Vallabhaneni, Raghuveer

Charlotte
Arko, III, Frank
Roush, Timothy

Durham
Cox, Mitchell
Mureebe, Leila
Shortell, Cynthia

Fayettville
Roulhac, Maurice

Geographical Listing of Active Members

Gastonia
Eze, Augustine

Granite Falls
Piercy, Kenneth

Greensboro
Dickson, Christopher
Early, Todd

Greenville
Bogey, Jr., William

Lenoir
Purcell, Peter

New Bern
Bell, III, William

Pinehurst
Atkinson, Clinton

Raleigh
Kim, Jason

Winston-Salem
Corriere, Matthew
Edwards, Matthew
Garg, Nitin

Hansen, Kimberley
Hurie, Justin
Thomason, III, Robert

NORTH DAKOTA
Fargo
Bakken, Andrew

OHIO
Chagrin Falls
Poliquin, James

Chillicothe
Jepsen, Stephen

Cincinnati
Giglia, Joseph
Lohr, Joann
Muck, Patrick
Zenni, Gregory

Cleveland
Clair, Daniel
Eagleton, Matthew
Kashyap, Vikram
Kelso, Rebecca
Lyden, Sean
Mastracci, Tara
McLaughlin, Daniel
Park, Woosup
Srivastava, Sunita

Columbus
El-Sayed, Hosam
Franz, Randall
Go, Michael
Haurani, Mounir
Litzendorf, Maria

Dublin
Kulwicki, Aaron

Duncan Falls
Katz, Sherman
Garfield Heights
Alvarez-Tostado, Javier

Holland
Paolini, David

Lancaster
Mannava, Krishna

Marietta
Parmer, Shane

Mayfield Heights
Rizzo, Anthony

Solon
Moise, Mireille

Springfield
Matsuura, John

Toledo
Comerota, Anthony
Nazzal, Munier
Pigott, John
Russell, Todd
Seiwert, Andrew

Geographical Listing of Active Members

Willoughby
Rollins, David
Youngstown
Delatore, Jason
Kollipara, Venkata

Zanesville
Campbell, Jessica

OKLAHOMA
Tulsa
Ma, Harry
Malgor, Rafael
Yeary, II, Edwin

OREGON
Clackamas
Crutchley, Teresa

Portland
Mitchell, Erica

Silverton
Waters, Harris

PENNSYLVANIA
Abington
Sullivan, Theodore

Allentown
Berger, Alan
Goodreau, James
McCullough, Jr., James
Welkie, John

Bellefonte
Simoni, Eugene

Bethlehem
Ivarsson, Bengt
Rosenfeld, Joel

Chambersburg
Guthrie, David

Coopersburg
Guzzo, James
Danville
Elmore, James
Franklin, David

Gibsonia
Singh, Michael

Harrisburg
Razzino, Richard

Hershey
Aziz, Faisal
Han, David
Reed, Amy

Lancaster
Comeau, Jason

New Hope
Eisenberg, Joshua

Newtown Square
Bigatel, David

Philadelphia
DiMuzio, Paul
Wang, Grace
Weingarten, Michael

Pittsburgh
Baril, Donald
Chaer, Rabih
Healy, Dean
Jeyabalan, Geetha
McEnaney, Ryan
Muluk, Satish
Wu, Timothy

Plains
Yavorski, Chester

Roaring Brook Twp
Busuttil, Steven

Sayre
Marica, Silviu
Sampson, Lawrence

West Reading
Brigham, Robert
Jaxheimer, Eric
Wexford
Rhee, Robert

Wilkes-Barre
Obmann, Melissa

Williamsport
Adams, Eric

Geographical Listing of Active Members

York
Harthun, Nancy
Quan, Reagan

PUERTO RICO
Coto Laurel
Martinez, Jorge

San Juan
de Jesus, Gustavo
Joglar, Fernando

RHODE ISLAND
Bristol
Gillespie, David

East Greenwich
Garcia-Toca, Manuel

Providence
Carney, Jr., Wilfred
Marcaccio, Edward
Slaiby, Jeffrey

SOUTH CAROLINA
Charleston
Keefer, Adam
Morrison, Edward
Ruddy, Jean Marie
Tonnessen, Britt

Florence
Stonerock, Charles
Winkler, Gabor

Greenville
Carsten, Christopher
Cull, David
Langan, III, Eugene
York, John

Greenwood
Hobson, John
Lanford, Jeffrey

Rock Hill
Taormina, Martin

Spartanburg
Calton, Jr., William

SOUTH DAKOTA
Rapid City
Orecchia, Paul

TENNESSEE
Alcoa
Reisser, John

Chattanooga
Collins, Jr., John
Joels, Charles
Phade, Sachin
Sprouse, II, Larry

Columbia
Richardson, Jr., James

Franklin
Pulliam, Cary

Hendersonville
Gerdes, Jodi

Jellico
Wilkens, Todd

Knoxville
Akers, Jr., Donald

Nashville
Dattilo, Jeffery
Edwards, Jr., William
Faulk, JimBob
Naslund, Thomas

Oak Ridge
Long, David

TEXAS
Amarillo
Irwin, Chance

Arlington
Senkowsky, F. Jon

Austin
Apple, Jeffrey
Church, Phillip
Seidel, Scott
Stewart, Mark

Belton
Warren, II, Thomas

Boerne
Bowser, Andrew

Geographical Listing of Active Members

Bryan
Bush, Ruth

Dallas
Gable, Dennis
Grimsley, Bradley
Kohn, James
Iam, Russell
Rectenwald, John
Shutze, William
Sundaram, Shankar

Denton
Ortega, Raul

El Paso
Cook, Patrick

Fort Worth
Paladugu, Ramesh

Garland
Stephanian, Edic

Houston
Bechara, Carlos
Bismuth, Jean
Charlton-Ouw, Kristofer
Choi, Lorraine
Coogan, Sheila
Coselli, Joseph
Davies, Mark
Gilani, Ramyar
Huynh, Tam
Kougias, Panos
Lin, Peter
Lumsden, Alan
Mills, Joseph
Moinuddeen, Khaja
Naoum, Joseph
Peden, Eric
Poi, Mun Jye

Humble
Bhatia, Devinder

Huntsville
Bavare, Charudatta

Irving
Sun, Lucy

Missouri City
Barshes, Neal

Nacogdoches
Brown, Lyle
Randel, Mark

San Antonio
Arthurs, Zachary
Davenport, Phyllis
Macris, Demetrios
Peck, Michael
Propper, Brandon
Sheehan, Maureen
Sykes, Mellick
Tamez, Jr., Daniel

Sugar Land
Foteh, Kousta

Temple
Atkins, Marvin
Bohannon, W. Todd

UTAH
Murray
Whitten, Matthew
Wirthlin, Douglas

Provo
Smilanich, Robert

Salt Lake City
Brooke, Benjamin
Goodman, Greg
Kraiss, Larry

South Ogden
Erdoes, Luke

VIRGINIA
Charlottesville
Tracci, Margaret

Chesapeake
Knipp, Brian
Christiansburg
Downing, Lamiere

Lynchburg
Widmeyer, Jeffrey

Geographical Listing of Active Members

Mechanicsville
Brown, Jeff

Richmond
Bosher, L. Paul
Larson, Robert
Levy, Mark

Vienna
Laredo, James

Virginia Beach
Parent, III, F. Noel

Yorktown
Deshmukh, Deepak

WASHINGTON
Bellevue
Ferris, Brian

Bellingham
Sohn, Michelle

Gig Harbor
Daab, Leo
Kreishman, Peter

Milton
Andersen, Charles

Puyallup
Osborne, Jr., Robert

Renton
Kasirajan, Karthik

Seattle
Ciocca, Rocco
Quigley, Terence
Quiroga, Elina
Shalhub, Sherene
Singh, Niten
Starnes, Benjamin
Tang, Gale

Spokane
Rizvi, Adnan

Vancouver
Teso, Desarom

WISCONSIN
Appleton
Vogt, Philip
Green Bay
Hutto, John

Madison
Hoch, John
Tefera, Girma

Milwaukee
Brown, Kellie
Lee, Cheong
Rossi, Peter
Seabrook, Gary

Wauhesha
Schmitt, David

WEST VIRGINIA
Charleston
Stone, Patrick

Bedford Park
Puckridge, Phillip

Geographical Listing of Active Members

AUSTRALIA
St. Leonards
Mohabbat, Walid

CANADA
London, Ontario
De Rose, Guy

Newmarket
Gupta, Deepak

Niagra Falls
Rammohan, Surianarayanan

Ottawa
Harris, Kenneth
Hill, Andrew

Thornhill
Lossing, Alan

Toronto
Huseynova, Khumar

COLOMBIA
Bogota
Molina-Hernandez, Alejandro

FRANCE
Paris
Koskas, Fabien

IRELAND
Galway
Sultan, Sherif

ISRAEL
Jerusalem
Rubinstein, Chen

NETHERLANDS
Utrecht
Moll, Frans

PERU
Lima
Zuniga, Carlos

SWEDEN
Stockholm
Hultgren, Rebecka
Wahlgren, Carl-Magnus

TRINIDAD AND TOBAGO
St. Clair
Maharaj, Dale

TURKEY
Istanbul
Calik, Mustafa

Mugla
Yolyapan, Aykut

United Kingdom
Hull
Chetter, Ian

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.

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.

VESS Bylaws

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

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

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.

VESS Bylaws

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 A nnual 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

W. L. Gore 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

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

Early Career 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

2015 **Ryan McEnaney, MD**
University of Pittsburgh, Pittsburgh, PA
Purinergic Signaling and Arteriogenesis

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
Microarry and Functional Cluster Analysis Implicates Transforming Growth Factor Beta 1 In A Swine Hemorrhagic Shock Model

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

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

2015 Not Awarded In 2015

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 *(continued)*

_____
City State Postal Code Country

_____
Daytime Telephone

Thank you!