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VESS Executive Council 2016 - 2017

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Vascular Surgery Board of the ABS

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Darrin Clouse, MD

AAVS

Tom Maldonado, MD and Peter Nelson, MD

SVS Young Surgeons Advisory

Misty Humphries, MD

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
2016	Park City, UT	Sean P. Roddy, MD

Award History

Year	Award	Recipient
2011	<ul style="list-style-type: none">• Academic Award—Faculty• Academic Award—Fellow• Travel Award	Guillermo A. Escobar, Ann Arbor, MI Bjoern Suckow, MD, Salt Lake City, UT Judith C. Lin, MD, Detroit, MI
2012	<ul style="list-style-type: none">• Academic Award—Faculty• Academic Award—Fellow• Travel Award• Norman M. Rich Military Award	John Curci, MD, St. Louis, MO Kathleen Lamb, MD, Philadelphia, PA Karen Woo, MD, Los Angeles, CA Cpt. Carole Villamaria, MD, Ft. Sam Houston, TX
2013	<ul style="list-style-type: none">• Norman M. Rich Military Award	Cpt. Marlin Wayne Causey, MD, Tacoma, WA
2014	<ul style="list-style-type: none">• Norman M. Rich Military Award• Young Faculty Research Award	Cpt. Daniel Scott, MD, San Antonio, TX Dawn M. Coleman, MD, Ann Arbor, MI
2015	<ul style="list-style-type: none">• Early Career Faculty Research Award• W. L. Gore Travel Award	Ryan McEnaney, MD, Pittsburgh, PA Matthew Mell, MD, Stanford, CA
2016	<ul style="list-style-type: none">• Best Paper Award• W. L. Gore Travel Award	Diego Ayo, MD, New York, NY Justin Hurie, MD, Winston-Salem, NC

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 **Burgess Creek Foyer** at the Steamboat Grand. Registration hours are as follows:

Thursday, February 2	7:00 am – 5:00 pm
Friday, February 3	6:00 am – 9:30 am
	3:00 pm – 6:30 pm
Saturday, February 4	6:00 am – 9:30 am
	3:00 pm – 6:00 pm
Sunday, February 5	6:30 am – 9:30 am

Scientific Sessions

All scientific sessions will be conducted in **Korbel Ballroom** at the Steamboat Grand unless otherwise noted.

Speaker Ready Area

The Speaker Ready Area will be located in a section of the **Burgess Creek Foyer** at the Steamboat Grand. 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 2	7:30 am – 5:30 pm
Friday, February 3	6:30 am – 9:30 am
	3:30 pm – 7:00 pm
Saturday, February 4	6:30 am – 9:30 am
	3:30 pm – 6:00 pm
Sunday, February 5	6:30 am – 9:30 am

Technology Forum

The 2017 Tech Exchange will focus solely on aortic pathology and will showcase some of the best that industry has to offer. In addition to focusing on the endografts themselves, we will also be highlighting some the latest capabilities in medical imaging.

The emphasis of this program is for industry to provide insight into current technology, as well as what the treating physicians may see in the near future as it relates to developments in the pipeline. It will also provide an intensive, hands-on experience in a small group format that provides a granular experience for the participating physicians.

The Technology Forum will be held on **Thursday, February 2, 2017** from **2:30 pm – 5:30 pm** in **Korbel II & III** at the Steamboat Grand Hotel. There is no fee for this forum, but registration is required.

Please Note: This program is not eligible for CME credits.

Round Table Discussions

Friday, February 3, 2017
10:00 am – 12:00 pm

Moderator: Peter Nelson, MD

Grant Writing: For Basic Translational or Clinical/Health Services Research
Jeanie Ruddy, MD

How To Work with the Enemy - Building a Practice in a Hostile Environment
Gabriella Velazquez, MD

When Should I Start Thinking About Getting Promoted?
How Do I Maximize My Chances?
John Rectenwald, MD

Saturday, February 4, 2017
10:30 am – 12:00 pm

Moderator: Peter Nelson, MD

How Do I Engage Industry to Help My Practice?
Justin Hurie, MD

Pitfalls to Avoid in Your First Years of Practice
Matthew Smeds, MD

How to Identify and Work with a Mentor
Kristofer Charlton-Ouw, MD

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 10.50 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:

- Describe changes in the perceptions of vascular training by vascular surgery residents and fellows
- Discuss the management of venous disease
- Describe the indications for and results of intervention, both open and endovascular, for lower extremity arterial disease
- Discuss the indications for and complications of dialysis access
- Discuss the ultrasound, CT, MR, and angiographic findings associate with derangements of the normal vascular system.
- Understand the indications for EVAR and complex EVAR for abdominal aortic aneurysms
- Describe changes in the perceptions of vascular training by vascular surgery residents and fellows
- 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.



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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
Cook Medical
Medtronic
TVA Medical
W. L. Gore & Associates

Notes

Schedule-At-A-Glance

Thursday, February 2, 2017

7:00 am – 5:00 pm	Registration
8:15 am – 12:15 pm	COOK FELLOW LUMINARIES PROGRAM
10:30 am – 11:00 am	Coffee Break
12:30 pm – 1:30 pm	Fellows Lunch
2:00 pm – 2:30 pm	Sponsored Symposium—Boston Scientific
2:30 pm – 5:30 pm	TECHNOLOGY FORUM – DIDACTIC & HANDS-ON
6:00 pm – 7:30 pm	WELCOME RECEPTION All attendees, guests & exhibitors are welcome.

Friday, February 3, 2017

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 Carotid Body Tumor Resection: Just as Safe Without Preoperative Embolization Adel Barkat, Adrienne Cobb, Pegge Halandras, Paul Crisostomo, Bernadette Aulivola - Loyola University Medical Center, Maywood, IL
7:12 am – 7:24 am	2 A National Study Evaluating Hospital Volume and Inpatient Mortality After Open Abdominal Aortic Aneurysm Repair in Vulnerable Populations Andrew A. Gonzalez ¹ , Danielle C. Sutzko ² , Nicholas C. Osborne ² - ¹ University of Illinois at Chicago, Chicago, IL; ² University of Michigan, Ann Arbor, MI
7:24 am – 7:36 am	3 Current Experience and Mid-Term Follow-Up of Immediate Access Arteriovenous Grafts Jason K. Wagner ¹ , Sandra Truong ¹ , Rabih Chaer ¹ , Ellen Dillavou ² , Eric Hager ¹ , Theodore Yuo ¹ , Michel Makaroun ¹ , Efthimios Avgerinos ¹ - ¹ University of Pittsburgh, Pittsburgh, PA; ² Duke University, Durham, NC
7:36 am – 7:48 am	4 Metabolic Syndrome but Not Obesity Adversely Affects Outcomes After Open Aortoiliac Bypass Surgery Alexa Perlick, Charles C. Miller, III, Harleen K. Sandhu, Shaikh Afaq, Hazim J. Safi, Ali Azizzadeh, Kristofer Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

Schedule-At-A-Glance

7:48 am – 7:56 am	5 (CR) Acute Type B Dissection Causing Collapse of EVAR Endograft and Iliac Limb Occlusion Nathan K. Itoga, Tiffany Wu, Michael D. Dake, Ronald L. Dalman, Jason T. Lee - Stanford University, Stanford, CA
7:56 am – 8:04 am	6 (RF) Real World Outcomes Using Arterial Closure Devices Michael C. Scott, Ahsan T. Ali, Mohammed M. Moursi, Guillermo A. Escobar, Lewis C. Lyons, Matthew R. Smeds - University of Arkansas for Medical Sciences, Little Rock, AR
8:04 am – 8:12 am	7 (RF) The BEST-CLI Trial: A Multidisciplinary Effort at Work! Alik Farber ¹ , Kenny Rosenfield ² , Jeff Syracuse ¹ , Cari Reynolds ¹ , Matthew Menard ³ - ¹ Boston Medical Center, Boston, MA; ² Massachusetts General Hospital, Boston, MA; ³ Brigham and Women's Hospital, Boston, MA
8:12 am – 8:24 am	8 Variation in Transfusion Practices and Their Associations with Perioperative Adverse Events in Patients Undergoing Open Abdominal Aortic Aneurysm Repair and Lower Extremity Arterial Bypass in the Vascular Quality Initiative (VQI) Zachary Osborne ¹ , Kristine Hanson ¹ , Benjamin Brooke ² , Marc Schermerhorn ³ , Peter Henke ⁴ , Rumi Faizer ⁵ , Andres Schanzer ⁶ , Philip Goodney ⁷ , Thomas Bower ¹ , Randall DeMartino ¹ - ¹ Mayo Clinic, Rochester, MN; ² University Hospital, Salt Lake City, UT; ³ Beth Israel Deaconess Medical Center, Boston, MA; ⁴ University of Michigan, Ann Arbor, MI; ⁵ University of Minnesota, Minneapolis, MN; ⁶ UMass Memorial Medical Group, Worcester, MA; ⁷ Dartmouth Institute, Hanover, NH
8:24 am – 8:35 am	9 Frailty Increases the Risk of Major Adverse Cardiac Events in Patients with Stable Claudication Melinda S. Schaller, Warren J. Gasper, Nancy K. Hills*, S. Marlene Grenon - University of California, San Francisco, San Francisco, CA
8:35 am – 8:47 am	10 Evaluating the Utilization of Prophylactic Inferior Vena Cava Filters After Trauma Lloyd Jones, Jr. ¹ , Navdeep Samra ¹ , Bo Hu ² , Quyen Chu ¹ , Wayne Zhang ¹ , Tze-Woei Tan ¹ - ¹ Louisiana State University HSC Shreveport, Shreveport, LA; ² Cleveland Clinic, Cleveland, OH
8:47 am – 8:55 am	11 (CR) Gonadal Vein Transposition for the Treatment of Nutcracker Syndrome Eric Shang, Naveen Balasundaram, Woosup M. Park - Cleveland Clinic Foundation, Cleveland, OH

Schedule-At-A-Glance

8:55 am – 9:03 am	12 (RF) Design and Implementation of a Digital Health Platform for Measuring Peripheral Artery Disease Outcomes: The Project VOICE Pilot Study Matthew A. Corriere ¹ , Donna Keith ² , Timothy E. Craven ² , Justin Brothwell Hurie ² , Randolph L. Geary ² , Gabriela Velazquez-Ramirez ² , Matthew S. Edwards ² - ¹ University of Michigan, Ann Arbor, MI; ² Wake Forest University School of Medicine, Winston Salem, NC
10:00 am – 12:00 pm	ROUND TABLE DISCUSSIONS See topics, page 9.
3:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks
4:00 pm – 6:00 pm	SCIENTIFIC SESSION II
4:00 pm – 4:12 pm	13 Prophylactic Groin Wound VAC Therapy? - Evidence for a "Pre-Emptive Strike" in Vascular Surgery Patients at Enhanced Risk for Postoperative Wound Infection Luke Pesonen, Abdulhameed Aziz, Brian Halloran - St. Joseph Mercy Hospital, Ypsilanti, MI
4:12 pm – 4:24 pm	14 Fellows Assessment of Their Training Sheila Blumberg, Anil Hingorani, Amrit Hingorani, Enrico Ascher, Natalie Marks, Eleanor Iadgarova - Total Vascular Care, Brooklyn, NY
4:24 pm – 4:36 pm	15 Outcomes of Tibial Endovascular Intervention in Patients with ESRD on Dialysis Hallie E. Baer-Bositis, Georges M. Haider, Taylor D. Hicks, Lori L. Pounds, Matthew J. Sideman, Mark G. Davies - UT HSC San Antonio, San Antonio, TX
4:36 pm – 4:48 pm	16 Surgical Intervention for Peripheral Artery Disease Does Not Improve Patient Compliance with Recommended Medical Therapy Tyler R. Halle, Jaime Benarroch-Gampel, Victoria Teodorescu, Ravi R. Rajani - Emory University School of Medicine, Atlanta, GA
4:48 pm – 4:56 pm	17 (RF) Anterograde Reperfusion Catheters are Associated with Improved Outcomes Among Patients Who are Undergoing Extra Corporeal Membrane Oxygenation Via Femoral Cannulation Adam C. Ring, Arjun Agrawal, Christoph E. Brehm, John Radtka, David Han, Faisal Aziz - PSU HMC, Hershey, PA

Schedule-At-A-Glance

4:56 pm – 5:04 pm	18 (CR) Fenestrated Plus Sandwiched-Reverse-Snorkel Technique for Endovascular Repair of a Pararenal Abdominal Aortic Aneurysm with Complex Renal Artery Anatomy Perry J. Xu, Mina Boutrous, Donald L. Jacobs - Saint Louis University School of Medicine, Saint Louis, MO
5:04 pm – 5:12 pm	19 (CR) An Innovative Endovascular Technique for Repair of Descending Thoracic Aortic Aneurysm Following an Open Coarctation Repair Pouria Parsa, Anthony Rios, Javier Vasquez, Jr., John Eidt, Dennis Gable - Baylor University Medical Center, Dallas, TX
5:12 pm – 5:24 pm	20 Surveillance Duplex Ultrasound After Carotid Endarterectomy: Contralateral Carotid Stenosis, Restenosis and Cost R. Clement Darling, III, John B. Taggart, Yaron Sternbach, Sean P. Roddy, Paul B. Kreienberg - Albany Medical College, Albany, NY
5:24 pm – 5:36 pm	21 Routine Frailty Assessment During Vascular Surgery Clinic Visits: Easier Than You Might Think Luke G. Mirabelli, Robert M. Cosker, Claire L. Griffin, Brigitte K. Smith, Mark R. Sarfati, Larry W. Kraiss, Benjamin S. Brooke - University of Utah, Salt Lake City, UT
5:36 pm – 5:48 pm	22 Pre-Operative Aspirin and Statin Use Does Not Affect Outcomes After Carotid Endarterectomy Brianna Krafcik, Alik Farber, Robert T. Eberhardt, Jeffrey A. Kalish, Denis Rybin, Gheorghe Doros, Steven Pike, Jeffrey J. Siracuse - Boston University, Boston, MA
5:48 pm – 6:00 pm	23 Validation and Performance of Ruptured Abdominal Aortic Aneurysm Risk Prediction Model Christopher Healey ¹ , Michael Neilson ¹ , David Clark ¹ , Brian Nolan ² - ¹ Maine Medical Center, Portland, ME; ² Dartmouth-Hitchcock Medical Center, Hanover, NH
6:00 pm	VESS MEMBER BUSINESS MEETING
7:15 pm	Free Evening
Saturday, February 4, 2017	
6:00 am – 7:00 am	Continental Breakfast
6:00 am – 9:30 am	Registration

Schedule-At-A-Glance

7:00 am – 9:00 am	SCIENTIFIC SESSION III
7:00 am – 7:12 am	24 Endovascular Optimization of Distal Seal During Stent-Graft Repair of Chronic Type-B Aortic Dissection (TBAD) Mel J. Sharafuddin, Rachael M. Nicholson, Samantha M. Alsop, Maen S. Aboul Hosn, Jeanette H. Man, Justin Walpole - University of Iowa Carver College of Medicine, Iowa City, IA
7:12 am – 7:24 am	25 Long-Term Follow-Up of Tibio-Distal Vein Bypass for Failed Tibial Angioplasty Florian K. Enzmann, Sebastian K. Eder, Patrick Nierlich, Manuela Aspalter, Siegmund Guggenbichler, Werner Dabernig, Thomas J Hölzenbein - PMU Salzburg, Salzburg, Austria
7:24 am – 7:36 am	26 The Current Risk-Benefit Outlook for Endovascular vs. Open Surgical Bifurcated Aortoiliac Arterial Reconstruction Therapy for Aortoiliac Occlusive Disease Tahlia L. Weis, Jean Marie Ruddy, Jacob G. Robison, John W. Hallett, Joshua D. Adams - Medical University of South Carolina, Charleston, SC
7:36 am – 7:48 am	27 Risk Factor Modification Behaviors of Practicing Vascular Surgeons Alexandra P. Bader, Claudia P. Barone, Matthew R. Smeds - University of Arkansas for Medical Sciences, Little Rock, AR
7:48 am – 7:56 am	28 (CR) Indications and Outcomes of Open Inferior Vena Cava Filter Removal Shaikh Afaq, Samuel S. Leake, Harleen K. Sandhu, Naveed U. Saqib, Ali Azizzadeh, Kristofer M. Charlton-Ouw - University of Texas, Houston, TX
7:56 am – 8:04 am	29 (RF) A Novel Off-the-Shelf Technique for Endovascular Repair of Type III and IV Thoracoabdominal Aortic Aneurysms Using the Gore Excluder and Viabahn Branches Mathew Wooster, Paul Armstrong, Murray Shames - University of South Florida, Tampa, FL
8:04 am – 8:12 am	30 (RF) Safety and Effectiveness of Retrograde Arterial Access for Endovascular Treatment of Critical Limb Ischemia (CLI) Danielle Cafasso, Jordan Stern, Peter Connolly, Sharif Ellozy, Darren Schneider, Andrew Meltzer - New York Presbyterian Hospital, New York, NY

Schedule-At-A-Glance

8:15 am – 8:45 am	AWARD SESSION <ul style="list-style-type: none">• Update from 2016 Winner(s)• 2017 Award Winners:<ul style="list-style-type: none">• Gore Travel Award• Medtronic Vascular Resident Research Award• VESS Early Career Faculty Research Award
8:50 am – 9:00 am	Introduction of the President Peter Nelson, MD
9:00 am – 9:45 am	PRESIDENTIAL ADDRESS Thomas Maldonado, MD
10:30 am – 12:00 pm	ROUND TABLE DISCUSSIONS See topics, page 9.
3:00 pm	Registration Re-Opens
3:30 pm – 4:00 pm	Coffee/Snacks
4:00 pm – 6:00 pm	SCIENTIFIC SESSION IV
4:00 pm – 4:12 pm	31 A Ten-Year Experience Using a Hybrid Endovascular Approach to Treat Aberrant Right Subclavian Arterial Aneurysms Mathew Wooster, Martin Back, Danielle Sutzko, Paul Armstrong, Murray Shames - University of South Florida, Tampa, FL
4:12 pm – 4:24 pm	32 Descriptive Analysis of Patients Undergoing Major Lower Extremity Amputation in the Vascular Quality Initiative Joshua Gabel, Brice Jabo, Sharon Kiang, Sheela Patel, Christian Bianchi, Jason Chiriano, Theodore Teruya, Ahmed Abou-Zamzam, Jr. - Loma Linda University, Loma Linda, CA
4:24 pm – 4:36 pm	33 An Accumulated Deficits Model Predicts Perioperative and Long-Term Adverse Events After Carotid Endarterectomy Natalie D. Sridharan, Rabih A. Chaer, Bryan Boyuan Wu, Mohammad H. Eslami, Michel S. Makaroun, Efthymios Avgerinos - University of Pittsburgh, Pittsburgh, PA
4:36 pm – 4:48 pm	34 Greater Compliance Within Instruction-for-Use for Concomitant Iliac Aneurysms and Adverse Aneurysm Characteristics - Initial Experience with the Nellix Endovascular Aneurysm Sealing System (EVAS) at a Single Institution Jeffrey JX Hing, Jack K. Chng, Kiang H. Tay, Tze T. Chong - Singapore General Hospital, Singapore

Schedule-At-A-Glance

4:48 pm – 4:56 pm	35 (RF) Persistent Type II Endoleaks Following Endovascular Aneurysm Repair: Graft Type Matters Cheong J. Lee, Al'haji Camara, Peter J. Rossi, Max Wohlaue, Kellie R. Brown, Brian Lewis, Robert Hieb, Parag J. Patel - Medical College of Wisconsin, Milwaukee, WI
4:56 pm – 5:04 pm	36 (CR) Utility and Limitations of Smartphone App Technology for Wound Monitoring Following Vascular Surgery: A Case Series Graham Donald, Julie Beckstrom, Luke Mirabelli, Benjamin Brooke - University of Utah, Salt Lake City, UT
5:04 pm – 5:12 pm	37 (RF) Changes in Geometry and Cardiac Deformation of the Thoracic Aorta After TEVAR Kelsey E. Hirotsu ¹ , Ga-Young Suh ² , Jason T. Lee ² , Michael D. Dake ² , Dominik Fleischmann ² , Christopher P. Cheng ² - ¹ Stanford University School of Medicine, Stanford, CA; ² Stanford University, Stanford, CA
5:12 pm – 5:24 pm	38 Toe Pressures are Superior to Duplex Parameters in Predicting Wound Healing Following Toe and Foot Amputations Patrick Stone - WVU Charleston, Charleston, WV
5:24 pm – 5:36 pm	39 Temporal Trends and Determinants of Inpatient Versus Outpatient Dialysis Access Operations: Is There an Effect on Perioperative Outcomes? Caitlin W. Hicks ¹ , Michael R. Bronsert ² , Karl E. Hammermeister ² , William G. Henderson ² , James H. Black, III ¹ , Natalia O. Glebova ² - ¹ Johns Hopkins Medical Institutes, Baltimore, MD; ² University of Colorado, Aurora, CO
5:36 pm – 5:48 pm	40 Superior 3-Year Value of Open and Endovascular Repair of AAA with High Volume Providers Antoinette Esce, Ankit Medhekar, Fergal Fleming, Katia Noyes, Roan J. Glocker, Jennifer L. Ellis, Kathleen G. Raman, Michael C. Stoner, Adam J. Doyle - University of Rochester School of Medicine and Dentistry, Rochester, NY
5:48 pm – 5:56 pm	41 (RF) Most Early Type 1A Endoleaks After EVAR Will Resolve Without Secondary Intervention Thomas FX O'Donnell, Michael R. Corey, Sarah E. Deery, Gregory Tsougranis, Rohit Maruthi, William D. Clouse, Richard P. Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

Schedule-At-A-Glance

5:56 pm – 6:04 pm	42 (RF) Cost-Effectiveness Analysis of Drug Coated Balloon vs. Drug Eluting Stent in the Superficial Femoral Artery Natalie D. Sridharan, Aureline Boitet, Kenneth Smith, Kathy Noorbakhsh, Efthymios Avgerinos, Mohammad H. Eslami, Michel Makaroun, Rabih Chaer - University of Pittsburgh, Pittsburgh, PA
7:00 pm – 10:00 pm	PRESIDENT'S DINNER
Sunday, February 5, 2017	
6:30 am – 7:00 am	Continental Breakfast
6:30 am – 9:30 am	Registration
7:00 – 9:15 am	SCIENTIFIC SESSION V
7:00 am – 7:12 am	43 Elevated Wall Tension Initiates Interleukin-6 Expression and Abdominal Aortic Dilation Adam Akerman, Robert Stroud, Elizabeth Nadeau, Katherine Owen, Rupak Mukherjee, John Ikonomidis, Jeffrey Jones, Jean Marie Ruddy - Medical University of South Carolina, Charleston, SC
7:12 am – 7:24 am	44 Using Modified Frailty Index as a Screening Tool to Predict Adverse Outcomes After Lower Extremity Open Revascularization Tarik Ali, Erik Lehman, Faisal Aziz - Penn State University, Hershey, PA
7:24 am – 7:36 am	45 Diabetes and Poor Runoff Predict Late Major Amputation After Percutaneous Intervention for Claudication Kara J. Kennedy, William Darrin Clouse, Emel Ergul, Virendra I. Patel, Glenn M. LaMuraglia, Richard P. Cambria, Mark Conrad - Massachusetts General Hospital, Boston, MA
7:36 am – 7:48 am	46 Outcomes of Mechanical Thrombectomy in Conjunction with Thrombolysis in the Treatment of Acute Limb Ischemia Sagar S. Gandhi, Alex Ewing, Bruce Gray - Greenville Health System, Greenville, SC
7:48 am – 7:56 am	47 (RF) Predictive and Prognostic Risk Factors of Renal Failure in Acute Aortic Dissection Samuel Leake, Harleen K. Sandhu, Hazim J. Safi, Anthony L. Estrera, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

Schedule-At-A-Glance

7:56 am – 8:04 am	48 (RF) Novel Application of Branched Endograft for Preservation of Pelvic Circulation Roy Miller ¹ , Patrick Sowa ² , Matthew Eagleton ¹ , Frederico Parodi ¹ - ¹ Cleveland Clinic, Cleveland, OH; ² Chicago Medical School, Chicago, IL
8:04 am – 8:16 am	49 Successful Use of Endovascular Aortic Sealing (EVAS) for Treatment of Aortic Rupture in a Porcine Model Brandon W. Propper, Shaun M. Gifford, Sean Hislop, Zachary M. Arthurs - San Antonio Military Medical Center, San Antonio, TX
8:16 am – 8:28 am	50 Left-Sided Varicocele as a Rare Presentation of May-Thurner Syndrome Jordan R. Stern ¹ , Virendra I. Patel ² , Danielle E. Cafasso ¹ , Nicole B. Gentile ¹ , Andrew J. Meltzer ¹ - ¹ New York-Presbyterian Hospital, Weill Cornell Medicine, New York, NY; ² Massachusetts General Hospital, Boston, MA
8:28 am – 8:40 am	51 The Impact of Arch Involvement in Acute Type B Aortic Dissection Hunter M. Ray, Kristofer M. Charlton-Ouw, Anthony L. Estrera, Charles C. Miller, Hazim J. Safi, Ali Azizzadeh - University of Texas Medical School at Houston, Houston, TX
8:40 am – 8:52 am	52 Positive Impact of an Aortic Center Designation Adam Tanious ¹ , Marcello Giarelli ² , Murray Shames ¹ - ¹ University of South Florida, Tampa, FL; ² Tampa General Hospital, Tampa, FL
8:52 am – 9:04 am	53 Coronary Artery Calcium Scoring: Role in Screening for Vascular Disease? William E. Raible, III, Yaron Sternbach, Alexander Kryszuk, Lance Sullenberger, Courtney R. Warner, Jeffrey H. Hnath, Sean P. Roddy, R. Clement Darling, III - Albany Medical Center, Albany, NY
9:15 am	Annual Meeting Adjourns

Notes

Full Program & Abstracts

Thursday, February 2, 2017

7:00 am – 5:00 pm	Registration
8:15 am – 12:15 pm	COOK FELLOW LUMINARIES PROGRAM <i>Location: Burgess Creek</i>
10:30 am – 11:00 am	Coffee Break <i>Location: Burgess Creek Foyer</i>
12:30 pm – 1:30 pm	Fellows Lunch <i>Location: Burgess Creek Foyer</i>
2:00 pm – 2:30 pm	Sponsored Symposium—Boston Scientific
2:30 pm – 5:30 pm	TECHNOLOGY FORUM – DIDACTIC & HANDS-ON <i>Location: Korbel II & III</i>
6:00 pm – 7:30 pm	WELCOME RECEPTION <i>Location: Korbel I</i>

All attendees, guests & exhibitors are welcome.

Friday, February 3, 2017

6:00 am – 7:00 am	Continental Breakfast <i>Location: Korbel Ballroom Foyer</i>
6:00 am – 9:30 am	Registration <i>Location: Burgess Creek Foyer</i>
7:00 am – 9:15 am	SCIENTIFIC SESSION I <i>Location: Korbel Ballroom</i>
7:00 am – 7:12 am	1 Carotid Body Tumor Resection: Just as Safe Without Preoperative Embolization Adel Barkat, Adrienne Cobb, Pegge Halandras, Paul Crisostomo, Bernadette Aulivola - Loyola University Medical Center, Maywood, IL

INTRODUCTION AND OBJECTIVES: Carotid body tumors (CBT) are rare entities. Surgical resection remains the gold standard for treatment. Given the vascularity, preoperative embolization may be used with the intent to minimize complications. Controversy exists over whether this is of any benefit. Proponents of embolization argue that embolization minimizes blood loss and complications. Critics argue that cost and stroke risk outweigh benefits. This study aimed to investigate the impact of embolization on outcomes following CBT resection.

METHODS: Patients undergoing CBT resection were identified using Healthcare Cost and Utilization Project State Inpatient Database (HCUP-SID) for 5 states 2006-2013. Patients were divided into two groups: tumor resection alone (CBTR) and embolization prior to resection (CBETR). Descriptive statistics were calculated using arithmetic means

Full Program & Abstracts

with standard deviations for continuous and proportions for categorical variables. Risk-adjusted odds of mortality, stroke, nerve injury, blood loss and length of stay (LOS) were calculated using mixed-effects regression models with fixed effects for age, race, sex, and comorbidities.

RESULTS: A total of 547 patients were identified. Of these, 472 underwent CBTR and 75 underwent CBETR. Nineteen underwent carotid reconstruction at the time of resection, of which 2 underwent embolization. Mean age was 54.7 ± 16 years. Male:female ratio was 1:2. Mean number of days between embolization and resection was 0.65 ± 0.72 , (range 0-3) days. There was no significant difference in age, sex, race or comorbidities. There was no significant difference between CBTR and CBETR in mortality (0.21% vs. 0% $p=0.69$), stroke (4.03% vs. 4.00% $p=0.99$), nerve injury (0.21% v 0% $p=0.69$), or blood loss (4.03% vs. 6.67% $p=0.3$). Following risk adjustment, LOS was significantly shorter in CBTR vs. CBETR (3.1 ± 3.7 vs. 5.8 ± 5.8 days $p=0.001$).

CONCLUSIONS: Carotid body tumor resection is a relatively rare procedure with varying degrees of difficulty. Across disciplines the utility of preoperative tumor embolization has been questioned. This study demonstrates no benefit of preoperative tumor embolization.

Full Program & Abstracts

7:12 am – 7:24 am

2

A National Study Evaluating Hospital Volume and Inpatient Mortality After Open Abdominal Aortic Aneurysm Repair in Vulnerable Populations

Andrew A. Gonzalez¹, Danielle C. Sutzko², Nicholas C. Osborne² - ¹University of Illinois at Chicago, Chicago, IL; ²University of Michigan, Ann Arbor, MI

INTRODUCTION AND OBJECTIVES: Many studies have demonstrated that vulnerable populations, including Blacks and low socioeconomic status (SES) patients, have higher post-operative mortality. Similarly, a large body of evidence documents a volume-outcome effect with abdominal aortic aneurysm (AAA) repair. We sought to investigate whether the volume-outcome effect is experienced differently by these vulnerable populations.

METHODS: We performed a cross-sectional retrospective cohort study evaluating 66,785 Medicare fee-for-service beneficiaries undergoing open AAA repair across 2,295 hospitals between 2003 and 2008. We selected, a priori, low-SES and Black race as vulnerable populations based upon previous reports showing each is independently associated with higher mortality. First we divided hospitals into quintiles of procedural volume. Next, we used logistic regression to calculate risk-adjusted rates of inpatient mortality for Blacks, Whites, high-SES and low-SES patients. Finally, we evaluated mortality across quintiles of procedural volume for each group.

RESULTS: Overall, patients treated in the lowest volume hospitals (LVHs) had higher risk-adjusted inpatient mortality compared to patients treated in the highest volume hospitals (HVHs) (10.17% vs. 4.67%, $p < 0.001$). Higher mortality was associated with Blacks versus Whites (6.22% vs. 5.23%, $p < 0.001$), and low-SES versus high-SES (5.52% vs. 5.06% $p < 0.001$). There were markedly larger differences in mortality between LVH and HVH for Blacks and low-SES patients as compared to Whites and high-SES patients. The adjusted odds ratio (aOR) for mortality in LVHs vs HVHs was 1.91 for Whites (95% confidence interval [CI] 1.40-2.60); 4.86 for Blacks (95% CI 2.40-9.86); 2.27 for high-SES (95% CI 1.43-3.59); and 2.42 for low-SES (95% CI 1.45-4.02).

CONCLUSIONS: While a volume-outcome effect was observed in all patients, Blacks and low-SES patients appeared to derive greater benefit from undergoing open AAA repair at high volume centers. The mechanism underlying these disparate outcomes remains unclear, but warrants further evaluation of potential contributing hospital or patient factors.

Full Program & Abstracts

7:24 am – 7:36 am

3

Current Experience and Mid-Term Follow-Up of Immediate Access Arteriovenous Grafts

Jason K. Wagner¹, Sandra Truong¹, Rabih Chaer¹, Ellen Dillavou², Eric Hager¹, Theodore Yuo¹, Michel Makaroun¹, Efthimios Avgerinos¹ - ¹University of Pittsburgh, Pittsburgh, PA; ²Duke University, Durham, NC

INTRODUCTION AND OBJECTIVES: The placement of immediate-access arteriovenous grafts (IAAVGs) is intriguing as a means of reducing or avoiding catheter use for dialysis. New IAAVGs are currently available with limited independent experience published. The purpose of this study was to assess the real-world performance of IAAVGs at a large tertiary referral center.

METHODS: Between January 2014 and April 2016 all consecutive patients who underwent placement of Acuseal (W. L. Gore, Flagstaff, AZ) or Flixine (Maquet, Wayne, NJ) IAAVGs were retrospectively identified from the electronic medical record and the VQI database. Primary, primary-assisted and secondary patency rates, time to first cannulation, time to tunneled catheter removal and overall survival were recorded.

RESULTS: Forty-three patients (mean age 61.2 ± 16.95 years, 57% male) underwent placement of IAAVG, 31 Acuseal (72%) and 12 Flixine (28%). Of the Acuseal cohort, seven were implanted with outflow through a HeRO catheter system (Merit Medical, South Jordan, UT). Mean follow-up time was 8.4 ± 8.2 months. Overall primary, primary assisted, and secondary patency at 12 and 18 months were 40% and 33.4%, %, 41.17% and 34.3%, 58.32% and 51.0%, respectively. 83% of grafts were successfully cannulated, and 78% of pre-existing catheters were removed. Mean time to successful graft cannulation and catheter removal were 14.85 ± 19.4 and 32.26 ± 28.5 days respectively. Within 1 week of placement, 41% of grafts were successfully accessed and 26% of TDCs were removed. No access related hematomas or infections occurred. Overall patient survival was 57.4% at 18 months.

CONCLUSIONS: IAAVGs facilitate uncomplicated early cannulation with reasonable mid-term patency. However, relatively delayed graft cannulation and prolonged catheter dwell times persist. Further study of methods for promoting early cannulation and catheter removal in this patient population is warranted.

Full Program & Abstracts

7:36 am – 7:48 am

4

Metabolic Syndrome but Not Obesity Adversely Affects Outcomes After Open Aortoiliac Bypass Surgery

Alexa Perlick, Charles C. Miller, III, Harleen K. Sandhu, Shaikh Afaq, Hazim J. Safi, Ali Azizzadeh, Kristofer Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

INTRODUCTION AND OBJECTIVES: To examine the effect of the so-called “obesity paradox” and metabolic syndrome on outcomes after open aortoiliac bypass surgery.

METHODS: All patients between 2003-2015 who had open surgical aortoiliac bypass for arterial occlusive disease were analyzed. Metabolic syndrome was defined by WHO criteria: diabetes and 2 or more of dyslipidemia, coronary disease, hypertension, and obesity ($BMI \geq 30$). Data were analyzed by stratified Kaplan-Meier and multiple Cox regression.

RESULTS: We performed 158 open bypass procedures during the study period with a 1:1.43 female-male ratio, mean age: 61 ± 11.5 years and mean glomerular filtration rate (GFR) of 83 ± 42 . 27% had metabolic syndrome (Table-1). 12 patients were obese but did not have metabolic syndrome. Reintervention-free survival for the entire cohort was 72% at 1-year, 67% at 2-years and 63% at 3-years. In those with and without metabolic syndrome, reintervention-free survival at years 1, 2 and 3 was 65%, 58% and 49% vs. 74%, 70% and 67%, respectively ($p < 0.03$). In multivariable analyses (table-2), metabolic syndrome (HR 1.8, $p < 0.027$) and baseline GFR (HR 2.1 for $GFR < 70$, $p < .002$) were the only predictors of reintervention-free survival. No differences were observed with obesity ($p = .58$) or any individual component comprising metabolic syndrome.

CONCLUSIONS: These results support the “obesity paradox” stating that obesity by itself is not a risk factor for reintervention/mortality after open aortoiliac-bypass surgery. Although the individual components do not predispose to worse outcome, metabolic syndrome is a constellation of factors that together are associated with adverse reintervention-free survival rates.

Full Program & Abstracts

Variable	Total (N=158)	Met (N=42)	No-Met (N=116)	p
Female	65 (41.1%)	18 (42.9%)	47 (40.5%)	0.855
Obese	25 (15.8%)	13 (30.9%)	12 (10.3%)	0.003
GFR<70	62 (39.7%)	18 (42.9%)	44 (37.9%)	0.585
*Thrombectomy	23 (14.6%)	9 (21.4%)	14 (12.1%)	0.199
*Endarterectomy	82 (51.9%)	21 (50.0%)	61 (52.6%)	0.774
*Angioplasty	29 (18.4%)	9 (21.4%)	20 (17.2%)	0.548
*Bypass	158 (100.0%)	42 (100.0%)	116 (100.0%)	1.0
Aortoiliac	3 (1.9%)	0 (0.0%)	3 (2.6%)	0.566
Aortofemoral	8 (5.1%)	2 (4.8%)	6 (5.2%)	0.649
Femoral-Femoral	20 (12.7%)	6 (14.3%)	14 (12.1%)	0.787
Axillobifemoral	8 (5.7%)	2 (4.8%)	6 (5.2%)	1.000
Axillofemoral	3 (1.9%)	3 (7.1%)	0 (0.0%)	0.018
Aortobiliac	1 (0.6%)	1 (2/4%)	0 (0.0%)	0.266
Aortobifemoral	109 (69.0%)	24 (57.1%)	85 (73.1%)	0.079
Femoral-Popliteal	12 (7.6%)	4 (9.5%)	8 (6.9%)	0.399
Other	10 (6.3%)	5 (11.9%)	5 (4.3%)	0.129
Revision	7 (4.43%)	2 (4.8%)	5 (4.3%)	1.000
Redo	26 (16.5%)	5 (11.9%)	21 (18.1%)	0.469
Aortobifemoral**	7 (4.4%)	0 (0.0%)	7 (6.0%)	
Femoral-Popliteal**	3 (1.9%)	1 (2.4%)	2 (1.7%)	
Femoral-Femoral**	1 (0.6%)	0 (0.0%)	1 (0.9%)	
Axillobifemoral**	1 (0.6%)	1 (2.4%)	0 (0.0%)	
Excision**	16 (10.1%)	2 (4.8%)	14 (12.1%)	

Full Program & Abstracts

Analysis of Maximum Likelihood Estimates

Parameter	DF	Parameter Estimate	Standard Error	Chi-Square	Pr > ChiSq	Hazard Ratio
Metabolic Syndrome	1	0.55910	0.24709	5.1200	0.0237	1.749
Baseline GFR < 60	1	0.72317	0.23383	9.5646	0.0020	2.061

Full Program & Abstracts

7:48 am – 7:56 am

5 (CR)

Acute Type B Dissection Causing Collapse of EVAR Endograft and Iliac Limb Occlusion

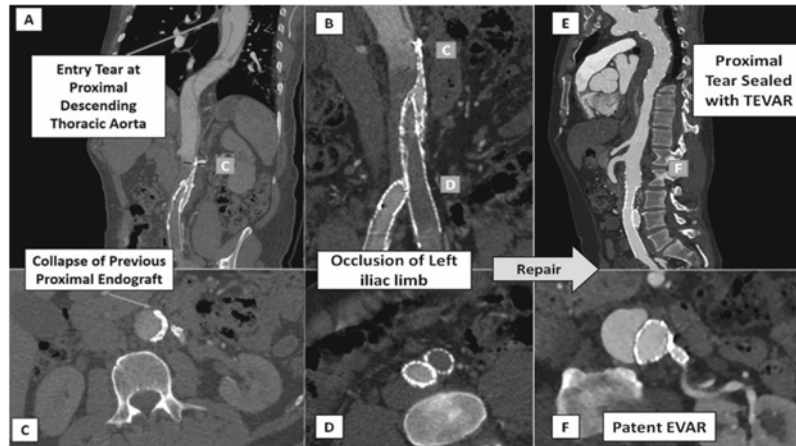
Nathan K. Itoga, Tiffany Wu, Michael D. Dake, Ronald L. Dalman, Jason T. Lee - Stanford University, Stanford, CA

INTRODUCTION AND OBJECTIVES: Lower extremity malperfusion can occur in up to 40% of patients with complicated type B aortic dissections. We describe a rare case of acute type B dissection causing collapse of a previously placed infrarenal stent-graft, resulting in acute limb ischemia due to left iliac limb thrombosis.

METHODS: A 59-year-old male with prior endovascular repair of a 4cm iliac aneurysm with an infrarenal EVAR device and hypogastric embolization presented with acute back and abdominal discomfort radiating to his back, bilateral buttock stabbing discomfort, and left > right thigh and calf rest pain. CT-A showed spiral type B dissection with collapse of the proximal portion of the EVAR device and left limb occlusion (FIGURE A-D).

RESULTS: Urgent treatment with TEVAR distal to the left subclavian covered the entry tear and redirected the majority of the flow to the true lumen. This led to near immediate expansion of the proximal portion of the EVAR device. After surgical femoral control, a balloon embolectomy of the occluded iliac limb was performed and the limb was re-lined. His lower extremity ischemic symptoms resolved and his abdominal and back pain dissipated. At latest 6 month follow-up, CT-A shows an intact TEVAR stent-graft and a widely patent EVAR stent-graft and the patient has no further abdominal, back, or leg symptoms (FIGURE E-F).

CONCLUSIONS: Acute type B dissection causing proximal abdominal EVAR collapse is an extremely rare presentation of false lumen pressurization and can be treated similarly to complicated type B dissection with the goal of restoring true lumen patency.



Full Program & Abstracts

7:56 am – 8:04 am

6 (RF)

Real World Outcomes Using Arterial Closure Devices

Michael C. Scott, Ahsan T. Ali, Mohammed M. Moursi, Guillermo A. Escobar, Lewis C. Lyons, Matthew R. Smeds - University of Arkansas for Medical Sciences, Little Rock, AR

OBJECTIVE: Vascular closure devices have been used to achieve hemostasis of percutaneous access sites following endovascular procedures, with reported decreased time for arterial control as well as decreased time to ambulation. We sought to determine real world rates and risk factors of postoperative bleeding complications and failures using these devices.

METHODS: All patients undergoing arterial endovascular procedures with percutaneous access between March 2010 and October 2015 at a single institution were identified and analyzed (n=894). Patients undergoing EVAR, open access, venous procedures, or upper extremity access were excluded. Comparison groups were formed between those using the Mynxgrip®, Angioseal™, Perclose® vascular closure devices and manual pressure. Patient demographics, intraoperative data, and postoperative complications were compared.

RESULTS: 615 (69%) patients received Mynxgrip, 123 (14%) Perclose, 44 (4%) Angioseal, and 112 (13%) manual pressure. Closure devices were more commonly used in cases in which greater than 5F sheaths were used ($p < .05$). There was no difference in complications between devices ($p = .94$), with a total of 56 (6.3%) patients having a bleeding complication and 9 (1%) returning to the OR as a result. Factors associated with bleeding complication included increased age ($p = .0006$), procedure more than diagnostic angiogram ($p = .005$), and end stage renal disease ($p = .04$). Device failure occurred in 35/782 (4.5%) vascular closure device deployments, with no difference between device type ($p = .63$). 4/35 device failure patients developed bleeding complications and none required operative repair.

CONCLUSIONS: Use of vascular closure devices has a low rate of bleeding complication, device failure and need for operative repair. Bleeding is associated with increased age, interventional procedure, and end stage renal disease. Mynxgrip, Perclose, and Angioseal have similar rates of complications. Use of these devices are a safe option for groin vessel closure.

Full Program & Abstracts

8:04 am – 8:12 am

7 (RF)

The BEST-CLI Trial: A Multidisciplinary Effort at Work!

Alik Farber¹, Kenny Rosenfield², Jeff Siracuse¹, Cari Reynolds¹, Matthew Menard³ - ¹Boston Medical Center, Boston, MA; ²Massachusetts General Hospital, Boston, MA; ³Brigham and Women's Hospital, Boston, MA

OBJECTIVE: We evaluated the participants in the Best Endovascular versus Surgical Therapy in Critical Limb Ischemia (BEST-CLI) trial to assess the specialty and geographic distribution of investigators and correlate multidisciplinary participation with enrollment.

METHODS: BEST-CLI is a prospective, NHLBI-sponsored, pragmatic, randomized, controlled trial that aims to compare treatment efficacy, functional outcomes and cost for patients with CLI and infrainguinal peripheral arterial disease undergoing best open surgical versus best endovascular revascularization. A significant ongoing effort has been exerted to involve all specialties treating CLI in the trial, including interventional cardiologists (IC), interventional radiologists (IR), vascular medicine specialists (VM) and vascular surgeons (VS), and to encourage cross-specialty collaboration. The centerpiece of this inter-disciplinary engagement has been the creation of site-specific CLI teams. The specialty make-up and geographic distribution of trial sites was queried from the trial database and the proportion of subjects enrolled was determined based on data collected from August 28, 2014 through September 8, 2016.

RESULTS: 128 of the 139 sites originally activated are open for enrollment as of September 8, 2016. The geographic distribution of sites include: Northeast (23.4%), Midwest (21.1%), South (24.2%), West (25%) with smaller numbers from Canada (6.3%). Current investigators include 126 IC, 115 IR, 7 VM and 563 VS. Site specialty complement includes 16% of sites with VS, IC and IR; 20% of sites with VS and IR; 31% of sites with VS and IC; 27% of sites with VS alone; and 5% of sites with VM in combination with other specialties. As of this communication, 692 of targeted 2100 patients have been enrolled into the trial: 77% from multidisciplinary sites and 23% from single specialty sites.

CONCLUSIONS: Sites participating in the BEST-CLI trial are evenly distributed across the United States and Canada. All involved specialties are actively enrolling patients into the trial.

Full Program & Abstracts

8:12 am – 8:24 am

8

Variation in Transfusion Practices and Their Associations with Perioperative Adverse Events in Patients Undergoing Open Abdominal Aortic Aneurysm Repair and Lower Extremity Arterial Bypass in the Vascular Quality Initiative (VQI)

Zachary Osborne¹, Kristine Hanson¹, Benjamin Brooke², Marc Schermerhorn³, Peter Henke⁴, Rumi Faizer⁵, Andres Schanzer⁶, Philip Goodney⁷, Thomas Bower¹, Randall DeMartino¹ - ¹Mayo Clinic, Rochester, MN; ²University Hospital, Salt Lake City, UT; ³Beth Israel Deaconess Medical Center, Boston, MA; ⁴University of Michigan, Ann Arbor, MI; ⁵University of Minnesota, Minneapolis, MN; ⁶UMass Memorial Medical Group, Worcester, MA; ⁷Dartmouth Institute, Hanover, NH

INTRODUCTION: Blood transfusions are associated with adverse events. We examined perioperative transfusion practices and associated complications following open vascular procedures nationwide in the Vascular Quality Initiative (VQI).

METHODS: Adults undergoing open abdominal aortic aneurysm repair (OAAA) and lower extremity arterial bypass (LEAB) within VQI (2003-2016) were identified. All emergent cases, patients with pre-operative hemoglobin <7 g/dL, pre-operative hospitalization >1 day, or a return to OR during the index hospitalization were excluded. Units of red blood cells transfused was the primary outcome. Secondary outcomes were post-operative MI and death. Patient, center and procedural factors were evaluated. Multivariable mixed effects negative binomial regression and multivariable logistic regression were performed.

RESULTS: We identified 24,131 procedures (OAAA 3885, 16.1%; bypass 20,246, 83.9%) among 22,532 patients (10.1% had >1 procedure). Overall, 37.5% of OAAA and 19.5% of LEAB were transfused. Transfusion rates varied across EBL quartiles and across various pre-operative hemoglobin levels. The overall rate of post-operative MI and death was 4.0% and 1.8% for OAAA; while 2.2% and 0.7% for bypass, respectively. In univariate and multivariable analysis was conducted, transfusions were associated with an increased risk of post-operative MI and death (Table 1). A mixed effects negative binomial model demonstrated variation in transfusions across centers ($p < 0.001$). Female gender, and preoperative anemia were significantly associated with transfusions (Table 2).

CONCLUSIONS: Blood transfusions are variable across centers in VQI. Transfusions are associated with a higher post-operative MI and death after OAAA and LEAB. Efforts to reduce transfusion may focus on center variability, gender and pre-operative anemia.

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Table 1. Univariate and Multivariable Analysis of Transfusion and Post-Operative MI and Mortality

Univariate Analysis				
Procedure	Total Pts	No Transfusion	Transfusion	p-value
OAAA	3,885 pts			
MI	157 (4.0%)	63 (2.6%)	94 (6.5%)	<0.001
Death	70 (1.8%)	16 (0.7%)	54 (3.7%)	<0.001
LEAB	20,246 pts			
MI	451 (2.2%)	158 (1.0%)	293 (7.4%)	<0.001
Death	133 (0.7%)	51 (0.3%)	82 (2.1%)	<0.001
Multivariable Analysis				
	Odds Ratio			
MI	Per unit transfused	95% CI lower	95% CI higher	p-value
OAAA	1.2	1.1	1.2	<0.001
LEAB	1.3	1.2	1.4	<0.001
Death				
OAAA	1.3	1.2	1.4	<0.001
LEAB	1.3	1.3	1.4	<0.001

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Table 2. Negative Binominal Model of Units of PRBC Transfused

Negative Binomial Model					
OAAA		Incidence rate ratio	Lower CI (95%)	Higher CI (95%)	p-value
	Pre-Op Hgb				
	12+	1			
	10 to < 12	1.91	1.63	2.23	<0.001
	<10	2.47	1.84	3.31	<0.001
	Unknown	0.12	0.05	0.28	<0.001
	Female (vs. Male)	1.40	1.23	1.60	<0.001
LEAB					
	Pre-Op Hgb				
	12+	1			
	10 to <12	2.12	1.96	2.29	<0.001
	<10	4.01	3.60	4.46	<0.001
	Unknown	1.50	1.03	2.20	0.04
	Female (vs. Male)	1.46	1.36	1.56	<0.001

Full Program & Abstracts

8:24 am – 8:35 am

9

Frailty Increases the Risk of Major Adverse Cardiac Events in Patients with Stable Claudication

Melinda S. Schaller, Warren J. Gasper, Nancy K. Hills*, S. Marlene Grenon - University of California, San Francisco, San Francisco, CA

INTRODUCTION AND OBJECTIVES: Frailty, a syndrome characterized by decreased physiologic reserves and resistance to stressors, is associated with disability, poor surgical outcomes, and mortality. We evaluated the impact of frailty on cardiovascular disease (CVD) events in patients with peripheral arterial disease (PAD), an elderly population with multiple cardiac comorbidities.

METHODS: We conducted a retrospective review of patients with stable claudication enrolled in vascular research studies between 2010-2015 at the San Francisco Veterans Affairs Medical Center. The modified frailty index (mFI) derived from the Canadian Study of Health and Aging was used to categorize frailty. Our outcome was time to occurrence of a major adverse cardiac event (MACE) - a myocardial infarction, coronary revascularization, stroke, transient ischemic attack, or CVD death. Cox proportional hazards models were used to calculate relative hazards (RH), with enrollment in study as the time of origin.

RESULTS: Table 1 presents the baseline characteristics of the 129 subjects, 29 of whom had a MACE. When compared to the lowest mFI, patients with medium frailty were 2.84 times more likely to have an event (95% CI 0.95, 8.46, $p=.06$), while patients with a high mFI were 4.77 times as likely (95% CI 1.43, 15.8, $p=.01$). Figure 1 illustrates the survival experience of these three groups (trend test, $p=0.0004$).

CONCLUSIONS: Higher mFI category is associated with increased risk of MACE in PAD patients with stable claudication. Frailty may serve as a useful adjunct for assessment of overall cardiac risk, particularly as treatment options are being contemplated.

Full Program & Abstracts

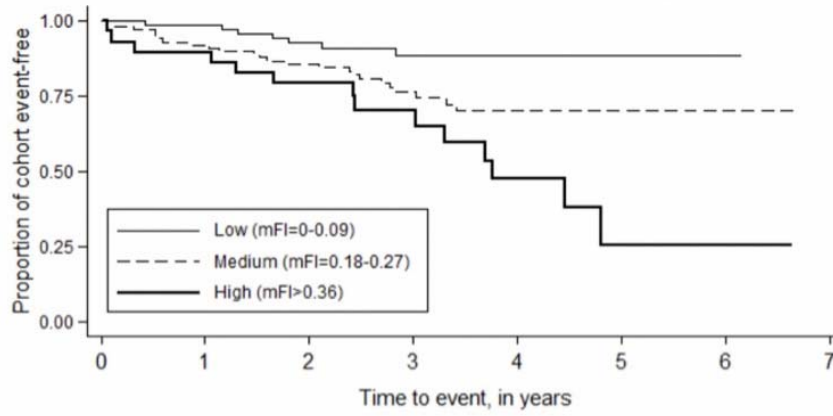
Table 1. Baseline Characteristics of Patients, Stratified by Modified Frailty Index*

General Characteristics	Low (n=38)	Medium (n=72)	High (n=19)
	n (%)	n (%)	n (%)
Age (years), mean ± SD	67.2 ± 8.6	68.6 ± 7.3	67.7 ± 4.0
Male gender	36 (95)	71 (99)	19 (100)
BMI, kg/m ² , mean ± SD	28.6 ± 4.5	28.3 ± 5.4	28.1 (6.4)
Rutherford Index, median (IQR)	2 (1, 3)	2 (1, 3)	3 (2, 3)
Index ABI, mean ± SD	0.76 ± 0.12	0.75 ± 0.16	0.65 (0.17)
Race			
Caucasian	6 (15.8)	14 (19.4)	2 (10.5)
African-American	2 (5.3)	6 (8.3)	0 (0.0)
Hispanic	29 (76.3)	51 (70.8)	17 (89.5)
Asian	1 (2.6)	1 (1.4)	0 (0.0)
Medications			
Aspirin	22 (57.9)	58 (80.6)	15 (78.9)
Statin	25 (65.8)	65 (90.3)	15 (78.9)
β-Blocker	14 (36.8)	47 (65.3)	15 (78.9)
ACE inhibitor	13 (34.2)	38 (52.8)	9 (47.4)
PAD Risk Factors			
History of smoking	36 (94.7)	65 (90.3)	19 (100)
Diabetes mellitus	1 (2.6)	36 (50.0)	10 (52.6)
Total cholesterol, mg/dL, median (IQR)	170 (144, 222)	148 (127, 170)	172 (122, 188)
Triglycerides, mg/dL, median (IQR)	123 (86, 190)	120 (85, 178)	171 (107, 198)
HDL, mg/dL, median (IQR)	43 (36, 57)	42 (36, 51)	42 (34, 58)
LDL, mg/dL, median (IQR)	94 (68, 146)	74 (58, 91)	87 (49, 107)
Serum creatinine, mg/dL, median (IQR)	0.95 (0.84, 1.1)	1.05 (0.88, 1.27)	1.10 (0.99, 1.38)
Albumin, g/dL, mean ± SD	4.04 ± 0.28	4.06 ± 0.36	3.96 ± 0.34
Baseline inflammation			
hsCRP, mg/L, median (IQR)	2.3 (1.2, 5.5)	2.5 (1.7, 6.2)	2.0 (1.0, 5.4)

*mFI categorized as low (0-0.09), medium (0.18-0.27), and high (>0.36). ABI, ankle-brachial index; ACE, angiotensin-converting enzyme; BMI, body mass index; HDL, high-density lipoprotein; hsCRP, high-sensitivity C-reactive protein; LDL, low-density lipoprotein; PAD, peripheral artery disease.

Full Program & Abstracts

Figure 1. Kaplan-Meier Estimates of Time to MACE by Frailty Categories of Low, Medium, and High Based on the Modified Frailty Index (mFI).



Full Program & Abstracts

8:35 am – 8:47 am

10

Evaluating the Utilization of Prophylactic Inferior Vena Cava Filters After Trauma

Lloyd Jones, Jr.¹, Navdeep Samra¹, Bo Hu², Quyen Chu¹, Wayne Zhang¹, Tze-Woei Tan¹ - ¹Louisiana State University HSC Shreveport, Shreveport, LA; ²Cleveland Clinic, Cleveland, OH

INTRODUCTION AND OBJECTIVES: The lack of evidence-based guideline has led to wide variation in the use of prophylactic inferior vena cava filter (PIVCF) in patients after injury. We seek to investigate the national trend of the use of PIVCF.

METHODS: A retrospective review of the National Trauma Databank (2002-2014) was performed to identify patients who received IVCF. Those without a diagnosis of venous thromboembolism (VTE) were identified as belonging to the prophylactic group. Multivariable logistic regression was used to examine association between the use of PIVCF and risk factors for VTE.

RESULTS: Of the 2,189,994 patients evaluated, 41,155(2%) had PIVCF. The overall rate of IVCF and PIVCF placement had decreased over the study period. For IVCF, the overall rate decreased from 2.9% to 1.6%, and for PIVCF placement, it decreased from 2.5% to 1.2% (P<.001). In multivariable analysis, risk factors associated with the use of PIVCF (odds ratio >1) were male gender, African American, Injury Severity Score >24, Glasgow Coma Scale <8, spinal cord injury with paraplegia, pelvic fracture, long bone fracture and solid organ injury (P<.001). Patients who were treated at a level II trauma center, facility with >200 beds, and those with insurance coverage were also more likely to received PIVCF (P<.001).

CONCLUSIONS: PIVCF utilization in trauma patients decreased over time. Considerable variation exists in its use, which is not fully accounted for by the risk of VTE. Further study is required to evaluate appropriate indications for placement of PIVCF in trauma patients.

Full Program & Abstracts

Table 1. Multivariable analysis of risk factors associated with venous thromboembolism and prophylactic IVC filter insertion in trauma patients.

Risk Factor	Prophylactic IVC Filter	p-value	Venous Thromboembolism	p-value
Patient Characteristic	Odds Ratio (95% Confidence Interval)		Odds Ratio (95% Confidence Interval)	
Male gender	1.2 (1.1-1.2)	<.001	1.6 (1.6-1.7)	<.001
African American	1.2 (1.1-1.2)	<.001	1.0 (0.9-1)	.15
Injury Severity Score >24	4.4 (4.2-4.5)	<.001	2.4 (2.4-2.5)	<.001
Glasgow Coma Scale < 8	1.4 (1.3-1.5)	<.001	1.4 (1.3-1.4)	<.001
Penetrating trauma	0.5 (0.5-0.6)	<.001	1.1 (1.1-1.2)	<.001
Spinal Cord Injury with Paraplegia	5.1 (4.7-5.6)	<.001	1.9 (1.7-2.2)	<.001
Pelvic Fracture	2.9 (2.7-3.0)	<.001	2.0 (1.9-2.1)	<.001
Long Bone Fracture	1.3 (1.3-1.4)	<.001	1.4 (1.4-1.5)	<.001
Solid Organ Injury	1.2 (1.1-1.3)	<.001	1.5 (1.5-1.6)	<.001
Trauma Center Characteristic				
Level II trauma center	1.1 (1.1-1.2)	<.001	0.7 (0.6-0.7)	<.001
200-400 beds	1.3 (1.2-1.4)	<.001	1.4 (1.3-1.5)	<.001
400-600 beds	1.4 (1.3-1.6)	<.001	1.5 (1.3-1.6)	<.001
>600 beds	1.3 (1.2-1.4)	<.001	1.6 (1.5-1.7)	
No insurance	1.0			
Inadequate insurance	1.7 (1.6-1.7)	<.001	1.3 (1.3-1.4)	<.001
Full insurance	1.4 (1.4-1.5)	<.001	1.2 (1.1-1.2)	>.001

Full Program & Abstracts

8:47 am – 8:55 am

11 (CR)

Gonadal Vein Transposition for the Treatment of Nutcracker Syndrome

Eric Shang, Naveen Balasundaram, Woosup M. Park -
Cleveland Clinic Foundation, Cleveland, OH

INTRODUCTION AND OBJECTIVES: Nutcracker syndrome, caused by mesoaortic compression of the left renal vein leading to symptoms related to venous hypertension, is an uncommon entity that may require operative intervention. Traditional open transposition of the left renal vein to the vena cava has been shown to have a re-intervention rate of up to 30%, while also having additional morbidity associated with laparotomy. More recently, endovascular stenting has been described in several small series, but have reported stent fracture, thrombosis and migration.

METHODS: We report the case of a 26 year old woman with 4 months of intermittent flank pain and hematuria, diagnosed with Nutcracker syndrome by both duplex ultrasound and axial based imaging.

RESULTS: The patient underwent catheter venography confirming left renal vein compression, which also demonstrated a dilated gonadal vein measuring 11mm leading to significant pelvic varices. Through a left lower quadrant retroperitoneal exposure, the gonadal vein was transposed to the L common iliac vein with completion venography demonstrating relief of renal venous congestion. The patient was discharged uneventfully with immediate resolution of symptoms, and remains symptom-free at 6 month followup.

CONCLUSIONS: Gonadal vein transposition is an effective alternative surgical treatment for Nutcracker syndrome.

Full Program & Abstracts

8:55 am – 9:03 am

12 (RF)

Design and Implementation of a Digital Health Platform for Measuring Peripheral Artery Disease Outcomes: The Project VOICE Pilot Study

Matthew A. Corriere¹, Donna Keith², Timothy E. Craven², Justin Brothwell Hurie², Randolph L. Geary², Gabriela Velazquez-Ramirez², Matthew S. Edwards² - ¹University of Michigan, Ann Arbor, MI; ²Wake Forest University School of Medicine, Winston Salem, NC

INTRODUCTION AND OBJECTIVES: Activity tracking has been embraced by consumers, but use for treatment outcomes has not been widely adopted. Patients with peripheral arterial disease (PAD) present challenges to using these devices. To assess feasibility and patient acceptance, we piloted a digital health platform specifically designed for patients with PAD.

METHODS: Claudicants were recruited for a one month prospective study of prescribed walking. Participants were provided an activity tracker and iPad app linking walking data to a PAD-specific website with educational materials, surveys, and symptom reporting. Participants set personal goals at enrollment, were contacted weekly basis for encouragement and troubleshooting, and completed the Walking Impairment Questionnaire (WIQ). Outcomes included days with tracked exercise, steps, duration, and distance. Adherence was evaluated as percentage of prescribed walking days completed. Technical support was provided by telephone and email, and topics were documented to identify potential barriers to implementation.

RESULTS: Twenty participants completed the study; 35% were female and 30% were African American. Mean age was 68.9±8.7 years, and mean ABI was 0.69±0.14. 55% of participants reported their highest educational level as high school or lower, and 65% had home internet access. Over a mean of 34±6 days, exercise was detected on 12±10 days. Weekly means were 315±403 minutes, 1.7±2.5 miles, and 4727±6909 steps. Adherence was 80.0±0.6% overall, and 50% of participants achieved ≥80% adherence (P=0.20 for trend between age and non-adherence). Weekly trends suggested a slight decline in walking days but increasing walk duration and distance. Participants sought support related to passwords, wireless connections, device synchronization, and appropriate reporting of pain symptoms.

CONCLUSIONS: Integration of activity tracking, outcomes reporting by patients, and educational materials within a shared online platform is feasible for patients with PAD. This approach has potential to enhance communication and allow in-depth, continuous outcomes assessment.

10:00 am – 12:00 pm

ROUND TABLE DISCUSSIONS

See topics, page 9.

3:00 pm

Registration Re-Opens
Location: Burgess Creek Foyer

3:30 pm – 4:00 pm

Coffee/Snacks
Location: Korbel Ballroom Foyer

Full Program & Abstracts

4:00 pm – 6:00 pm

SCIENTIFIC SESSION II

Location: Korbel Ballroom

4:00 pm – 4:12 pm

13

Prophylactic Groin Wound VAC Therapy? - Evidence for a "Pre-Emptive Strike" in Vascular Surgery Patients at Enhanced Risk for Postoperative Wound Infection

Luke Pesonen, Abdulhameed Aziz, Brian Halloran - St. Joseph Mercy Hospital, Ypsilanti, MI

INTRODUCTION AND OBJECTIVES: Vascular groin wounds have higher than expected surgical site infection (SSI) rates and some patients are at enhanced risk. The Wiseman et al. model identifies patients at enhanced risk of post-discharge SSI. We hypothesize that prophylactic groin wound vacuum-assisted dressing (VAC) placement in enhanced risk patients will decrease SSI and readmission.

METHODS: A single institution, retrospective analysis was conducted from January 2013 through September 2016 evaluating 14 limbs (12 patients) with a groin wound VAC placed for SSI postoperatively. Nine patients had the VAC placed at readmission. Additionally, 5 limbs (4 patients) received a VAC prophylactically secondary to concern for wound breakdown, infection, or maceration. We calculated the Wiseman score for all patients, determined total cost of the 9 readmissions, and determined the 30 day post-discharge SSI incidence for the prophylactic VAC group.

RESULTS: Per the Wiseman model, 8 limbs with postoperative SSI were high risk and 2 were moderate/high risk. Nine of these 12 patients had a VAC placed at readmission with an average readmission cost of \$11,637, compared to a primary VAC cost of \$3,482 over 23 days. For the prophylactic group, 4 limbs were high risk and 1 was moderate/high risk without post-discharge SSI. The Wiseman score showed no statistical significance and tight correlation between the retrospective high & high-moderate risk groups versus the prophylactic VAC group (31.3 ± 4.9 v. 29.2 ± 3.9 , $p=0.46$).

CONCLUSIONS: We identified 12 patients with a groin wound VAC placed after SSI following vascular surgery and 8 of these patients were retrospectively quantitated as either high risk or moderate/high risk for post discharge SSI. The Wiseman score showed objective validation in the prognosis of anticipating groin wound breakdown. These initial results suggest prophylactic VAC placement for enhanced risk patients may proactively decrease wound morbidity and provide significant cost benefit.

Full Program & Abstracts

4:12 pm – 4:24 pm

14

Fellows Assessment of Their Training

Sheila Blumberg, Anil Hingorani, Amrit Hingorani, Enrico Ascher, Natalie Marks, Eleanor Iadgarova - Total Vascular Care, Brooklyn, NY

INTRODUCTION AND OBJECTIVES: In an attempt to assess the fellows' perception of their training, we conducted a survey consisting of 20 questions at an annual national meeting in March from 2004 to 2015. In order to obtain accurate data, all surveys were kept anonymous.

METHODS: The fellows rated their endovascular, open, and vascular lab experiences as excellent, satisfactory, or mixed. They were queried into who taught them their endovascular skills, the quality of their didactics, and amount of small cases they did not learn from. 674 of 908 attendees (74%) completed the survey. Males made up 81% of those surveyed. 59% were between 31 and 35 years of age. Second-year (5+2) fellows made up 52% of those surveyed.

RESULTS: 84% were satisfied with their endovascular experience during their fellowship while 83% were satisfied with their open case experience. Interventional skills were mostly obtained from a vascular surgeon (93%), interventional radiologist (9%), cardiologist (1%), or a mixture (4%). The didactics were felt to be excellent, satisfactory, or to need some or much improvement in: 43%, 44%, 10% and 4% respectively. The distribution of non-learning cases was felt to be excellent, satisfactory, or to need some or much improvement in: 50%, 40%, 8%, and 2% respectively. However, only 68% felt their vascular laboratory experience was excellent or satisfactory. Only 35% actually performed vascular duplex exams, and only 47% felt comfortable managing a vascular laboratory. Comparing the data from 2004 and 2015, significant improvements were found with satisfaction with experience in endovascular cases, the percentage of endovascular cases taught by vascular surgeons, and overall program didactics. There were no significant differences in gender distribution, satisfaction with vascular lab experience, or comfort level in running a vascular laboratory.

CONCLUSIONS: This survey highlights the self-assessment of vascular trainees and suggests that several significant issues exist in the minds of vascular trainees that have not been addressed. These represent opportunities for further improvement.

Full Program & Abstracts

4:24 pm – 4:36 pm

15

Outcomes of Tibial Endovascular Intervention in Patients with ESRD on Dialysis

Hallie E. Baer-Bositis, Georges M. Haider, Taylor D. Hicks, Lori L. Pounds, Matthew J. Sideman, Mark G. Davies - UT HSC San Antonio, San Antonio, TX

BACKGROUND: Tibial interventions for critical limb ischemia are frequent in patients with ESRD presenting with critical ischemia. The aim of this study was to examine impact of ESRD on the patient centered outcomes following tibial endovascular Intervention

METHODS: A database of patients undergoing lower extremity endovascular interventions between 2006 and 2016 was retrospectively queried. Patients with critical ischemia (Rutherford 4 and 5) were identified. Patients were categorized by the presence or absence of ESRD. Patient orientated outcomes of clinical efficacy (CE; absence of recurrent symptoms, maintenance of ambulation and absence of major amputation), amputation-free survival (AFS; survival without major amputation) and freedom from major adverse limb events (MALE; Above ankle amputation of the index limb or major re-intervention (new bypass graft, jump/interposition graft revision) were evaluated.

RESULTS: 1434 patients (56% male, average age 59 years) underwent tibial intervention for critical ischemia. Technical success was 99% with a mean of 2 vessels treated per patient and a mean pedal runoff score of 6. Overall MACE was equivalent at 90 days after the procedure. At 5 years, patients with ESRD had significantly lower CE, AFS and MALE at 5 years (Table).

	No ESRD	ESRD	P-Value
Number of Limbs at Risk	1212	222	—
High Risk III score (%)	18%	60%	0.01
Mortality (%)	0.5%	3%	0.01
Morbidity (%)	3%	10%	0.01
5yr-CE (Mean±SEM %)	58±4	19±8	0.001
5yr-AFS (Mean±SEM %)	55±3	18±9	0.001
5yr-MALE (Mean±SEM %)	60±5	11±6	0.001

CONCLUSIONS: Patients with ESRD do not achieve satisfactory clinical efficacy and amputation free survival after tibial intervention. Defining such subgroups will allow stratification of the patients and appropriate application of interventions.

Full Program & Abstracts

4:36 pm – 4:48 pm

16

Surgical Intervention for Peripheral Artery Disease Does Not Improve Patient Compliance with Recommended Medical Therapy

Tyler R. Halle, Jaime Benarroch-Gampel, Victoria Teodorescu, Ravi R. Rajani - Emory University School of Medicine, Atlanta, GA

INTRODUCTION AND OBJECTIVES: Non-adherence to smoking cessation, antiplatelet and statin therapies in patients with peripheral artery disease (PAD) are associated with worse long-term outcomes. We hypothesized that patients who underwent invasive revascularization procedures would be more likely to adhere to these therapies than patients who were managed medically.

METHODS: Prospective surveys pertaining to medication and behavioral compliance of patients with symptomatic peripheral artery disease were performed. Specifically, adherence to smoking cessation, antiplatelet therapy, and anti-lipid therapy were evaluated. A retrospective review of the electronic medical record was then performed to obtain procedural data and divide patients into medically managed or surgically managed (open revascularization, percutaneous revascularization, amputation) cohorts.

RESULTS: 100 patients were enrolled. Overall, 59.1% were able to quit smoking, 66.7% were adherent to statin therapy, and 72.7% were adherent to antiplatelet therapy. There was no difference in regards to successful smoking cessation (61.5% vs 53.6%), antiplatelet (73.9% vs 74.1%) or statin (65.2% vs 70.4%) therapies among patients treated with or without surgery, respectively. Amputation was also not associated with adherence to these therapies.

CONCLUSIONS: Surgical revascularization does not influence the likelihood of adherence to smoking cessation, antiplatelet therapy, or statin therapies in patients with symptomatic peripheral artery disease. These patients should be counseled regarding revascularization options with the understanding that their likelihood of medical treatment compliance will be unaffected by any proposed intervention.

Full Program & Abstracts

	Medical (n=29)	Surgical (n=71)
Age in years	63.4±8.8	63.8±9.8
Sex		
Male	20 (69.0)	38 (53.5)
Female	9 (31.0)	33 (46.5)
Rutherford Score		
I-III	28 (96.6)	21 (29.6)
IV		16 (22.5)
V	1 (3.4)	18 (25.4)
VI		4 (5.6)
Unknown		12 (16.9)
	<i>n</i> =28	<i>n</i> =65
Quit Smoking	15 (53.6)	40 (61.5)
	<i>n</i> =27	<i>n</i> =69
Antiplatelet adherent	20 (74.1)	51 (73.9)
	<i>n</i> =29	<i>n</i> =66
Statin adherent	19 (70.4)	43 (65.2)

Values are reported as mean ± standard deviation for continuous variables and as frequency (*n*) and percentages (%) for categorical variables.

Full Program & Abstracts

4:48 pm – 4:56 pm

17 (RF)

Anterograde Reperfusion Catheters are Associated with Improved Outcomes Among Patients Who are Undergoing Extra Corporeal Membrane Oxygenation Via Femoral Cannulation

Adam C. Ring, Arjun Agrawal, Christoph E. Brehm, John Radtka, David Han, Faisal Aziz - PSU HMC, Hershey, PA

INTRODUCTION: Extracorporeal membrane oxygenation (EMCO) provides continuous cardiopulmonary support in patients with severe cardiac and pulmonary failure. This therapy necessitates insertion of large diameter peripheral vascular sheaths, and distal reperfusion catheters are often utilized as well. The purpose of this study was to evaluate the outcomes for adult ECMO patients who received distal reperfusion catheters.

METHODS: Data were collected on adult ECMO patients from 6/2008-12/2015. Demographic data, ECMO indications, duration of ECMO therapy, and the use of distal reperfusion catheters were recorded. Patients were divided into two groups: Group I (distal reperfusion catheter), Group II (no distal reperfusion catheter). The primary outcome was mortality or development of any ischemic vascular complication.

RESULTS: A total of 247 patients (65% Male, 35% Female) with a mean age of 52.1 ± 16.7 years were identified. Indications for ECMO were as follows: cardiogenic shock (73%), respiratory failure (12%), cardiopulmonary failure (14%), other (1%). Group I had 189 patients (75%) and Group II had 58 patients (25%). There was no difference in demographic variables or ECMO cannulation strategies between the two groups. Vascular complications were observed in 63 (25%) patients. There was a statistically significant decrease in the 30-day mortality in patients who had a distal reperfusion catheter in place (42% vs. 60%, $p=0.02$). However, there was no difference in the rate of lower ischemia between the two groups (7% vs 15%; $p=0.12$). A total of eight patients required leg amputation, with six of those occurring despite a functioning reperfusion catheter.

CONCLUSIONS: The thirty-day mortality for patients on VA ECMO remains high. Despite no differences in patient demographics or indications for ECMO, there is a significant decrease in the mortality rates in patients with a leg reperfusion catheter. The mechanism for this may be related more stable hemodynamics or to decreased acid washout upon decannulation.

Full Program & Abstracts

4:56 pm – 5:04 pm

18 (CR)

Fenestrated Plus Sandwiched-Reverse-Snorkel Technique for Endovascular Repair of a Pararenal Abdominal Aortic Aneurysm with Complex Renal Artery Anatomy

Perry J. Xu, Mina Boutrous, Donald L. Jacobs - Saint Louis University School of Medicine, Saint Louis, MO

INTRODUCTION AND OBJECTIVES: Endovascular repair of pararenal abdominal aortic aneurysms (AAA) is well-documented with strategies such as fenestrated-grafts (f-EVAR) and snorkel-grafts. However, application of these known strategies can be limited by complex anatomy. Here, we describe a case that uses the novel technique: 'Fenestrated plus Sandwiched-Reverse-Snorkel' (F-SRS) that successfully combines the f-EVAR and snorkel strategies to effectively treat a 6.0cm pararenal AAA with complex renal arteries.

METHODS: A 69-year-old man was diagnosed with a pararenal AAA involving the celiac, superior mesenteric artery (SMA), and both renal arteries, extending to the bifurcation. The SMA and left renal artery (LRA) originated at the same level, and then 8cm distal, the right renal artery (RRA) originated. This separation of renal arteries prohibited standard f-EVAR reconstruction. Therefore, the F-SRS technique was devised, and consists of a ZFEN (Cook, Bloomington Indiana) device with a celiac scallop and SMA and LRA fenestrations, combined with a 'sandwiched-reverse-snorkel' for the RRA.

The distal bifurcated ZFEN component was unconventionally deployed first, through which a Viabahn (W.L.Gore, Flagstaff Arizona) stent was positioned in the RRA, fashioning a reverse snorkel configuration. Through the contralateral iliac, the proximal fenestrated ZFEN component was deployed with iCAST (Atrium, Germany) stents in the SMA and LRA. A bridging stent was placed between the ZFEN components, and was deployed in conjunction with the Viabahn stent, sandwiching the RRA reverse snorkel.

RESULTS: The patient had complete exclusion of the pararenal AAA with the novel F-SRS technique. One-month postoperative imaging revealed decrease in aneurysm size from 6.0cm to 5.1cm, patent graft components with good flow, and no evidence of endoleak.

CONCLUSIONS: F-SRS is a novel technique that hybridizes the f-EVAR and snorkel strategies, allowing for endovascular repair of a pararenal AAA with complex renal artery anatomy. Long-term follow-up is needed to assess the overall success of F-SRS.

Full Program & Abstracts

5:04 pm – 5:12 pm

19 (CR)

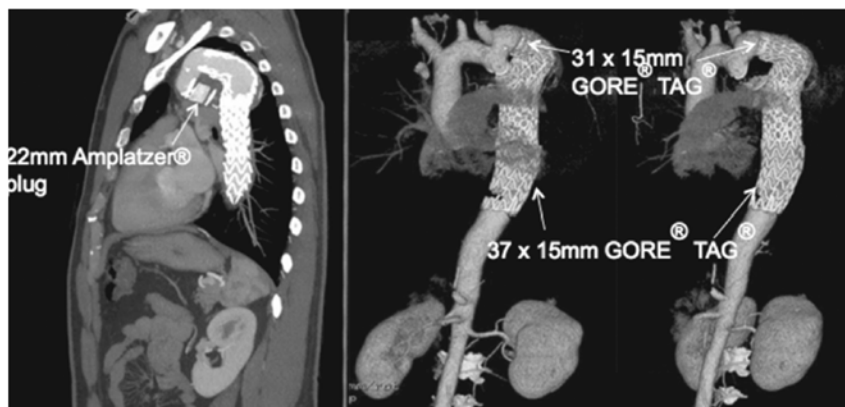
An Innovative Endovascular Technique for Repair of Descending Thoracic Aortic Aneurysm Following an Open Coarctation Repair

Pouria Parsa, Anthony Rios, Javier Vasquez, Jr., John Eidt, Dennis Gable - Baylor University Medical Center, Dallas, TX

BACKGROUND: The incidence of aneurysms after surgical treatment of aortic coarctation has been reported to be 11-24%. Aneurysm formation occurs at and around the coarctation site due to the inherent aortic wall medial abnormality secondary to a reduction in smooth muscle cells.

CASE REPORT: Our patient was a 48-year-old male with a significant history of aortic coarctation who had undergone open surgical repair 8 years prior to admission with an aorto-aortic bypass using a 22mm Dacron graft. Patient presents with an aneurysm of the descending aorta (7.5x5.9 cm). Furthermore, ongoing flow in the area of coarctation was detected and was feeding directly into the aneurysm. Intravascular ultrasound (IVUS) was performed to measure the diameter of the coarctation, which was approximately 14mm which was occluded with a 22mm Amplatzer® plug. IVUS confirmed a 24mm diameter of the vascular graft as measured with Terarecon 3D imaging. We selected a 31 x 15mm Conformable GORE® TAG® Thoracic Endoprosthesis. The graft was then extended down into the mid-descending aorta with a 37 x 15mm GORE® TAG® Thoracic Endoprosthesis. A completion angiogram showed no endoleak into the aneurysmal sac with excellent flow in the supraaortic vessels and distal aortic arch.

CONCLUSIONS: Our case is unique due its combination of the coarctation closure by a vascular plug and the TEVAR treatment of the post-coarctation aneurysm. Endovascular repair of post-coarctation aneurysms is a safe and effective option. The vascular occlusion of the aortic coarctation by a vascular plug seemed to be quite innovative since there is no known reported case of that procedure. The 30-day CT shown in figure 1.0 showed an excellent result and no significant endoleaks were noted.



Full Program & Abstracts

5:12 pm – 5:24 pm

20

Surveillance Duplex Ultrasound After Carotid Endarterectomy: Contralateral Carotid Stenosis, Restenosis and Cost

R. Clement Darling, III, John B. Taggart, Yaron Sternbach, Sean P. Roddy, Paul B. Kreienberg - Albany Medical College, Albany, NY

INTRODUCTION/OBJECTIVES: The optimal frequency and value of surveillance duplex ultrasound (DU) following carotid endarterectomy (CEA) is currently unclear.

METHODS: A vascular registry was queried for consecutive CEAs performed from 7/1/2012-6/30/2013. Patients were excluded if standard CEA was not performed. DU was performed at 6 month intervals for 2 years, then either annually or semiannually depending on the contralateral carotid artery degree of stenosis. Contralateral carotid stenosis, re-stenosis, secondary interventions, stroke and costs were evaluated/analyzed.

RESULTS: From 7/1/2012 through 6/30/2013, 308 standard CEA were performed. 64 (21%) CEA were lost to follow-up. 244 (79%) CEA in 230 patients were performed, 14 (6%) patients were identified for staged bilateral CEA at initial evaluation and 216 contralateral carotid arteries were followed. The status of the contralateral carotid at the time of first DU: 158 <50%, 47 50-59%, 2 60-69%, 9 occluded. Stenosis progression in the 207 at risk contralateral carotid arteries occurred in 15 (7%) patients, with 4 (2%) progressing to >70% and undergoing CEA (average time to CEA 30 months). Restenosis at a CEA site occurred in 6 (2.4%) of 244 patients with 2 (0.8%) undergoing redo CEA. 644 surveillance duplex ultrasound studies were performed with an average of 2.79 studies/patient with a median of >3 per patient. Neurological events unrelated to CEA occurred in two patients. The total estimated cost of surveillance for this cohort was \$163,898.

CONCLUSION: In early to intermediate follow-up, a second carotid intervention after CEA is uncommon (6/230, 2.6%). Following established surveillance guidelines, the cost to detect each patient in need of intervention was \$27,316, with 644 patient office encounters. It is currently unclear if less frequent surveillance can yield timely detection of patients in need of a second carotid intervention.

Full Program & Abstracts

5:24 pm – 5:36 pm

21

Routine Frailty Assessment During Vascular Surgery Clinic Visits: Easier Than You Might Think

Luke G. Mirabelli, Robert M. Cosker, Claire L. Griffin, Brigitte K. Smith, Mark R. Sarfati, Larry W. Kraiss, Benjamin S. Brooke
- University of Utah, Salt Lake City, UT

INTRODUCTION AND OBJECTIVES: Frailty assessment can help vascular surgeons predict perioperative risk and long-term mortality for their patients. Unfortunately, comprehensive frailty assessments take too long to integrate into clinic workflow. This study was designed to evaluate two rapid methods for assessing frailty during vascular clinics—a patient-reported survey and provider-reported frailty scale.

METHODS: We prospectively enrolled 120 patients presenting to an academic medical center vascular surgery clinic between May-August 2016. Patients underwent frailty assessment using two rapid methods: 1) the Frail Non-Disabled (FiND) survey (5 questions) and 2) the Clinical Frailty Scale (CFS; 9-point scale from robust to severely frail). These were followed by the Fried Frailty Index, a validated tool with 5 measures (weight loss, exhaustion, grip strength, walking speed, & activity level). The correlation between Fried scores (validated standard) with frailty diagnoses derived from FiND and CFS was analyzed using the Spearman-rank test, Cohen’s kappa and receiver operating curves.

RESULTS: Evaluated patients included 66 (55%) females with a mean age of 61 years, of which 53 (44%) were pre-operative and 24 (20%) were categorized as frail using the Fried Index. There was medium to high correlation between Fried Index derived frailty scores and those using the CFS and the FiND survey (Table). The CFS was highly specific for diagnosing frailty and exhibited high inter-rater reliability between surgeon and medical assistant scores (kappa: 0.69, P<0.001). The FiND survey was very sensitive (94.4%), but less specific for diagnosing frailty.

CONCLUSIONS: Frailty can be quickly and effectively assessed during vascular surgery clinic using both patient-reported (FiND) and provider-reported (CFS) methods. Implementing routine frailty assessment into clinic workflow can be a valuable tool for risk-prediction and surgical decision-making.

	Clinical Frailty Scale: Surgeon Score	Clinical Frailty Scale: MA Score	FiND Survey: Patient Score
Fried Frailty Index Non Frail (0-2, n=96) vs. Frail (3-5, n=24)	Sensitivity: 50.0% Specificity: 91.7% ROC Area = 0.708 Spearman’s rho = 0.45 P<0.001	Sensitivity: 37.5% Specificity: 95.8% ROC Area = 0.667 Spearman’s rho = 0.43 P<0.001	Sensitivity: 94.4% Specificity: 41.9% ROC Area = 0.682 Spearman’s rho = 0.32 P=0.004

Full Program & Abstracts

5:36 pm – 5:48 pm

22

Pre-Operative Aspirin and Statin Use Does Not Affect Outcomes After Carotid Endarterectomy

Brianna Krafcik, Alik Farber, Robert T. Eberhardt, Jeffrey A. Kalish, Denis Rybin, Gheorghe Doros, Steven Pike, Jeffrey J. Siracuse - Boston University, Boston, MA

INTRODUCTION AND OBJECTIVES: Aspirin and statin use has been advocated as an adjunct to carotid endarterectomy (CEA). Our goal was to assess use of these preoperatively and their effects on perioperative outcomes after CEA.

METHODS: ACS-NSQIP targeted CEA database was queried (2011-2014). Multivariable analysis assessed the effect preoperative medication use on CEA.

RESULTS: 13521 CEAs were identified. 57.9% were asymptomatic. Preoperative aspirin use was in 89.3% and statins were in 80.5%. Aspirin use was more common with male gender, non-smoking, diabetics, hypertension, COPD, dyspnea, asymptomatic carotid disease. On univariate analysis aspirin had no effect on 30 day mortality (0.7% vs. 1%, $P=.28$), MI (1.9% vs. 1.7%, $P=.73$), stroke (1.8% vs. 1.8%, $P=.94$), TIA (0.9% vs. 1%, $P=.63$), or MACE (3.9% vs. 4%, $P=.8$). On multivariate analysis, preoperative aspirin use did not affect 30 day mortality (OR 0.67, 95% CI 0.37-1.3, $P=.19$), MI (OR 0.9, 95% CI 0.59-1.38, $P=.637$), stroke (OR 0.92, 95% CI 0.61-1.4, $P=0.69$) or MACE (OR 0.88, 95% CI 0.66-1.18, $P=.39$). Statin use was more common in patients with higher BMI, functional independence, diabetes, hypertension, anticoagulation, non-smokers, and asymptomatic disease ($P<.05$). On univariate analysis statin use did not affect 30 day mortality 0.8% vs. 1%, $P=.21$), MI (1.9% vs. 1.4%, $P=.085$), stroke (1.8% vs. 1.9%, $P=.55$), TIA (0.9% vs. 1.1%, $P=.43$) or MACE (4% vs. 3.6%, $P=.36$). On multivariate analysis, preoperative statin use did not affect 30 day mortality (OR 0.94, 95% CI 0.55-1.6, $P=.825$), MI (OR 1.1, 95% CI 0.77-1.58, $P=.573$), stroke (OR 0.891, 95% CI 0.64-1.2, $P=.42$) or MACE (OR 1.03, 95% CI 0.81-1.32, $P=.806$).

CONCLUSIONS: Preoperative aspirin and statin use for CEA was associated with higher comorbidities and asymptomatic disease. They did not affect perioperative outcomes suggesting that short-term use is not essential. CEA timing should not be affected by preoperative aspirin or statin use.

Full Program & Abstracts

5:48 pm – 6:00 pm

23

Validation and Performance of Ruptured Abdominal Aortic Aneurysm Risk Prediction Model

Christopher Healey¹, Michael Neilson¹, David Clark¹, Brian Nolan² - ¹Maine Medical Center, Portland, ME; ²Dartmouth-Hitchcock Medical Center, Hanover, NH

INTRODUCTION AND OBJECTIVES: At the 2016 VESS Winter Meeting we presented a model, Rapid rAAA Score (RrAAAS), which predicts mortality in operative candidates with ruptured AAA (rAAA). The RrAAAS was previously derived from Vascular Study Group of New England (VSGNE) data (649 rAAA patients), using pre-operative age, creatinine, and blood pressure. This study validates that model using the larger National Vascular Quality Initiative (VQI) dataset, and compares its performance to previous models.

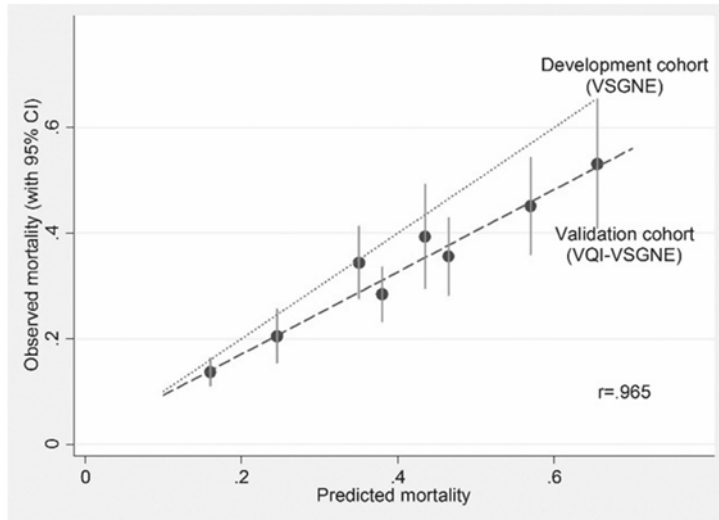
METHODS: The Vascular Quality Initiative (VQI) registry was queried for patients (n= 2704) undergoing rAAA repair from 2006-2016, including 715 patients from VSGNE. The performance of our original model, RrAAAS, was tested on this dataset excluding VSGNE patients (VQI-VSGNE), and its performance was then compared to the performance of the Glasgow Aneurysm Score (GAS) and Edinburgh Ruptured Aneurysm Score (ERAS).

Results: The discrimination of all three models was similar (AUROC .66 - .67). Neither GAS nor ERAS provides a direct prediction of mortality; observed mortality in the VQI-VSGNE cohort tended to be somewhat lower than predictions of the original RrAAAs. A recalibrated equation predicting the percent mortality was:

Mortality (%) = 16 + 12*(age>76) + 8*(creatinine>1.5) + 20*(sbp<70) .

CONCLUSIONS: The previously described RrAAAs has similar discrimination as the GAS and ERAS, is easier to obtain in an emergency setting, and has been recalibrated to reflect the experience of a large national sample. The RrAAAs could be useful for clinicians caring for these patients, and could be used for risk-adjustment when comparing regional differences in mortality associated with rAAA repair.

Full Program & Abstracts



6:00 pm

VESS MEMBER BUSINESS MEETING

Location: Korbel Ballroom

7:15 pm

Free Evening

Full Program & Abstracts

Saturday, February 4, 2017

6:00 am – 7:00 am	Continental Breakfast <i>Location: Korbel Ballroom Foyer</i>
6:00 am – 9:30 am	Registration <i>Location: Burgess Creek Foyer</i>
7:00 am – 9:00 am	SCIENTIFIC SESSION III <i>Location: Korbel Ballroom</i>
7:00 am – 7:12 am	24 Endovascular Optimization of Distal Seal During Stent-Graft Repair of Chronic Type-B Aortic Dissection (TBAD) Mel J. Sharafuddin, Rachael M. Nicholson, Samantha M. Alsop, Maen S. Aboul Hosn, Jeanette H. Man, Justin Walpole - University of Iowa Carver College of Medicine, Iowa City, IA

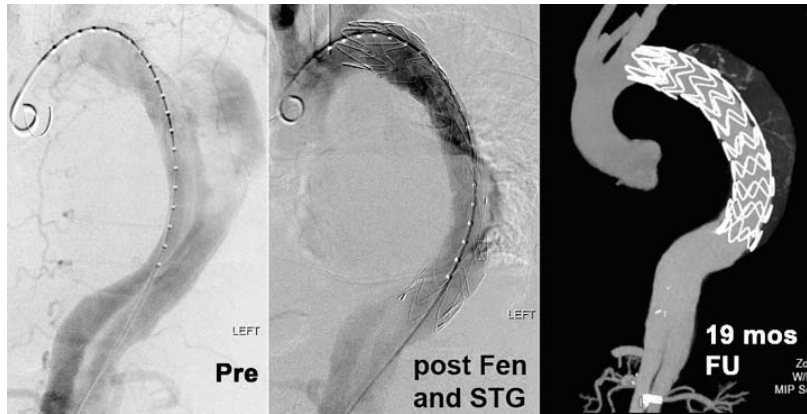
INTRODUCTION AND OBJECTIVES: Achieving distal seal can be challenging in TBAD involving the visceral segment. We describe our approach of optimizing the distal landing zone through planned wide septal fenestration to enable full circumference contact of the endoprosthesis.

METHODS: Our experience included 8 procedures in 6 patients (4 males, age 72±10) between May 2014 and June 2016. Presentation was chronic dissection (delay 36±20 months), prior type-A dissection repair was present in 4 patients. Indication was enlarging aneurysm in all procedures, with associated chronic visceral ischemia in 2. Compliant balloon molding of the endograft to the landing zone was performed in all patients

RESULTS: one death occurred due to aortic perforation during wire-pull fenestration in a heavily calcified aorta. The remaining procedures were accomplished safely and successfully. Snared wire-pull fenestration was used in 3 procedures. Multi-point large balloon fenestration was evolved as a safer approach in our last 5 procedures. Adjunct procedures included: renal artery or SMA stent-graft (4), carotid-subclavian transposition (3). Two repeat procedures were performed in 2 patients due to delayed loss of seal (8, 12 months). Both had short seal zone and residual endoleak at the initial procedure. management consisted of additional fenestration and distal extension. Followup imaging (8±7 months, range: 1-19) showed stable or regressed sac diameter in all with near-complete thrombosis of the false lumen

CONCLUSIONS: Distal zone optimization using accurately planned large diameter fenestration can enable distal seal in challenging chronic descending aortic dissections. However, these procedures should be reserved to patients with suitable anatomy. Adhering to reasonably straight landing segment, seal zone length ? 20 mm and seal zone diameter ?40 mm may minimize the risk of delayed failures.

Full Program & Abstracts



Full Program & Abstracts

7:12 am – 7:24 am

25

Long-Term Follow-Up of Tibio-Distal Vein Bypass for Failed Tibial Angioplasty

Florian K. Enzmann, Sebastian K. Eder, Patrick Nierlich, Manuela Aspalter, Siegmund Guggenbichler, Werner Dabernig, Thomas J Hölzenbein - PMU Salzburg, Salzburg, Austria

INTRODUCTION AND OBJECTIVES: Technical progress in angioplasty expanded its application to very distal arterial lesions of the lower extremity. In cases of failed angioplasty bypass surgery may be required for limb salvage. There are no reports in literature on tibio-distal bypass within the last 20 years. We investigated long term outcome of these very distal bypasses in patients with critical limb ischemia mainly performed because of failed angioplasty.

METHODS: 52 procedures in 50 patients (71% male, mean age: 64.8 years [28-90], 71% diabetic, 29% renal failure) originating from tibial arteries were performed at an academic tertiary care center. SVS reporting standards were applied. In all cases autologous vein grafts were used (Saphenous: 82%, Lesser saphenous: 16%, arm vein 2%). Distal target artery was tibial in 2% and inframalleolar in 98%. 29 (55,8 %) of the bypasses were performed after failed angioplasty.

RESULTS: The primary patency and primary assisted patency rates were 55% vs. 60% after one and 47% vs. 50% after 5 years, respectively. Limb salvage was 94% after one and 84% after 5 years. Survival rate was 93% after one and 78% after 5 years. The mean follow up was 4 years. There was no significant difference with or without previous failed angioplasty in patency or limb salvage. In multivariate analysis the hazard ratio for inferior limb salvage was 7.9 for patients with ischemia Rutherford category 6.

CONCLUSIONS: Our data show that tibio-distal bypass can be performed effectively in a high risk population, despite failed angioplasty. The procedure demonstrates to be an effective and durable technique for limb salvage in critical limb ischemia and limited options for distal revascularization. Patency rates are satisfactory with excellent long term limb salvage.

Full Program & Abstracts

7:24 am – 7:36 am

26

The Current Risk-Benefit Outlook for Endovascular vs. Open Surgical Bifurcated Aortoiliac Arterial Reconstruction Therapy for Aortoiliac Occlusive Disease

Tahlia L. Weis, Jean Marie Ruddy, Jacob G. Robison, John W. Hallett, Joshua D. Adams - Medical University of South Carolina, Charleston, SC

INTRODUCTION AND OBJECTIVES: Open surgical repair (OPEN) has been the gold standard for aortoiliac (AI) disease for over seven decades. Recently, endovascular and hybrid options (ENDO/ENDO-H) have been selected increasingly to avoid aortic operations. We describe our recent concurrent experience to highlight the risks and benefits of each and provide contemporary data to our patients.

METHODS: We reviewed a prospective database to identify all patients undergoing aortoiliac revascularization in the past two years. For comparison, we ascertained: basic demographics and key intraoperative and postoperative outcomes. Primary endpoints were 30-day post-procedural mortality and major adverse limb events (MALE). Secondary outcomes included cardiac events, acute renal insufficiency, 30-day readmission rate, access/wound complications, and interventions for assisted patency. We also compared procedural duration, blood loss, and hospital length of stay.

RESULTS: Between 2014-2016, we treated 25 patients for aortoiliac disease with bifurcated aortic stent grafts with or without concomitant femoral revascularization (ENDO/ENDO-H; n=13) or open aortobifemoral bypass grafts (OPEN; n=12). Both groups exhibited similar indications with intermittent claudication being the primary reason for intervention. The ENDO/ENDO-H cohort had a higher prevalence of coronary disease (45% vs 8%, p=0.04) and diabetes (46% vs 0%, p=0.008) yet no 30-day deaths and one MALE. Meanwhile, the OPEN cohort had two mortalities but no MALE (NS). Patients undergoing OPEN repair were more likely to have acute postoperative renal insufficiency (p=0.004). Of interest, the procedural durations were similar (NS). OPEN patients had increased blood loss and longer lengths of hospital stay (p=0.04 and 0.004, respectively). Readmission rates, access/wound complications, and assisted patency re-interventions were similar.

CONCLUSIONS: Despite increased cardiovascular comorbidity, patient outcomes from bifurcated aortic stent grafts with or without concomitant femoral revascularization (ENDO/ENDO-H) currently meet or exceed those for aortobifemoral bypass (OPEN) and are therefore recommended for patients who meet anatomic criteria for an ENDO/ENDO-H first approach.

Full Program & Abstracts

7:36 am – 7:48 am

27

Risk Factor Modification Behaviors of Practicing Vascular Surgeons

Alexandra P. Bader, Claudia P. Barone, Matthew R. Smeds -
University of Arkansas for Medical Sciences, Little Rock, AR

OBJECTIVES: National smoking rates have declined, however it remains the primary risk factor for nearly all vascular disease. While vascular surgeons often treat patients via both medical and surgical/endovascular means, involvement in risk factor modification may be lacking. We sought to understand surgeon's involvement in tobacco cessation and risk factor modification.

METHODS: Anonymous electronic surveys examining tobacco cessation and risk factor modification were sent to VESS members (n=633). Data collected included risk factor modification techniques, procedures performed on smoking patients, and respondent demographics.

RESULTS: 149 (24%) surveys were completed. While the majority of respondents ask patient's smoking status, assess willingness to quit, and advise patients to quit (97%, 84% and 95% respectively), only 33% prescribe medications to assist in cessation, 7% see patients in tobacco cessation follow up, and 4% verify cessation with cotinine levels or carbon monoxide monitoring. Surgeons who prescribed medications for cessation are more likely to assess patient's willingness to quit ($p=.03$), prescribe/advise nicotine replacement ($p=.0001$), and screen for hyperlipidemia ($p=.009$). Respondents were not likely to screen for hyperlipidemia/hypertension/diabetes or prescribe medications for these diseases. There was no difference in perceived education received during training in risk factor modification, but only 26% of respondents thought they were well trained. Comparing academic to private practice surgeons, there was no difference in cessation techniques used, however academic surgeons were less likely to perform endovascular procedures for claudication in patients who continued to smoke (29% vs. 46%, $p=.03$), and prescribe an initial antihyperlipid medication (65% vs. 39%, $p=.0018$).

CONCLUSIONS: Tobacco dependence remains a critical issue for vascular surgery patients, however, there is wide variation in cessation techniques used. The majority of surgeons are not well versed in cessation techniques and risk factor modification, and efforts should thus be made to provide this education in vascular surgery training programs.

Full Program & Abstracts

7:48 am – 7:56 am

28 (CR)

Indications and Outcomes of Open Inferior Vena Cava Filter Removal

Shaikh Afaq, Samuel S. Leake, Harleen K. Sandhu, Naveed U. Saqib, Ali Azizzadeh, Kristofer M. Charlton-Ouw - University of Texas, Houston, TX

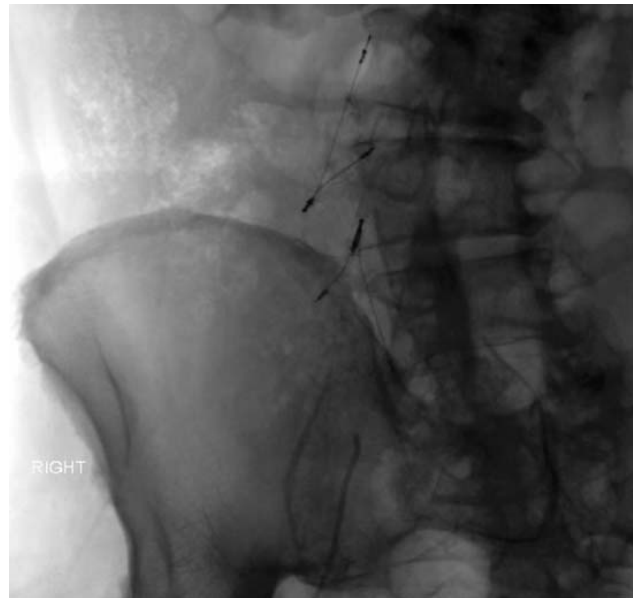
INTRODUCTION AND OBJECTIVES: Despite recommendations for retrieval of inferior vena cava (IVC) filters, most are not removed in a timely manner. Longer IVC filter dwell times are associated with caval wall perforation and tilting that make retrieval difficult. Open surgical IVC filter removal is reserved for patients with symptoms/complications referable to the filter, such as chronic back and abdominal pain. We present our management algorithm and surgical technique.

METHODS: Our database was searched for IVC filter removals from 2010-2016. All open surgical cases were extracted and imaging reviewed. In most cases, we perform a 10 -cm mini-laparotomy and retract the duodenum without mobilizing the right colon. We minimize dissection of the IVC if there are dense adhesions or scarring by using sponge sticks for proximal and distal control. An endovenectomy is performed as needed and the cavotomy primarily repaired without patching.

RESULTS: We retrieved filters from 207 patients during the study period. Seven patients required open surgical removal. One patient had 2 filters (Figure) and another had 3 filters. Except for 2 cases referred to us with urgent complications, the remaining patients all suffered from chronic back or abdominal pain. The symptomatic patients failed previous attempts at percutaneous retrieval and all had significant filter strut penetration through the caval wall into adjacent structures (Table). Postoperatively, all patients had relief of pain.

CONCLUSION: Most patients can have optional IVC filters percutaneously retrieved. Patients who fail percutaneous IVC filter retrieval can expect low morbidity and prompt resolution of symptoms after open surgical removal.

Full Program & Abstracts



Full Program & Abstracts

7:56 am – 8:04 am

29 (RF)

A Novel Off-the-Shelf Technique for Endovascular Repair of Type III and IV Thoracoabdominal Aortic Aneurysms Using the Gore Excluder and Viabahn Branches

Mathew Wooster, Paul Armstrong, Murray Shames -
University of South Florida, Tampa, FL

OBJECTIVE: To describe a novel off-the-shelf technique to repair type III and type IV thoracoabdominal aortic aneurysms (TAAA) in absence of available prefabricated branched devices.

METHODS: All patients undergoing endovascular repair of type III and IV TAAAs using this technique were included from a prospectively maintained registry. The proximal bifurcated device is deployed with the contralateral gate above the celiac axis. From an axillary approach, through the contralateral gate (and including a single snorkel along side the mainbody), 3 or 4 renovisceral artery branches are sequentially cannulated and stented using Viabahn covered stents. All branches are simultaneous balloon dilated to ensure gutter seal in the contralateral gate. Via the ipsilateral limb, the device can then be extended with a flared iliac extension and/or additional bifurcated device to obtain seal in the distal aorta or iliac arteries.

RESULTS: Eight patients (male =6, mean 78 years of age) were identified since January 2015. All underwent repair using Gore C3 device with 3 (n = 5) or 4 (n=3) renovisceral branches. The celiac artery was sacrificed in four patients and one renal artery in one patient. Mean fluoroscopy time was 88.7 minutes with mean of 92.3cc contrast utilized. Median length of stay was 7 days with 3 days in intensive care. No major cardiac, respiratory, renal, neurologic or wound complications occurred. Three patients had early endoleaks treated with endovascular techniques (n =2) or open surgical ligation (n =1) during the index hospitalization. Two late endoleaks were identified; one type II with stable sac size and one type III requiring iliac limb relining. All limbs and branches remain patent at the time of the last imaging study.

CONCLUSION: We present an endovascular technique for repair of type III and IV TAAAs which appears to be both feasible and safe with good short term outcomes.

Full Program & Abstracts

8:04 am – 8:12 am

30 (RF)

Safety and Effectiveness of Retrograde Arterial Access for Endovascular Treatment of Critical Limb Ischemia (CLI)

Danielle Cafasso, Jordan Stern, Peter Connolly, Sharif Ellozy, Darren Schneider, Andrew Meltzer - New York Presbyterian Hospital, New York, NY

INTRODUCTION AND OBJECTIVES: Retrograde arterial access (RA) of the popliteal, tibial, or pedal arteries may facilitate endovascular treatment of complex infrainguinal lesions. Here, we assess the safety and effectiveness of this technique.

METHODS: Retrospective review of prospectively collected institutional data (consecutive M2S entries) was performed to identify patients with CLI undergoing peripheral vascular intervention (PVI) since 1/2012. Demographics, co-morbidities, procedural characteristics, and outcomes were analyzed, and comparisons made between patients undergoing RA of the popliteal or distal arteries and those treated by standard technique alone.

RESULTS: 430 patients with CLI underwent PVI. Of these, 21 (4.8%) were treated by RA of the popliteal (5, 23.8%), tibial (10, 47.6%), and pedal (6, 28.6%) arteries. Patients treated with RA were more likely to have a history of recent (<5 years) CABG (24% vs. 9%; $P=0.04$) and demonstrated trends towards advanced age (76.0 ± 11.1 vs. 71.7 ± 13.4 ; $P=0.07$) and prior PVI (76% vs. 54%; $P=0.07$). RA facilitated technical success in 90.5% of attempted cases. There were no instances of perforation, distal embolization, or loss of distal target with RA. In the RA group, freedom from reintervention (PVI or surgical bypass) was 68.6% at 6 months and 1 year. Freedom from major amputation at 6 months and 1 year was 86.2% and 78.3%, respectively.

CONCLUSIONS: Retrograde access of the popliteal, tibial, or pedal vessels can be performed safely, and facilitate limb salvage in patients with complex lesions and limited options for revascularization. With appropriate patient selection and attention to technique, complications are uncommon and durability comparable to those treated by conventional techniques.

Full Program & Abstracts

8:15 am – 8:45 am	AWARD SESSION <i>Location: Korbel Ballroom</i> <ul style="list-style-type: none">• Update from 2016 Winner(s)• 2017 Award Winners:<ul style="list-style-type: none">• Gore Travel Award• Medtronic Vascular Resident Research Award• VESS Early Career Faculty Research Award
8:50 am – 9:00 am	Introduction of the President Peter Nelson, MD <i>Location: Korbel Ballroom</i>
9:00 am – 9:45 am	PRESIDENTIAL ADDRESS Thomas Maldonado, MD <i>Location: Korbel Ballroom</i>
10:30 am – 12:00 pm	ROUND TABLE DISCUSSIONS See topics, page 9.
3:00 pm	Registration Re-Opens <i>Location: Burgess Creek Foyer</i>
3:30 pm – 4:00 pm	Coffee/Snacks <i>Location: Korbel Ballroom Foyer</i>

Full Program & Abstracts

4:00 pm – 6:00 pm

SCIENTIFIC SESSION IV

Location: Korbel Ballroom

4:00 pm – 4:12 pm

31

A Ten-Year Experience Using a Hybrid Endovascular Approach to Treat Aberrant Right Subclavian Arterial Aneurysms

Mathew Wooster, Martin Back, Danielle Sutzko, Paul Armstrong, Murray Shames - University of South Florida, Tampa, FL

BACKGROUND: To describe a technique of combined extra-anatomic arch branch revascularization with aortic arch endovascular exclusion for treatment of aberrant right subclavian artery aneurysms.

METHODS: Means of revascularization included carotid-subclavian bypass or subclavian transposition, and origin occlusion was performed by surgical ligation or endovascular embolization at surgeon discretion. Completion of aneurysm exclusion was performed using thoracic aortic endografts (TEVAR) using standard oversizing. Procedures were staged as appropriate based on patient condition to minimize potential airway edema from bilateral neck exposures.

RESULTS: Ten patients, 8 females and 2 males ranging from 32-85 years of age were identified. Presenting symptoms were dysphagia (n=9) and acute type B aortic dissection (n=1). All patients required revascularization/exclusion of bilateral subclavian arteries to enable >20mm proximal aortic fixation. TEVAR with planned coverage of both subclavian origins was performed using transfemoral access (n=9) or iliac conduit (n=1) and required a single device (100-157mm) in all cases except the aortic dissection, which required total coverage of the descending thoracic aorta. Extra-anatomic revascularization and thoracic endografting were staged by 1-2 days in most cases. Subclavian revascularization was by carotid-subclavian bypass using PTFE (n=17), or subclavian transposition (n=3) with proximal occlusion by embolization (n=11) or ligation (n=9). No major complications occurred including spinal cord ischemia, stroke, arm ischemia, or wound complications. Length of stay ranged from 6 to 21 days with all patients having resolution of dysphagia on follow up (mean 37 months). Directed imaging available for seven patients demonstrated absence of endoleak, regression or stability of aneurysm size, and patency of all subclavian revascularizations.

CONCLUSION: We present a hybrid repair technique with low operative morbidity that has shown to be durable in follow up and to provide symptomatic relief for patients with aberrant right subclavian artery aneurysms causing esophageal compression.

Full Program & Abstracts

4:12 pm – 4:24 pm

32

Descriptive Analysis of Patients Undergoing Major Lower Extremity Amputation in the Vascular Quality Initiative

Joshua Gabel, Brice Jabo, Sharon Kiang, Sheela Patel, Christian Bianchi, Jason Chiriano, Theodore Teruya, Ahmed Abou-Zamzam, Jr. - Loma Linda University, Loma Linda, CA

INTRODUCTION AND OBJECTIVES: Despite an aggressive climate of limb salvage and revascularization, 7% of patients with peripheral artery disease (PAD) undergo major lower extremity amputation (LEA). The purpose of this study was to describe the current demographics of patients undergoing major LEA in the Vascular Quality Initiative (VQI).

METHODS: The VQI amputation registry was reviewed to identify patients who underwent major LEAs. Patient factors, limb characteristics, procedure type, and intraoperative variables were analyzed by level of amputation using chi-square analysis for significance with associated p-values.

RESULTS: Between 2013-2015, 3,180 major LEAs were completed with a BKA:AKA ratio of 1.29:1. Mean age was 66 years, 85% living at home prior to admission, and 68% ambulatory. Co-morbidities included diabetes (67%), CAD (32%), ESRD (22%), and COPD (23%). Mean ABI was 0.78, with 28% history of ipsilateral revascularization. Indications were ischemic rest pain or tissue loss (58%), uncontrolled infection (31%), acute ischemia (9%), and neuropathic tissue loss (2%). Post-operatively, 28% were discharged home, complication rate was 16%, and 30-day mortality 6%. Patients who received an AKA vs BKA were more likely female (40.45% vs 31.67%), >70 years (47.95% vs. 32.81%), underweight (18.42% vs. 9.34%), non-ambulatory (40.41% vs 25.11%), ASA class >3 (53.84% vs 43.78%), ABI <0.6 (58.38% vs. 43.78%), and non-private insurance (77.88% vs 69.5%). Patients undergoing AKA were less likely to have post-operative complications (13% vs 18%), but had higher 30-day mortality (9% vs 5%)(All P<0.001).

CONCLUSIONS: In the VQI registry, major LEA was performed predominantly for ischemic rest pain and tissue loss with a BKA:AKA ratio of 1.29:1. Patients undergoing AKA vs BKA were older, more frail, had lower ABI, fewer post-operative complications, but higher 30-day mortality. This registry offers an important real world resource for studies pertaining to vascular surgery patients undergoing major lower extremity amputation.

Full Program & Abstracts

4:24 pm – 4:36 pm

33

An Accumulated Deficits Model Predicts Perioperative and Long-Term Adverse Events After Carotid Endarterectomy

Natalie D. Sridharan, Rabih A. Chaer, Bryan Boyuan Wu, Mohammad H. Eslami, Michel S. Makaroun, Efthymios Avgerinos - University of Pittsburgh, Pittsburgh, PA

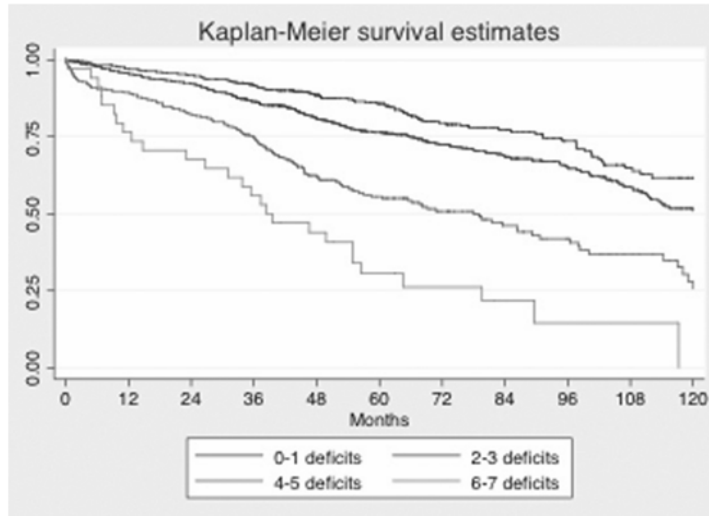
INTRODUCTION AND OBJECTIVES: Decreased reserve in multiple organ systems, accumulated deficits (AD), may better stratify perioperative risk than traditional indices. We hypothesized that an AD model would predict perioperative major adverse events (MAEs) and long-term survival after carotid endarterectomy (CEA).

METHODS: Patients undergoing CEA between 1/1/2000 and 12/31/2010 were retrospectively identified. Seven deficit items from the Canadian Study of Health and Aging Frailty Index (coronary disease, renal insufficiency, pulmonary disease, peripheral vascular disease, heart failure, hypertension, and diabetes) were tabulated. Predictors of perioperative MAEs (stroke, death, or myocardial infarction) and long-term survival were evaluated using regression.

RESULTS: 1,782 CEAs in 1,496 patients (mean age 71.3 ± 9.3 years, 56.3% male, 35.4% symptomatic) were included. The risk of MAEs at 30-days for patients with ≤ 3 deficits was 2.53% vs 8.81% with ≥ 4 deficits and 15.18% with ≥ 5 deficits ($p < 0.001$). Each AD increased the odds of a MAE and hospital stay > 2 days by 1.64 ($p < 0.001$) and 1.15 ($p < 0.001$) respectively. Presence of ≥ 4 deficits was more predictive of perioperative MAE (OR 3.62, $p < 0.001$) than recent symptomatology (OR 1.57, $p = 0.08$) or octogenarian status (OR = 2.00, $p = 0.02$). AD predicted significantly decreased survival (Figure, $p < 0.001$). Patients with ≥ 4 deficits have a hazards-ratio for death of 2.6 ($p < 0.001$). Survival is estimated at 79.5% (95% CI: 0.77 - 0.82) at five-years in patients with ≤ 3 deficits vs. 52.4% (95% CI: 0.46 - 0.58) with ≥ 4 deficits. Five-year survival for asymptomatic octogenarian males with ≥ 4 deficits was only 26.8%.

CONCLUSIONS: An AD model is more predictive of perioperative MAEs after CEA than age or symptom status and remains predictive of long-term survival. In asymptomatic male octogenarians with ≥ 4 deficits, five-year survival is severely limited.

Full Program & Abstracts



Full Program & Abstracts

4:36 pm – 4:48 pm

34

Greater Compliance Within Instruction-for-Use for Concomitant Iliac Aneurysms and Adverse Aneurysm Characteristics - Initial Experience with the Nellix Endovascular Aneurysm Sealing System (EVAS) at a Single Institution

Jeffrey JX Hing, Jack K. Chng, Kiang H. Tay, Tze T. Chong - Singapore General Hospital, Singapore

INTRODUCTION AND OBJECTIVES: The Nellix was introduced to Asia in 2014. Data in Asians have been sparse. Two balloon expandable stents, each surrounded by a polymer-filled endobag are deployed in parallel to obliterate and seal the aneurysm. This paradigm shift to treating abdominal aortic aneurysms confers advantages in various adverse aneurysm morphology off IFU for standard EVAR devices. We examine outcomes of fifteen Asian patients with concomitant infrarenal aortic and iliac artery aneurysms treated with the Nellix at our institution.

METHODS: Between July 2014 and August 2016, fifteen male patients underwent elective EVAS at a single tertiary centre by the same team of vascular surgeons and interventional radiologists. Patient demographics, clinical presentations, aneurysm morphology, perioperative complications and follow up imaging according to standardised protocol were studied. Pre-operative CT images were analysed using validated automatic 3-dimensional sizing software EndoSize.

RESULTS: The novel stent-graft deployment proves consistent, and achieved a 100% technical success. Eleven patients (70%) complied within specified Nellix IFUs, as compared to 20% if standard EVAR IFU were applied. The difference is due to presence of concurrent common iliac aneurysms (n=5), short neck length (n=3), angulated necks (n=3). Adjunct procedures included three open access endarterectomy with embolectomy, one coil embolisation of internal iliac artery, one bilateral renal artery chimneys, and one proximal stent deployment. There was no conversion to open surgery. Average operative time was 133 minutes. Median length of stay was four days. 30-day mortality was 0%. Postoperative morbidity included exacerbation of pre-existing renal impairment (n=6), peripheral vascular disease (n=3) and postimplantation syndrome (n=5). No complication of aneurysm or endobag rupture, endoleak, limb thromboses, migration, or fracture was detected.

CONCLUSIONS: Early data in our centre is encouraging and highlights high procedural success with minimal complications with the Nellix despite challenging patient anatomy.

Full Program & Abstracts

4:48 pm – 4:56 pm

35 (RF)

Persistent Type II Endoleaks Following Endovascular Aneurysm Repair: Graft Type Matters

Cheong J. Lee, Al'haji Camara, Peter J. Rossi, Max Wohlaer, Kellie R. Brown, Brian Lewis, Robert Hieb, Parag J. Patel - Medical College of Wisconsin, Milwaukee, WI

OBJECTIVES: Persistent type II endoleak is associated with increased risk of aneurysm growth and reintervention following EVAR. We sought to determine significant perioperative and graft-specific risk factors for development of type II endoleak following EVAR with current generation endografts.

METHODS: A retrospective review of a prospectively collected database of patients undergoing EVAR between 2008-2015 was performed. Patient demographics, procedural variables, and endograft types were collected. Univariate and multivariate analysis was used to determine predictors of persistent type II endoleaks.

RESULTS: Two hundred and twenty three patients undergoing EVAR during this time period met inclusion criteria. The overall incidence of type II endoleaks at the time of EVAR was 21.5 % (48/223). At 12 months follow up the incidence remained similar at 21.3% (46/216, 7 patients had indeterminate endoleaks). Smoking status was protective against persistent type II endoleaks ($p = 0.007$). The presence of a patent IMA was associated with the development of persistent type II endoleaks ($p = 0.016$). The rates of persistent type II endoleaks were dependent on endograft type ($p = 0.004$): Cook Zenith 12.3% (8/65), Endologix AFX 0% (0/17), Gore Excluder 30.6% (26/91), Medtronic Endurant 24.5% (12/50). On multivariate analysis, smoking status was independently protective ($p = 0.0061$), and the Gore Excluder device was significant determinant associated with higher rates of type II endoleak ($p < 0.01$). Persistent type II endoleaks were not associated with aneurysm size, presence of iliac artery aneurysms, number of device implants, or COPD status.

CONCLUSION: With current endograft iterations, short body configurations such as the Medtronic Endurant and the Gore Excluder had the highest rates of persistent type II endoleak (25 % and 31 %) while long body configurations such as the Cook Zenith and Endologix AFX had the lowest (12 % and 0%).

Full Program & Abstracts

4:56 pm – 5:04 pm

36 (CR)

Utility and Limitations of Smartphone App Technology for Wound Monitoring Following Vascular Surgery: A Case Series

Graham Donald, Julie Beckstrom, Luke Mirabelli, Benjamin Brooke - University of Utah, Salt Lake City, UT

INTRODUCTION/OBJECTIVES: Wound surveillance and surgical site infections are one of the most common reasons for return hospital visits, readmission and resource utilization following vascular surgery. The availability of smartphone applications (apps) that allow transmission of wound images between patients and their provider provides a potential solution for improving post-operative wound surveillance. We report on our early experience using smartphone app technology for wound monitoring following vascular surgery.

METHODS: Between November 2014 and April 2016, we recruited vascular surgery patients at an academic medical center with surgical wounds needing surveillance following discharge if they lived > 10 miles away and possessed a compatible smartphone device. Participants were asked to install a smartphone app (MobiMD) that permitting transfer of images on a HIPPA- safe environment, and then transmit wound images at a frequency and duration determined by their vascular surgery team. Data was analyzed regarding number of readmissions, clinic visits, and emergency department (ED) visits experienced by patients while using the mobile app.

RESULTS: Out of 38 screened patients, only 15 (39%) patients had suitable smartphone device and were willing to submit follow-up wound images. Enrolled patients were predominately male (67%) with mean age of 48 years (range 20-84), lived on average 230 miles away from the hospital, and transmitted a mean of 5 wound images. One patient visited the ED and 2 (13%) patients required readmission, but 7 (47%) patients did not require any clinic follow-up for wound checks. The most common reasons given for not enrolling was lack of a smartphone and not feeling comfortable with the technology.

CONCLUSIONS: Smartphone apps provide innovative technology allowing vascular surgeons patients to monitor surgical wounds closely and may avoid having patients travel long distances for wound checks. However, there are still many barriers to overcome before this technology can be more widely disseminated.

Full Program & Abstracts

5:04 pm – 5:12 pm

37 (RF)

Changes in Geometry and Cardiac Deformation of the Thoracic Aorta After TEVAR

Kelsey E. Hirotsu¹, Ga-Young Suh², Jason T. Lee², Michael D. Dake², Dominik Fleischmann², Christopher P. Cheng² -
¹Stanford University School of Medicine, Stanford, CA;
²Stanford University, Stanford, CA

INTRODUCTION AND OBJECTIVES: Thoracic endovascular aortic repair (TEVAR) has increased in utilization for non-emergent thoracic aortic disease treatment. The interaction between endografts and the thoracic aorta with its dynamic anatomy is poorly characterized for repetitive physiologic stressors and long-term durability. Through 3D modeling we quantified cardiac-induced aortic deformation before and after TEVAR to assess endograft impact on dynamic anatomy.

METHODS: 8 patients with acute (n=4)/chronic (n=3) Type B dissections, or chronic arch aneurysm (n=1), underwent TEVAR (Gore C-TAG: single graft n=5, multiple n=3). Cardiac-resolved CT images were acquired pre and post-TEVAR. 3D models of thoracic aorta and branch vessels were constructed for systolic and diastolic phases. Axial length and curvature of the ascending aorta, arch, and stented lumens were computed from aortic lumen centerlines delineated with branch vessel landmarks. Cardiac-induced deformation was computed from mid-diastole to end-systole.

RESULTS: Pre-TEVAR, there were no significant cardiac-induced changes for aortic axial length or curvature. Post-TEVAR, the ascending aorta increased in axial length (2.3±3.4%, p<0.05) and decreased in mean curvature (0.01±0.01 cm⁻¹, p<0.05) from diastole to systole. From pre to post-TEVAR, axial length change increased in the ascending aorta (p<0.02), mean curvature decreased in the arch and stented aorta p<0.05), and peak curvature decreased in the stented aorta (p<0.05).

Pre-TEVAR → Post-TEVAR changes of geometry and deformation	Ascending aorta (right coronary to brachiocephalic branch)	Aortic arch (brachiocephalic to left subclavian branch)	Stented aorta (proximal to distal graft end)
Axial length change (diastole → systole, %)	1.15 ± 1.01*	-1.46 ± 9.14	-0.38 ± 3.65
Mean curvature (diastole, cm ⁻¹)	0.00 ± 0.01	-0.02 ± 0.02*	-0.03 ± 0.02*
Mean curvature (systole, cm ⁻¹)	0.00 ± 0.02	-0.02 ± 0.02*	-0.03 ± 0.04*
Peak curvature (diastole, cm ⁻¹)	0.02 ± 0.06	-0.00 ± 0.03	-0.23 ± 0.27*
Peak curvature (systole, cm ⁻¹)	-0.00 ± 0.05	-0.02 ± 0.04	-0.24 ± 0.21*
Maximum curvature change (diastole → systole, cm ⁻¹)	0.00 ± 0.08	-0.01 ± 0.06	-0.22 ± 0.25*

values are mean±SD, negative curvature indicates straightening of aorta from pre to post, * indicates p<0.05 from pre to post

Full Program & Abstracts

CONCLUSIONS: TEVAR for a range of indications not only causes direct geometric changes to the stented aorta but also dynamic changes to the ascending and stented aorta. In our cohort, endograft placement straightens the stented aorta and mutes cardiac-induced bending due to longitudinal stiffness. To accommodate this reduced motion in the stented aorta, the ascending aorta undergoes greater length and curvature changes from diastole to systole, relative to pre-TEVAR.

Full Program & Abstracts

5:12 pm – 5:24 pm

38

Toe Pressures are Superior to Duplex Parameters in Predicting Wound Healing Following Toe and Foot Amputations

Patrick Stone - WVU Charleston, Charleston, WV

The goal of our study was to identify clinical factors that associated with wound healing following toe, forefoot, and midfoot amputations.

METHODS: We retrospectively examined records of patients receiving elective toe, forefoot, or midfoot amputation at our institution over a 5 year span (2010-2015). A total of 333 amputations received non-invasive vascular assessment of the lower extremity pre-amputation and follow-up at 90 days post-amputation. Univariate and multivariate logistic regression was used to identify variables predicting wound healing as defined as wound breakdown requiring re-amputation within 90 days.

RESULTS: Wound healing occurred in 81% of amputations. A total of 23 (7%) patients required revisions of the foot while 39 (12%) patients required major amputations by 90 days. Univariate analysis found that toe pressure at or above the median value (47 mmHg, $p=0.04$), bi/triphasic anterior tibial ($p=0.01$) and posterior tibial artery ($p=0.01$) waveforms associated with wound healing. When these diagnostic parameters were examined in the presence of confounders (increasing age, chronic kidney disease, and concomitant revascularization), only toe pressure ≥ 47 mmHg predicted amputation site healing (odds ratio: 3.1(95% CI: 1.0-9.4), $p=0.04$).

CONCLUSION: Pre-amputation toe pressures of 47 mmHg and above associated with wound healing. No other non-invasive vascular studies significantly predicted wound healing in the presence of confounders. Thus, toe pressures could be used in clinical decision making and should be routinely obtained pre-amputation.

Full Program & Abstracts

5:24 pm – 5:36 pm

39

Temporal Trends and Determinants of Inpatient Versus Outpatient Dialysis Access Operations: Is There an Effect on Perioperative Outcomes?

Caitlin W. Hicks¹, Michael R. Bronsert², Karl E. Hammermeister², William G. Henderson², James H. Black, III¹, Natalia O. Glebova² - ¹Johns Hopkins Medical Institutes, Baltimore, MD; ²University of Colorado, Aurora, CO

INTRODUCTION AND OBJECTIVES: As health care costs rise, a movement toward reducing hospital admissions has emerged, particularly for operations that may be performed in outpatient setting. We aim to describe temporal trends in the proportion of dialysis access procedures performed on inpatient vs. outpatient basis, and to determine the effects of these changes on morbidity and mortality.

METHODS: 2005-2014 ACS NSQIP database was queried using CPT codes for primary arteriovenous fistula creation. Changes in proportions of inpatient vs. outpatient operations by year and 30-day postoperative morbidity and mortality were analyzed using univariable statistics, multivariable logistic regression, and propensity matching.

RESULTS: 5,860 dialysis access operations were identified, of which 3,988 (68%) were done on outpatient basis. Inpatient procedures were associated with higher morbidity (44 vs. 18%) and mortality (3 vs. 0.8%) than outpatient procedures ($P < .01$). The proportion of procedures done on outpatient basis increased over time, from 46% in 2005 to 73% in 2014 ($P < .01$). Morbidity and mortality significantly increased from 2005 to 2014 for inpatient (morbidity 18 to 28%, mortality: 2 to 6%), but not outpatient (morbidity 6 to 3%, mortality: 2 to 1%) procedures. Determinants of inpatient procedure included age, black race, ASA class, congestive heart disease, emergent intervention, poor functional status, and work RVU (all, $P < .01$). After propensity matching on 26 variables, mortality was similar for inpatient vs. outpatient procedures (OR 1.7, 95% CI 0.9-3.4), but morbidity was persistently higher for inpatients (OR 2.9, 95% CI 2.2-3.9).

CONCLUSIONS: Dialysis access operations are increasingly performed on outpatient basis; inpatient procedures appear to be reserved for patients with acute illnesses and serious comorbidities, and have worse outcomes. After matching, inpatients continue to have higher morbidity, arguing against performing dialysis access procedures in inpatients admitted for other ailments. For appropriately selected patients, performing dialysis access operations on outpatient basis is preferable.

Full Program & Abstracts

5:36 pm – 5:48 pm

40

Superior 3-Year Value of Open and Endovascular Repair of AAA with High Volume Providers

Antoinette Esce, Ankit Medhekar, Fergal Fleming, Katia Noyes, Roan J. Glocker, Jennifer L. Ellis, Kathleen G. Raman, Michael C. Stoner, Adam J. Doyle - University of Rochester School of Medicine and Dentistry, Rochester, NY

INTRODUCTION AND OBJECTIVES: Conflicting literature exists regarding resource utilization for cardiovascular care when stratified by provider volume. This study investigates the differences in value of abdominal aortic aneurysm (AAA) repair by high and low volume providers. The hypothesis of this study is that high volume providers will provide superior value AAA repairs when compared to low volume providers.

METHODS: Using the New York Statewide Planning and Research Cooperative System (SPARCS) database and its linked death database, patients undergoing intact open and endovascular aneurysm repair (EVAR) were identified over a 10-year period. Charge data was normalized to year 2016 dollars and the data stratified by repair modality and annual surgeon volume. Univariate technique was used to compare the two groups over a 3-year follow up period.

RESULTS: 911 surgeons performed open AAA repairs and 615 performed EVAR. For both repair modalities, and despite a patient population with more vascular risk factors, the cumulative adjusted charge for all aneurysm related care was significantly less for high volume providers than low volume providers. The calculated 3-year value — patient life years per cumulative charge — was also superior for high volume providers compared to low volume providers (Table). This difference in charge and value persisted after propensity score matching for race, sex, insurance status, and common vascular comorbidities including hypertension, dyslipidemia, and a history of smoking.

CONCLUSIONS: High volume surgeons performing repair of aortic aneurysms provide superior value when compared to low volume providers. The improved value margin is driven by both lower charge and improved survival, despite an increased incidence of cardiovascular comorbidities. This study adds support for the regionalization of care for patients with aortic aneurysm.

Full Program & Abstracts

	OPEN			EVAR		
	High Volume	Low Volume	p-value	High Volume	Low Volume	p-value
n	6,342	5,806		8,817	5,642	
Volume <i>(mean repairs / surgeon-yr)</i>	19.3±0.2	3.9±0.04	<0.0001	36.4±0.3	5.7±0.05	<0.0001
Hypertension (%)	62.3±0.6	57.9±0.7	<0.0001	65.4±0.5	62.9±0.6	<0.005
Dyslipidemia (%)	37.3±0.6	29.6±0.6	<0.0001	49.2±0.5	42.9±0.7	<0.0001
History of Smoking (%)	22.3±0.5	17.6±0.5	<0.0001	32.1±0.5	24.8±0.5	<0.0001
Survival (%) <i>(3-yr)</i>	82.2±0.5	79.3±0.5	<0.0001	81.1±0.4	80.6±0.5	NS
Total charges <i>(k\$)</i>	78.2±1.2	106.3±1.8	<0.0001	81.0±1.1	107.4±1.7	<0.0001
Value <i>(yr/100k\$)</i>	6.9±0.1	5.5±0.1	<0.0001	6.2±0.1	4.6±0.1	<0.0001

Full Program & Abstracts

5:48 pm – 5:56 pm

41 (RF)

Most Early Type 1A Endoleaks After EVAR Will Resolve Without Secondary Intervention

Thomas FX O'Donnell, Michael R. Corey, Sarah E. Deery, Gregory Tsougranis, Rohit Maruthi, William D. Clouse, Richard P. Cambria, Mark F. Conrad - Massachusetts General Hospital, Boston, MA

OBJECTIVES: The natural history of early proximal attachment site endoleaks (1A) following EVAR is not well known. Our aim was to identify risk factors for persistent type 1A endoleak and determine its effect on the long-term outcomes of EVAR.

METHODS: We identified all patients who underwent infrarenal EVAR at a single institution between 1998-2015. Intraoperative arteriograms were reviewed to identify patients with a type 1A endoleak. Aneurysm features were characterized and studied for predictors of persistent endoleaks at the conclusion of the case and within one month. Patient records and the Social Security Death Index were used to record one and five year survival.

RESULTS: We identified 1,484 EVARs, 122 (8%) of which were complicated by Type 1A endoleak, with a median followup of 4 years. In 95 cases (78%), supplementary intraoperative procedures were undertaken. Resolution was achieved in 63 cases requiring additional procedures (66%) and in 16 cases without additional intervention (59%), for an overall success rate of 65%. At one month, only 16 endoleaks persisted (13%), and only 6 persisted at 1 year (6%). Seven patients (6%) required reintervention between 3 days and 9 years postoperatively. Only one patient experienced aneurysm rupture at 3 years. On univariate analysis, only neck calcification (RR 2.48 [95% confidence interval 1.62-3.79], $P < 0.01$) predicted persistent endoleak at case end. Predictors of persistent endoleak at one month were neck diameter (OR 1.17 [1.05-1.31], $P < .01$) and conical neck (RR 4.3 [1.67-11.07], $P < .01$). Postoperative endoleak was associated with decreased one year survival (79% vs 90%, $P = 0.02$), but not five year survival (52% vs 58%, $P = 0.45$).

CONCLUSIONS: Aneurysm rupture after type 1A endoleak is rare, and most will resolve within one year. These data suggest that early persistent Type 1A endoleaks can be safely observed in most patients.

Full Program & Abstracts

5:56 pm – 6:04 pm

42 (RF)

Cost-Effectiveness Analysis of Drug Coated Balloon vs. Drug Eluting Stent in the Superficial Femoral Artery

Natalie D. Sridharan, Aureline Boitet, Kenneth Smith, Kathy Noorbakhsh, Efthymios Avgerinos, Mohammad H. Eslami, Michel Makaroun, Rabih Chaer - University of Pittsburgh, Pittsburgh, PA

INTRODUCTION AND OBJECTIVES: Drug coated balloons (DCBs) may increase durability of endovascular treatment of superficial femoral artery (SFA) disease while avoiding stent-related risks. Our purpose was to use meta-analytic data of DCB studies to compare cost-effectiveness of potential SFA treatments: DCB, drug eluting stent (DES), plain old balloon angioplasty (POBA) or bare metal stent (BMS).

METHODS: A search for randomized controlled trials comparing DCB to POBA for SFA disease was performed. Hazard ratios were extracted for target lesion revascularization (TLR); odds ratios for primary patency (PP). Cost-effectiveness analysis, assuming a payer perspective, utilized a decision model to simulate one-year PP. Parameter estimates for DCBs were derived from meta-analysis. Costs were based on current Medicare outpatient reimbursements.

RESULTS: Eight studies (1352 patients) met inclusion criteria for meta-analysis. DCB outperformed POBA with respect to TLR over time (pooled HR = 0.41, $p < 0.001$) and one-year PP (pooled OR 3.30, $p < 0.001$). In the decision model, highest one-year PP was in DES (79%), followed by DCB (74%), BMS (71%) and POBA (64%). With baseline cost of \$9259.39 per PP at one-year in the POBA-first group, the incremental cost per PP limb for each other strategy compared to POBA was calculated: \$14,136.10/ additional PP for DCB, \$38,549.80/PP for DES, and \$59,748.85/PP for BMS. BMS is dominated by being more expensive and less effective than DCB. Compared directly to DCB, DES costs \$87,377.20/ additional PP limb at one-year. Based on the projected PP, the number needed to treat for DES compared to DCB is 20, an additional cost of \$234,169.60/year. At current reimbursements, the use of >2 DCBs/procedure would no longer be cost-effective compared to DES.

CONCLUSIONS: Current data and reimbursements support DCB as a cost-effective strategy in the SFA; any additional effectiveness of DES comes at a high price. Use of multiple DCBs/intervention significantly decreases cost-effectiveness.

7:00 pm – 10:00 pm

PRESIDENT'S DINNER

Location: Champagne Powder Room

Full Program & Abstracts

Sunday, February 5, 2017

6:30 am – 7:00 am	Continental Breakfast <i>Location: Korbel Ballroom Foyer</i>
6:30 am – 9:30 am	Registration <i>Location: Burgess Creek Foyer</i>
7:00 – 9:15 am	SCIENTIFIC SESSION V <i>Location: Korbel Ballroom</i>
7:00 am – 7:12 am	43 Elevated Wall Tension Initiates Interleukin-6 Expression and Abdominal Aortic Dilation Adam Akerman, Robert Stroud, Elizabeth Nadeau, Katherine Owen, Rupak Mukherjee, John Ikonomidis, Jeffrey Jones, Jean Marie Ruddy - Medical University of South Carolina, Charleston, SC

INTRODUCTION: Hypertension (HTN) is a risk factor for abdominal aortic aneurysm (AAA) development. Elevated plasma levels of Angiotensin-II (ANGII) and interleukin-6 (IL-6) are associated with HTN and AAA. IL-6 induces monocyte chemoattractant protein-1 (MCP-1) which recruits macrophages that play a role in aortic remodeling. Therefore, this study examined the mechanistic relationship between elevated IL-6 and dilation of the abdominal aorta (AA).

METHODS: A novel IL-6 infusion model (4.36 μ g/kg/day) was created utilizing an osmotic infusion pump in wild-type normotensive mice. After 28 days AA diameter was measured by digital microscopy and excised for CD68 immunostaining and cell-sorting by flow-cytometry with CD45 and F4/80 to identify macrophages (n=3). Aortic segments from wild-type mice were hung on parallel wires in an *ex vivo* tissue myograph at normotension (1.2g) in the presence of IL-6 (50 ng/mL) for 3 hours and expression of MCP-1 was evaluated by RT-PCR. Isolated aortic vascular smooth muscle cells (VSMCs) from wild-type normotensive mice were subjected to 18% biaxial cyclic-stretch or held static (control) for 3 hours (n=6), and IL-6/MCP-1 expression were evaluated in the presence/absence of ANGII by RT-PCR.

RESULTS: IL-6 infusion resulted in a 24.5 \pm 2.4% (p<0.05) increase in AA diameter at 2 weeks. Aortic dilation was accompanied by an accumulation of macrophages in the AA medial layer as defined by an increase in CD68+ staining, and 5-fold increase in CD45+/F480+ macrophages when compared to controls. Wild-type AA segments exposed *ex vivo* to IL-6 increased transcription of MCP-1. Isolated VSMCs treated with ANGII resulted in increased IL-6 expression (70.6 \pm 29.7%, p<0.05) when compared to non-treated controls. Cyclic-stretch of VSMCs resulted in increased IL-6 (183.6 \pm 38.9%) and MCP-1 (204.7 \pm 29.7%) expression (p<0.05) when compared to controls.

CONCLUSIONS: Elevated tension may result in increased IL-6, MCP-1, macrophage number, and AA dilation. Therefore, interrupting steps in this pathway may form the basis of novel therapeutics.

Full Program & Abstracts

7:12 am – 7:24 am

44

Using Modified Frailty Index as a Screening Tool to Predict Adverse Outcomes After Lower Extremity Open Revascularization

Tarik Ali, Erik Lehman, Faisal Aziz - Penn State University, Hershey, PA

OBJECTIVE: There has been recent interest in using Frailty to predict outcomes in surgical patients. A simplified form of the original Frailty index from the Canadian Study of Health and Aging has been established as the modified frailty index (mFI). In our study we have sought to apply the mFI to infra- inguinal vascular bypasses and to predict outcomes.

METHODS: The 2010 American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database was used: patients undergoing infrainguinal arterial bypass surgery were identified We used an mFI with 11 variables, based on mapping the Canadian Study of Health and Aging Frailty Index to the NSQIP comorbidities. A bivariate and multivariate analysis was done using logistic regression analysis. Factors associated with increased risk of mortality were identified.

RESULTS: A total of 4,704 patients (64% Males, 36% Females) underwent infrainguinal arterial bypass. Incidence of post operative myocardial infarct: 1% (For MFI:0-0.9) vs. 4%; mortality: 0.6% (For MFI:0-0.9) vs. 7.4% (For MFI 0.54-0.63); Renal failure 0.58% (For MFI 0-0.09) vs. 0.83% (For MFI 0.54-0.63) and graft failure 4.8% (For MFI 0-0.09) vs. 7.4% (For MFI 0.54-0.63). Following factors were associated with increased 30-day mortality: Age>80 years (OR 9), ASA Class 4 (OR 27), emergency operation (OR 3.4), dialysis (OR 5.1), stroke (OR 11), sepsis (OR 4.5) Acute renal failure (OR 31).

CONCLUSIONS: This study demonstrates that the mFI can be used as a valuable tool to identify patients at a higher risk for post operative morbidity and mortality after lower extremity revascularization. Higher mFI predicts increased risk of post operative complications. It can be used as a screening tool to identify patients who are at a high risk for developing complications.

Full Program & Abstracts

7:24 am – 7:36 am

45

Diabetes and Poor Runoff Predict Late Major Amputation After Percutaneous Intervention for Claudication

Kara J. Kennedy, William Darrin Clouse, Emel Ergul, Virendra I. Patel, Glenn M. LaMuraglia, Richard P. Cambria, Mark Conrad - Massachusetts General Hospital, Boston, MA

INTRODUCTION AND OBJECTIVES: Percutaneous intervention (PI) is frequently used to treat patients with claudication with reasonable early results. However, long-term follow-up is rare. The purpose of this study is to examine the long-term outcomes of patients who underwent infrainguinal PI for claudication.

METHODS: All patients who underwent an SFA/popliteal PI for claudication from 5/2002-12/2009 were identified. End points included: primary patency, assisted patency, progression to critical limb ischemia (CLI) and limb salvage as determined by Kaplan-Meier life-table analysis and, factors predictive of failure were evaluated by multivariate methods.

RESULTS: There were 568 patients treated during the study period. Clinical demographics included: mean age 68 years, male 68%, diabetes 39%, dialysis 2%. Lesions were classified as TASC A/B in 85% of patients and 23% had 0/1 vessel runoff. PI was confined to the femoropopliteal segment in 86% and involved multiple segments in 14%. Interventions included angioplasty only in 56% while the remaining 44% received at least one stent. The average follow-up was 8.5 years. The 10 year primary patency was 33% with an assisted patency of 67% (there were 136(33%) peripheral re-interventions) and a limb salvage rate of 97% (there were 19 major amputations). Progression to CLI occurred in 47 (9%) patients and the 10 year freedom from CLI was 92%. Negative predictors of primary patency included diabetes and 0/1 vessel runoff. Predictors of progression to CLI were diabetes and TASC C/D lesions while clopidrogel was protective. Predictors of limb loss included diabetes, 0/1 vessel runoff and CHF.

CONCLUSIONS: The majority of patients with claudication will do well after SFA/popliteal PI. However, around 10% of patients will progress to CLI over time. In addition, major amputation, though rare, is seen with longer follow-up and is driven by diabetes and extent of anatomic disease. Peripheral intervention for claudication should be approached cautiously in these high-risk patients.

Full Program & Abstracts

7:36 am – 7:48 am

46

Outcomes of Mechanical Thrombectomy in Conjunction with Thrombolysis in the Treatment of Acute Limb Ischemia

Sagar S. Gandhi, Alex Ewing, Bruce Gray - Greenville Health System, Greenville, SC

INTRODUCTION AND OBJECTIVES: Acute lower extremity ischemia (ALI) is caused by acute thrombosis or embolization. Once thrombus is removed then an underlying lesion can be identified and treated. Thrombolytic therapy (TT) and/or mechanical thrombectomy (MT) can dissolve/remove thrombus; however, MT alone may require the adjunctive use of TT. The aim of this study was to compare the use of MT plus TT versus TT alone for the treatment of ALI.

METHODS: We retrospectively reviewed all patients with ALI who underwent MT with or without TT between January 2008 and April 2014 (N=99). Patients with incomplete medical charts were excluded (n=16). Remaining patients were divided into 2 cohorts based on treatment: Group 1 included patients who underwent MT + TT (n=54), Group 2 included those who underwent TT alone (n=29). Lesions were further characterized by anatomic location: iliac disease (n=14), femoropopliteal disease (n=53), tibial disease (n=2), and multilevel disease (n=14). Data collection included patient and limb characteristics, duration of treatment, complications, clinical outcomes, adjunctive interventions, and follow-up.

RESULTS: No significant differences were seen between treatment groups in terms of patient characteristics, occlusion length and location, Rutherford Class, mean duration of ischemia time (p=0.22), or mean lysis time (p=0.58). Treatment groups were also similar with regard to outcomes, including peri-procedure complications, patency, reintervention, limb salvage, and amputation-free survival (Table).

CONCLUSIONS: There was no difference between MT + TT and TT alone in terms of periprocedural complications or outcomes. In the quest to resolve ALI, initial thrombus extraction with MT may not reduce the need, duration, or efficacy of TT.

Full Program & Abstracts

7:48 am – 7:56 am

47 (RF)

Predictive and Prognostic Risk Factors of Renal Failure in Acute Aortic Dissection

Samuel Leake, Harleen K. Sandhu, Hazim J. Safi, Anthony L. Estrera, Kristofer M. Charlton-Ouw - University of Texas Medical School at Houston, Houston, TX

OBJECTIVES: To identify the risk factors for the development of acute renal failure after acute aortic dissection (ARF-AAD), its effect on survival, and the rate of recovery after discharge.

METHODS: All patients with AAD between 1999 and 2014 were analyzed for comorbidities, intraoperative and postoperative outcomes using contingency table, multiple logistic and Cox regression. Dialysis was instituted at the recommendation of nephrology consultants.

RESULTS: 131/1079 (12%) cases of ARF-AAD required dialysis. In addition, 22 patients had chronic dialysis prior to occurrence of aortic-dissection. Mean age was 60 ± 14 years with 26% females; 64% type A, and 36% type B. 44/131 were discharged on dialysis while remainder either recovered renal-function or died. 30-day-mortality was 35% in ARF-AAD vs. 10% in non-ARF ($p < .001$). Risk-factors for early mortality included coronary-disease (OR-2.2, $p = .017$), rupture (OR-2.3, $p = .013$), ARF (OR-3.6, $p < .001$), hypotension (OR-3.6, $p < .001$), and coagulopathy (OR-2.1, $p = .025$). Over median follow-up of 4.6-years, survival (Figure) was significantly lower among ARF-AAD ($p < .001$). On multivariable analysis, hypotension (OR-3.6, $p < .001$), reoperation (OR-4.4, $p < .001$), and malperfusion (excluding renal) (OR-2.2, $p = .005$) were significantly predictive of ARF-AAD. Recovery among those who survived the initial 30-days post-AAD was 26%, over median of 1.6 (IQR:0.6-2.5) months. Regardless of dissection-type, preexisting renal failure (HR-2.3, $p < 0.001$) and ARF-AAD (HR-2.4, $p < .001$) were associated with reduced survival, and this effect on mortality is pronounced during the initial 2-4 months (fig 2).

CONCLUSIONS: New and preexisting renal failure is associated with higher mortality after AAD. Among survivors of AAD who required dialysis at discharge, only a minority recover enough renal function to ever stop dialysis. However, after the initial dissection event and recovery, the survival rate is similar among those with and without need for ongoing dialysis.

Full Program & Abstracts

Figure 1. Effect of ARF Requiring Dialysis on Survival in Acute Aortic Dissection (AAD)

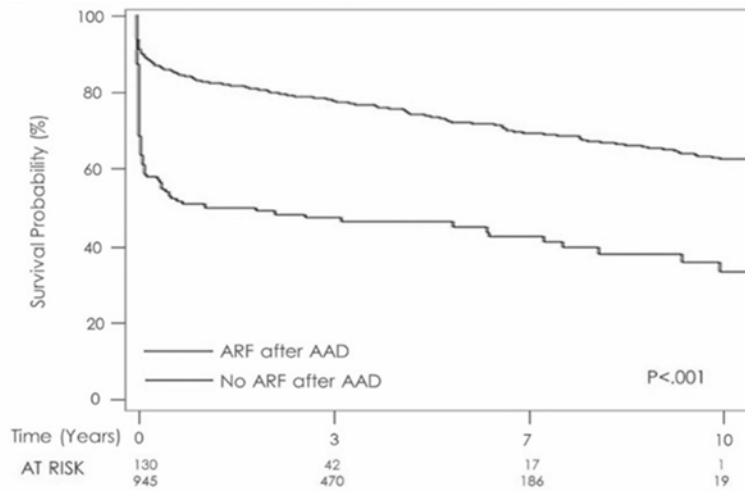
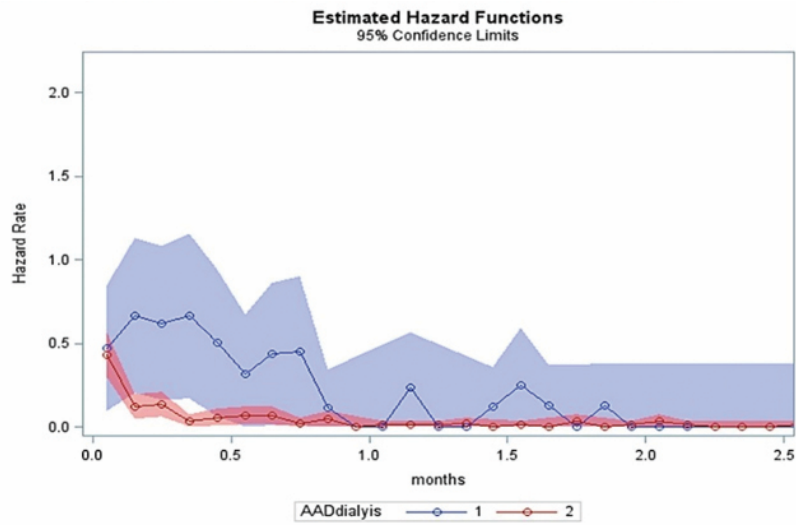


Figure 2. Hazard of Mortality Over Initial Period Following Discharge



Full Program & Abstracts

7:56 am – 8:04 am

48 (RF)

Novel Application of Branched Endograft for Preservation of Pelvic Circulation

Roy Miller¹, Patrick Sowa², Matthew Eagleton¹, Frederico Parodi¹ - ¹Cleveland Clinic, Cleveland, OH; ²Chicago Medical School, Chicago, IL

INTRODUCTION/OBJECTIVES: Endovascular repair of a proximal anastomotic pseudoaneurysm of an end to side aortobifemoral bypass (ABF) can lead to pelvic ischemia. We present a novel application of a branch aortic endograft to repair such a pseudoaneurysm while preserving flow into the ABF and native aortoiliac system.

METHODS: A 71 year old male with a history of aortoiliac occlusive disease and lifestyle limiting claudication was treated with an aortobifemoral bypass in 1999. The patient developed an 8.8cm pseudoaneurysm at the aortic anastomosis. A CTA demonstrated patent right common and internal iliac arteries with an occluded right external iliac artery.

RESULTS: A 24x80mm endograft with an 8mm posterior branch based on the Cook Zenith device (Bloomington, IN) was delivered via a right femoral exposure. The preloaded wire of the main body was snared via left brachial access. A 10 Fr sheath was advanced into the side branch of the graft to deliver a 10x10 Fluency (Bard, Covington, Georgia) stent graft into the right common iliac artery. The branch was reinforced proximally with a balloon expandable stent. The patient was discharged after 5 days. At 1-month, a CTA demonstrated a patent ABF, patent branch graft into the pelvis, and exclusion of the pseudoaneurysm.

CONCLUSION: Branch grafts can provide minimally invasive revision of failing ABF, in this case an anastomotic pseudoaneurysm, while preserving pelvic circulation and lower extremity perfusion.



Full Program & Abstracts

8:04 am – 8:16 am

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Successful Use of Endovascular Aortic Sealing (EVAS) for Treatment of Aortic Rupture in a Porcine Model

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INTRODUCTION AND OBJECTIVES: Endovascular Aortic Sealing (EVAS) represents a recent transformation in approach for treatment of aortic aneurysms. Initial reporting has shown that EVAS using the Nellix device is safe with similar complication rates to standard endovascular aortic repair (EVAR). What remains unknown is how EVAS technology will behave in the ruptured setting. The purpose of this report is to discuss how EVAS system and endobag technology behave when deployed in a porcine model of aortic rupture.

METHODS: A controlled left retroperitoneal rupture was created in 20 large swine. Following rupture an EVAS system was deployed across the rupture site to seal the area. The primary endpoint was seal from ongoing hemorrhage. Other parameters were examined to include endobag extravasation, aortic wall pressure measurements and device behavior in a live tissue model

RESULTS: Of the EVAS systems used, 15 Nellix (Endologix, Irvine CA) devices and 5 novel EVAS systems were used. Of the correctly deployed devices 100% sealed the rupture (n=19). One device was deployed above the rupture site and seal was not achieved secondary to mal-positioning. Endobag extravasation was seen with an average protrusion of 7.7mm . No other areas of aortic injury were noted secondary to Endobag trauma. Pressure recording from behind the endobag indicate loss of pulsatile flow to the aortic wall with polymer curing.

CONCLUSIONS: Endovascular Aortic Sealing for rupture is feasible and performs well in a porcine model of aortic rupture. Polymer extravasation is seen and may be controllable by the implanter. Once the polymer has cured, pulsatile aortic wall pressure is no longer present. EVAS represents an emerging technology for treatment of aortic rupture.

Full Program & Abstracts

8:16 am – 8:28 am

50

Left-Sided Varicocele as a Rare Presentation of May-Thurner Syndrome

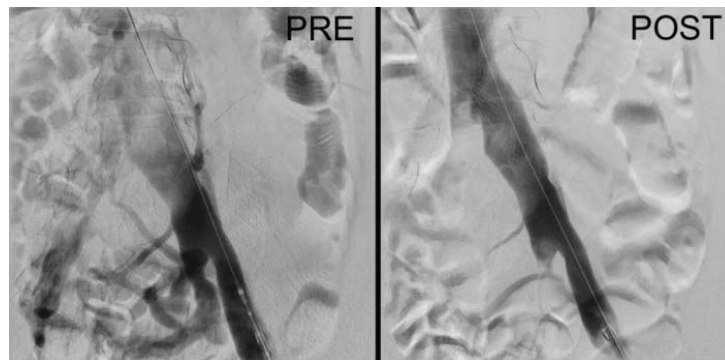
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INTRODUCTION AND OBJECTIVES: May-Thurner syndrome (MTS), the clinical sequelae of left iliac vein compression between the right iliac artery and the spine, is an accepted cause of lower extremity edema and venous thromboembolism. It is more prevalent in younger women, and typically presents with left lower extremity symptoms. Atypical presentations such as right-sided symptoms, chronic pelvic pain, and even fatal venous rupture have been reported. Here we describe iliac vein compression presenting as a chronic left-sided testicular varicocele.

METHODS: A 22 year-old man presented with left testicular varicocele, scrotal edema and pain after failing multiple attempts at surgical repair. MRI revealed left iliac vein compression and marked cross-pelvic collaterals. Venography and IVUS confirmed left common iliac vein compression and typical changes of MTS. There was no gonadal vein reflux. An iliac vein stent (Wallstent, Boston Scientific) was placed.

RESULTS: A good technical result was achieved, with elimination of internal iliac vein reflux and marked reduction in pelvic collateral flow (see image). The patient reported resolution of his symptoms.

CONCLUSIONS: Varicocele is a leading cause of testosterone insufficiency and infertility in young males. In the majority of cases, successful treatment can be achieved by addressing reflux in the internal spermatic vein (ISV) and/or gonadal vein (GV) by a variety of surgical or endovascular approaches. In unusual cases, the culprit pathology may be reflux in the vein of the vas deferens, which unlike the ISV and GV, drains into the internal iliac vein. In such cases, iliac vein compression usually associated with MTS may result in varicocele. To our knowledge, this is the first report of refractory varicocele secondary to iliac vein compression successfully treated with endovenous stenting.



Full Program & Abstracts

8:28 am – 8:40 am

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The Impact of Arch Involvement in Acute Type B Aortic Dissection

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INTRODUCTION: The affect of aortic arch involvement in patients with uncomplicated acute type B aortic dissection (ATBAD) is unknown. This study aims to determine the impact of arch involvement on outcomes in ATBAD.

METHODS: We reviewed our prospective database of patients with ATBAD from 2000 to 2015. Complications included rupture, clinical malperfusion, refractory pain and hypertension. Neurologic deficits were defined as stroke, paraplegia or paraparesis. Data were analyzed by standard univariate statistical methods, multiple logistic regression and Kaplan-Meier statistics.

RESULTS: Among 531 patients with ATBAD, 58.7% were uncomplicated ATBAD (uATBAD) and 41.3% were complicated ATBAD (cATBAD). The average age was 60.8 years (64% male) with a median follow up time of 4 years. Arch involvement was present in 176 (33%) patients with ATBAD and was associated with increased admission stroke ($p=0.009$; OR 10.23) and rupture ($p=0.037$; OR 2.25). Arch involvement in ATBAD did not impact long-term survival compared to non-arch patients ($p=0.21$). When stratified for cATBAD, arch involvement again did not demonstrate a significant difference ($p=0.156$). The adjusted predictors of long-term mortality in ATBAD include low glomerular filtration rate (GFR) on admission ($p=0.005$; HR 1.66), age ($p=0.007$; HR 1.017) and cATBAD ($p<0.0001$; HR 2.204). After adjustment for cATBAD, admission GFR, and open surgical repair, arch involvement remains a predictor of major respiratory complications ($p=0.0003$; OR 2.113) and neurologic deficits ($p=0.0178$; OR 1.94). However, after adjustment for cATBAD, GFR, and open repair, arch involvement was not associated with early mortality ($p=0.18$; OR 0.8-3.53). Arch involvement was also not associated with connective tissue disorder ($p=0.854$) or retrograde dissection ($p=0.175$).

CONCLUSIONS: Patients with ATBAD and aortic arch involvement are at increased risk of early neurologic and respiratory complications. Arch involvement does not affect short- or long-term survival. Arch involvement in ATBAD does not appear to necessitate a change in management.

Full Program & Abstracts

8:40 am – 8:52 am

52

Positive Impact of an Aortic Center Designation

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OBJECTIVES: In January 2015 we created a multidisciplinary Aortic Center with the collaboration of Vascular Surgery, Cardiac Surgery, Interventional Radiology, Anesthesia and Hospital Administration. We report the initial success of creating a Comprehensive Aortic Center.

METHODS: All aortic procedures performed from January 1, 2015 until December 31, 2015 were entered into a prospectively collected database and compared with available data for 2014. Primary outcomes included the number of all aortic related procedures, transfer acceptance rate, transfer time and proportion of elective/emergent referrals.

RESULTS: The Aortic Center included 5 vascular surgeons, 2 cardiac surgeons, and 2 interventional radiologists. Workflow processes were implemented to streamline patient transfers as well as physician and operating room notification. Total aortic volume increased significantly from 189 to 300 cases. This reflected an overall 59% ($P = .0167$) increase in all aorta-related procedures. We had a 65% overall increase in transfer requests with 156% increase in acceptance of referrals and 136% drop in transfer denials ($P < .0001$). Emergent abdominal aortic cases accounted for 17% ($n = 45$) of our total aortic volume in 2015. The average transfer time from request to arrival decreased from 515 minutes to 352 minutes, though this change was not statistically significant. We did see a significant increase in use of air-transfers for aortic patients ($P = .0041$). Factorial analysis showed that time for transfer was affected only by air-transfer use, regardless of the year the patient was transferred.

CONCLUSION: Designation as a comprehensive Aortic Center with implementation of strategic workflow systems and a culture of “no refusal of transfers” resulted in a significant increase in aortic volume for both emergent and elective aortic cases. Case volumes increased for all specialties involved in the center. Improvements in transfer center and EMS communication demonstrated a trend toward more efficient transfer times.

Full Program & Abstracts

8:52 am – 9:04 am

53

Coronary Artery Calcium Scoring: Role in Screening for Vascular Disease?

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INTRODUCTION AND OBJECTIVES: Coronary Artery Calcium Scores (CACS) for coronary artery disease (CAD) screening is well established. However, there is no known association between CACS and non-coronary atherosclerotic disease. We hypothesize that CACS may be an accurate predictor of peripheral arterial disease, which this initial study evaluates.

METHODS: Patients from a prospectively collected vascular procedure registry were cross referenced with a local CACS database from January 1, 2006 to October 31, 2015. A retrospective chart review was performed. The study group consisted of patients who underwent interventions for systemic atherosclerotic disease and was subdivided into zero, low, intermediate, and high subgroups based on CACS. Patients who underwent procedures unrelated to systemic atherosclerosis (i.e. varicose veins, spinal exposure, trauma) constituted controls.

RESULTS: Of 11137 patients with CACS, 262 (2.4%) underwent vascular interventions. Two-hundred patients were in the study group and 62 in the control group. The study group was significantly older (72.8 vs 65.1, $p<0.01$), predominantly male (57% vs 21%, $p<0.01$), and with greater prevalence of hypertension, CAD, hyperlipidemia, COPD, renal disease, and tobacco use (all $p\leq 0.05$). Study and control group patients underwent 428 and 106 procedures, respectively. The incidence of vascular intervention in the study group was significantly higher for all CACS subgroups, and increased linearly as CACS increased ($r=0.94$, $p=0.05$). Symptomatic lower extremity ischemia necessitated more interventions with increasing CACS (OR 2.52, 3.66, 4.70 [$p=0.03$] for low, intermediate, high subgroups, respectively).

Full Program & Abstracts

TABLE 1 - Procedure Data:

	Control (n = 106)	Study Group (n = 428)	P-value	Odds Ratio	95% CI Lower	95% CI Upper
CACS = 0	36 (55.4%)	29 (44.6%)	<0.01	0.14	0.08	0.25
CACS = 1-100	32 (31.4%)	70 (68.6%)	0.01	0.45	0.28	0.74
CACS = 101-400	27 (23.3%)	89 (76.7%)	0.36	0.77	0.47	1.26
CACS > 400	11 (4.4%)	240 (95.6%)	<0.01	11.03	5.74	21.18
CACS > 0	70 (14.9%)	399 (85.1%)	<0.01	7.08	4.08	12.28

	CACS 0 (n = 29)	CACS 1-100 (n = 70)	P	OR	CI	CACS 101-400 (n = 89)	P	OR	CI	CACS > 400 (n = 240)	P	OR	CI
Symptomatic lower extremity ischemia	2 (6.9%)	11 (15.7%)	0.33	2.52	0.52-12.2	19 (21.4%)	0.10	3.66	0.80-16.8	62 (25.8%)	0.03	4.70	1.09-20.4
Acute limb ischemia	2 (6.9%)	3 (4.3%)	0.63	0.60	0.10-3.82	2 (2.3%)	0.25	0.31	0.04-2.31	6 (2.5%)	0.21	0.35	0.07-1.80
Carotid (symptomatic)	0 (0.0%)	3 (4.3%)	0.55	--	--	4 (4.5%)	0.57	--	--	4 (1.7%)	1.0	--	--
Carotid (asymptomatic)	3 (10.3%)	6 (8.6%)	1.0	0.81	0.19-3.49	10 (11.2%)	1.0	1.1	0.28-4.29	32 (13.3%)	0.78	1.33	0.38-4.66
Aorta (ruptured)	1 (3.5%)	1 (1.4%)	1.0	0.41	0.02-6.72	1 (1.1%)	0.43	0.32	0.02-5.25	2 (0.83%)	0.29	0.24	0.02-2.68
Aorta (elective)	5 (17.2%)	3 (4.3%)	0.05	0.21	0.05-0.97	16 (18.0%)	1.0	1.05	0.35-3.18	27 (11.3%)	0.36	0.61	0.21-1.73
AV access	1 (3.5%)	8 (11.4%)	0.28	3.61	0.43-30.2	5 (5.6%)	1.0	1.67	0.19-14.9	4 (1.7%)	1.0	0.47	0.05-4.40
Diagnostic	11 (37.9%)	22 (31.4%)	0.64	0.75	0.30-1.85	23 (25.8%)	0.24	0.57	0.23-1.39	63 (26.3%)	0.19	0.58	0.26-1.30
Wound/Amputation	1 (3.5%)	9 (12.9%)	0.27	1.70	0.18-15.9	1 (1.1%)	0.43	0.32	0.02-5.25	23 (9.6%)	0.34	2.97	0.39-22.8
Other	3 (10.3%)	4 (5.7%)	0.67	0.53	0.11-2.51	8 (9.0%)	1.0	0.86	0.21-3.47	17 (7.1%)	0.71	0.66	0.18-2.41

CACS, Coronary Artery Calcium Score; CI, 95% confidence interval; Symptomatic lower extremity ischemia, open and endovascular interventions for critical limb ischemia or claudication; Acute limb ischemia, open and endovascular interventions; Carotid, open and endovascular interventions; Aorta, open and endovascular interventions; AV access, arteriovenous fistula or graft; Wound/Amputation, wound debridement or amputation at any level; Other, uncategorized procedures (i.e. direct repair of pseudoaneurysm or catheter site). Odds ratio not calculated when there were zero cases.

CONCLUSIONS: Elevated CACS may be associated with higher incidence of significant non-coronary atherosclerosis. Patients with higher CACS require more vascular interventions overall, notably for symptomatic lower extremity ischemia. Ultimately, CACS may prove useful in identifying those at risk for peripheral arterial interventions.



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Matthew Alef..... University of Vermont Medical Center
Grady AlsabrookPeripheral Vascular Associates
Nathan AransonVirginia Mason Medical Center
Joseph Ayers United States Navy
Abdulhameed Aziz IHA Vascular and Endovascular Specialists
Bradley BooneCardiothoracic and Vascular Surgeons
Scott Damrauer Hospital of the University of Pennsylvania
Rachel Danczyk Albuquerque VA Medical Center
Steven DubenecVascular Associates Camperdown
Natalia Glebova..... University of Colorado Denver
Taylor S. Gwin Louisiana State University
Christopher Healey..... Maine Medical Center
Loay Kabbani Henry Ford Hospital
Sean Matheiken Royal Free Hospital, London, UK
Nathan Orr University of Kentucky
Federico Parodi Cleveland Clinic
David Robinson.....Royal Prince Alfred Hospital
Mikel Sadek..... New York University Medical Center
Jennifer StablefordDartmouth-Hitchcock Medical Center
Adithya SureshSurgical Associates of Tampa Bay
Rami O. Tadros.....Icahn School of Medicine/Mt. Sinai
Jose Trani..... Cooper University Hospital
Shant Vartanian.....University of California, San Francisco
Gabriela Velazquez Wake Forest University Baptist Hospital
Marvin V. Weaver, Jr.Icahn School of Medicine/Mt. Sinai
John Weber..... Oklahoma Heart Institute
Jill N. Zink..... American Board of Surgery

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Shahram Aarabi	University of Washington
Matthew Abate	University of Arkansas for Medical Sciences Center
Shilpa Agarwal	SUNY Upstate University
Peter Andrawes	Staten Island University Hospital
Philip Auyang	Houston Methodist
Joshua Balderman	Washington University in St. Louis
Michael Barfield	Duke University
Andrew Baxter	NYU Langone medical center
Robert Beaulieu	Johns Hopkins Hospital
Jaime Benarroch-Gampel	Washington University/Barnes Jewish Hospital
Joseph-Vincent Blas	Greenville Health Systems
Mina Boutrous	St. Louis University
Brandon Cain	University of Alabama at Birmingham
Jason Cook	Washington University in Saint Louis / BJC Hospital
James Davis	Mayo Clinic
Thomas Desmarais	Washington University/Barnes Jewish Hospital
Bryan Ehler	Johns Hopkins Hospital
Anna Eliassen	University of Michigan
Sagar Gandhi	Greenville Health System
Megan Gardner	Indiana University Vascular Surgery
Elizabeth Genovese	University of Pittsburgh Medical Center
Danielle Horne	University of Michigan
Frances Hu	Emory University School of Medicine
Senthil Jayarajan	Washington University/Barnes Jewish Hospital
Nii-Kabu Kabutey	University of California, Irvine
Joseph Karam	Washington University in St. Louis
Manar Khashram	University of Otago
Jerry Kim	Harbor-UCLA Medical Center
Christopher Kinsella	Saint Louis University
Shameem Kunhammed	St. Louis University
Charles Leithead	University of Alabama at Birmingham
Joyce Lu	Albany Medical College
Mark Lytle	Eglin AFB Medical Center
Adeola Odugbesi	SUNY Upstate Medical University
Anna Ohlsson	University of Washington
John Ohman	Washington University in St. Louis
Zachary Osborne	Mayo Clinic
Willythssa Pierre-Louis	University of Cincinnati Medical Center
George Pontikis	Loyola University Medical Center
Thomas Reeve	Wake Forest School of Medicine
Ashley Rickey	Wake Forest Baptist Medical Center
Jarrad Rowse	Cleveland Clinic

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Sara Soule..... University of Colorado
David Tobey..... University of New Mexico
Ryan Turley..... Duke University
Sean Wengerter..... Mount Sinai
Greg Westin..... NYU Medical Center
Max Wohlauer..... Cleveland Clinic
Henry Zhan..... Texas A&M HSC College of Medicine
Yin Zhao..... University of Pittsburgh School of Medicine

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Hershberger, Richard

Northfield

Golan, John

Skokie

Gupta, Navyash
Morcos, Omar

Winfield

Verta, Jr., Michael

INDIANA

Evansville

Patterson, Donald

Indianapolis

Cikrit, Dolores
Dalsing, Michael
Jacob, Dennis
Motaganahalli, Raghunandan
Sawchuk, Alan
Shafique, Shoaib

Geographical Listing of Active Members

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.

Orr, Nathan

Stewart, II, John

Xenos, Eleftherios

Louisville

Bergamini, Thomas

George, Jr., Salem

Jung, Matthew

Klamer, Thomas

Lambert, Jr., Glenn

Rachel, Elizabeth

Thomas, Bradley

Yancey, Andrea

LOUISIANA

Baton Rouge

Connors, III, Michael

McNeil, James

Olinde, Andrew

Perkowski, Paul

Schellack, Jon

Covington

Mena, Jose

Marrero

Batson, Robert

New Iberia

Dauterive, Jr., Edward

New Orleans

Adinolfi, Michael

Bazan, Hernan

Crenshaw, Gregory

Palit, Tapash

Sheahan, Claudie

Smith, Taylor

Sternbergh, III, W. Charles

MAINE

Bangor

Cambria, Robert

Hart, Joseph

Sherwood, Andrew

Portland

Blazick, Elizabeth

MARYLAND

Baltimore

Arnold, Margaret

Black, III, James

Buchbinder, Dale

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

Fredrick

McNeill, Paul

Glen Burnie

Neschis, David

Owings

Pietropaoli, John

Potomac

O'Donnell, Sean

Rockville

Salander, James

MASSACHUSETTS

Boston

Chaikof, Elliot
Clouse, W. Darrin
Conrad, Mark
Hamdan, Allen
Kansal, Nikhil
Kwolek, Christopher
Schermerhorn, Marc

Dartmouth

Pin, Richard

East Falmouth

Gillespie, David

Framingham

Simosa, Hector

Lawrence

Muto, Paula

North Chelmsford

Burke, Jr., Paul

Springfield

Kaufman, Jeffrey
Maru, Sandip
Morris, Marvin
Rhee, San Won

Wellesley

lafrati, Mark

Winchester

Breckwoldt, William

Worcester

Robinson, III, William

MICHIGAN

Ann Arbor

Aziz, Abdulhameed
Coleman, Dawn
Corriere, Matthew
Criado, Enrique
Eliason, Jonathan
Gallagher, Katherine
Osborne, Nicholas

Bingham Farms

Brown, O. William

Bloomfield Hills

Hernandez, Diego

Bloomfield Hills

Kabbani, Loay

Detroit

Lin, Judith
Rits, Yevgeniy
Rubin, Jeffrey

Grand Blanc

Shuster, Thomas

Grand Rapids

Chambers, Christopher
Cuff, Robert
Greenberg, Joshua
Mansour, M.

Kalamazoo

Jain, Krishna
Munn, John
Vaddineni, Sarat

Petoskey

Kazmers, Andris

Royal Oak

Shanley, Charles

Geographical Listing of Active Members

Southfield

Nolan, Kevin

Troy

Engle, Jennifer

Ypsilanti

Heidenreich, Michael

MINNESOTA

Ann Arbor

Vandy, Frank

Duluth

Bunch, Christopher
Eginton, Mark

Minneapolis

Alexander, Jason
Ihnat, Daniel
Santilli, Steven
Shafi, Sn
Sullivan, Timothy

Rochester

Ballinger, Beth Ann
Bower, Thomas
DeMartino, Randall
Fleming, Mark
Oderich, Gustavo

MISSISSIPPI

Biloxi

Collins, David

Hattiesburg

Thompson, J. Keith

Jackson

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

MISSOURI

Jefferson City

Phillips, Victor

Liberty

Deiparine, Michael

Springfield

Schmittling, Zachary
Upton, Brandi

St. Louis

Curci, John
Geraghty, Patrick
Jim, Jeffrey
Pennell, Richard
Peterson, Brian
Raman, Kathleen
Rubin, Brian
Sanchez, Luis
Wittgen, Catherine
Zakhary, Emad
Zayed, Mohamed

MONTANA

Billings

Morasch, Mark

Missoula

O'Brien, Patrick

NEBRASKA

Omaha

Baxter, B. Timothy
Johanning, Jason
Longo, Gernon
Ramos, Tammy
Waltke, Eugene
Wattenhofer, Scott

NEW HAMPSHIRE

Lebanon

Brooke, Benjamin
Goodney, Philip
Nolan, Brian

Nashua

Rodriguez, Christian

Browns Mills

Winkler, Gabor

Geographical Listing of Active Members

NEW JERSEY

Englewood

Bernik, Thomas

Gradell

Geuder, James

Hackensack

O'Connor, David
Simonian, Gregory
Wilderman, Michael

Long Branch

Hirko, Mark

Montclair

Weiswasser, Jonathan

Morristown

Ombrellino, Michael

New Brunswick

Graham, Alan
Rao, Niranjana
Vogel, Todd

Newark

Curi, Michael
Huang, Joe
Padberg, Jr., Frank

Princeton

Goldman, Kenneth

Short Hills

Sales, Clifford

Somers Point

Gosin, Jeffrey
Herrington, James

Somerset

Franco, Charles

Toms River

Haque, Shahid

Voorhees

O'Neill, Alissa

Westfield

Levison, Jonathan

NEW MEXICO

Albuquerque

Danczyk, Rachel
Goff, Jr., James
Ketteler, Erika
Langsfeld, Mark
Marek, John

Las Vegas

Luh, Eddy

Nellis AFB

Jones, III, Wilmer

NEW YORK

Albany

Chang, Benjamin
Darling, III, R. Clement
Hnath, Jeffrey
Kreienberg, Paul
Mehta, Manish
Ozsvath, Kathleen
Roddy, Sean
Saltzberg, Stephanie
Sternbach, Yaron
Taggart, John

Bronx

Greenstein, Stuart
Lipsitz, Evan
Suggs, William

Brooklyn

D'Ayala, Marcus
Hingorani, Anil
Rao, Atul
Shah, Hemal

Buffalo

Cherr, Gregory
Dosluoglu, Hasan

Geographical Listing of Active Members

Cooperstown

Ayers, Joseph
Cooper, Shelby

Great Neck

Panetta, Thomas
Purtill, William

Greenlawn

Gennaro, Mark

Hawthorne

Laskowski, Igor

Lake Success

Doscher, William
Frankini, Larry
Rosca, Mihai
Schwartz, Mark

Mineolo

Wain, Reese

New Hyde Park

Landis, Gregg

New Rochelle

Karanfillian, Richard

New York

Adelman, Mark
Aiello, Francesco
Benvenisty, Alan
Berland, Todd
Cayne, Neal
Connolly, Peter
Faries, Peter
Fishman, Eric
Garg, Karan
Giangola, Gary
Harrington, Elizabeth
Jacobowitz, Glenn
Lantis, II, John
Maldonado, Thomas
Marin, Michael
McKinsey, James
Meltzer, Andrew
Mendes, Donna

Morrissey, Nicholas

Mussa, Firas
Nalbandian, Matthew
Rockman, Caron
Schneider, Darren
Tadros, Rami
Weaver, IV, Marvin
Yang, Paul

New York

Kokkosis, Angela
Tonnessen, Britt

Queensbury

Paty, Philip

Rochester

Ellis, Jennifer
Rochester
Fanciullo, Dustin
Geary, Kevin
Glocker, Roan
Riggs, Patrick
Stoner, Michael

Staten Island

Deitch, Jonathan
Schor, Jonathan

Stony Brook

Loh, Shang
Tassiopoulos, Apostolos

Syracuse

Amankwah, Kwame
Costanza, Michael
Gahtan, Vivian
Gonzalez, Lorena
Surowiec, Scott

Utica

Lauterbach, Stephen

NORTH CAROLINA

Asheville

Douglas, Michael

Geographical Listing of Active Members

Chapel Hill
Farber, Mark
Vallabhaneni, Raghuveer

Charlotte
Arko, III, Frank
Roush, Timothy

Durham
Cox, Mitchell
Mureebe, Leila
Shortell, Cynthia

Fayetteville
Roulhac, Maurice

Gastonia
Eze, Augustine

Greensboro
Dickson, Christopher
Early, Todd

Greenville
Bogey, Jr., William

Hickory
Piercy, Kenneth

Lenoir
Purcell, Peter

New Bern
Bell, III, William

Pinehurst
Atkinson, Clinton

Raleigh
Kim, Jason

Winston-Salem
Edwards, Matthew
Hansen, Kimberley
Hurie, Justin
Velazquez, Gabriela

NORTH DAKOTA
Fargo
Bakken, Andrew

OHIO
Cincinnati
Giglia, Joseph
Lohr, Joann
Muck, Patrick
Smith, Denise
Zenni, Gregory

Cleveland
Choi, Lorraine
Clair, Daniel
Eagleton, Matthew
Kashyap, Vikram
Kelso, Rebecca
Lyden, Sean
Mastracci, Tara
McLaughlin, Daniel
Moise, Mireille
Park, W. Michael
Ryan, Timothy
Srivastava, Sunita

Columbus
Franz, Randall
Columbus
Go, Michael
Haurani, Mounir
Kulwicki, Aaron
Litzendorf, Maria

Dayton
Matsuura, John

Duncan Falls
Katz, Sherman

Garfield Heights
Alvarez-Tostado, Javier

Lancaster
Mannava, Krishna

Marietta
Parmer, Shane

Geographical Listing of Active Members

Mayfield Heights

Rizzo, Anthony

Toledo

Comerota, Anthony
Nazzal, Munier
Paolini, David
Pigott, John
Russell, Todd
Seiwert, Andrew

Willoughby

Rollins, David

Youngstown

Delatore, Jason
Kollipara, Venkata

Zanesville

Campbell, Jessica

OKLAHOMA

Tulsa

Ma, Harry
Malgor, Rafael
Weber, John

OREGON

Portland

Crutchley, Teresa
Portland
Mitchell, Erica

Silverton

Waters, Harris

PENNSYLVANIA

Abington

Sullivan, Theodore

Allentown

Berger, Alan
Goodreau, James
Guzzo, James
McCullough, Jr., James
Welkie, John

Bellefonte

Simoni, Eugene

Bethlehem

Ivarsson, Bengt
Rosenfeld, Joel

Chambersburg

Guthrie, David

Danville

Elmore, James

Hershey

Aziz, Faisal
Han, David
Reed, Amy

Lancaster

Comeau, Jason

Philadelphia

Damrauer, Scott
DiMuzio, Paul
Eisenberg, Joshua
Wang, Grace
Weingarten, Michael

Pittsburgh

Chaer, Rabih
Healy, Dean
Jeyabalan, Geetha
McEnaney, Ryan
Muluk, Satish
Rhee, Robert
Singh, Michael
Wu, Timothy

Plains

Yavorski, Chester

Sayre

Marica, Silviu
Sampson, Lawrence

West Reading

Brigham, Robert
Jaxheimer, Eric

Geographical Listing of Active Members

Wilkes-Barre
Obmann, Melissa

Williamsport
Adams, Eric

York
Harthun, Nancy

PUERTO RICO
Coto Laurel
Martinez, Jorge

San Juan
de Jesus, Gustavo
Joglar, Fernando

RHODE ISLAND
Providence
Marcaccio, Edward
Slaiby, Jeffrey

SOUTH CAROLINA
Charleston
Garg, Nitin
Keefer, Adam
Morrison, Edward
Veeraswamy, Ravi

Florence
Stonerock, Charles

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

TENNESEE
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
Wilkins, 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

Geographical Listing of Active Members

Austin

Apple, Jeffrey
Church, Phillip
Seidel, Scott
Stewart, Mark

Bryan

Bush, Ruth

Dallas

Gable, Dennis
Grimsley, Bradley
Kohn, James
Lam, Russell
Rectenwald, John
Shutze, William
Sundaram, Shankar

Denton

Ortega, Raul

Fredericksburg

Bowser, Andrew

Garland

Stephanian, Edic

Houston

Barshes, Neal
Bavare MD, FACS, Charudatta
Bechara, Carlos
Bismuth, Jean
Charlton-Ouw, Kristofer
Coogan, Sheila
Coselli, Joseph
El-Sayed, Hosam
Gilani, Ramyar
Huynh, Tam
Kougias, Panos
Lin, Peter
Mills, Joseph
Peden, Eric
Poi, Mun Jye

Humble

Bhatia, Devinder
Foteh, Kousta

Irving

Sun, Lucy

Nacogdoches

Brown, Lyle
Randel, Mark

San Antonio

Arthurs, Zachary
Davenport, Phyllis
Davies, Mark
Macris, Demetrios
Sheehan, Maureen
Sykes, Mellick
Tamez, Jr., Daniel

Temple

Atkins, Marvin
Bohannon, W. Todd
Rueda, Carlos
Warren, Il, Thomas

UTAH

Murray

Whitten, Matthew
Wirthlin, Douglas

Provo

Smilanich, Robert

Salt Lake City

Goodman, Greg
Kraiss, Larry

South Ogden

Erdoes, Luke

VIRGINIA

Charlottesville

Tracci, Margaret

Christiansburg

Downing, Lamiere

Falls Church

Busuttil, Steven

Geographical Listing of Active Members

Hampton
Deshmukh, Deepak

Mechanicsville
Brown, Jeff

Portsmouth
Knipp, Brian

Richmond
Bosher, L. Paul
Larson, R.
Levy, Mark

WASHINGTON
Bellevue
Ferris, Brian

Bellingham
Sohn, Michelle

Milton
Andersen, Charles

Puyallup
Osborne, Jr., Robert

Renton
Kasirajan, Karthik

Seattle
Aranson, Nathan
Quigley, Terence
Quiroga, Elina
Singh, Niten
Starnes, Benjamin
Tang, Gale

Spokane
Rizvi, Adnan

Tacoma
Daab, Leo
Kreishman, Peter

Vancouver
Teso, Desarom

WISCONSIN
Green Bay
Hutto, John

Madison
Hoch, John
Tefera, Girma

Milwaukee
Brown, Kellie
Lee, Cheong
Rossi, Peter
Seabrook, Gary

Waukesha
Schmitt, David

WEST VIRGINIA
Charleston
Stone, Patrick



Notes



Notes



Notes

VESS Bylaws

ARTICLE I – NAME

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

ARTICLE II – OBJECTIVES

The objectives of this Society shall be:

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

The Society shall carry on activities:

1. As a corporation exempt from Federal income tax under Section 501 (C) (3), of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law), or;
2. As a corporation, contributions to which are deductible under Section 170; Furthermore, no part of the net income of the Society or its property or assets shall at any time inure to the benefit of any individual member, or of any private individual, or be used to promote the candidacy of any person seeking political office.

ARTICLE III – MEMBERSHIP

There shall be six types of membership:

- A. Active
 - B. Active Senior
 - C. Inactive Senior
 - D. Honorary
 - E. Candidate
 - F. Associate
- A. Active membership of this Society shall be limited to physicians of good professional standing who have completed an ACGME-approved vascular surgical residency or fellowship, or equivalent foreign advanced training, who have a sustained major interest and active practice in peripheral vascular surgery and who are certified by the American Board of Surgery or its equivalent. Active members shall be required to pay annual dues. Active members have voting privileges, can serve on committees, sponsor new member applications as well as submit and sponsor papers for presentation at the annual meeting.

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- B. Active senior membership shall be granted to members who have been in practice for greater than 15 years. Active senior members may complete terms of elected office, and are required to pay dues. Active senior members can sponsor papers for fellows and residents, participate in the business meeting as well as vote, but do not present papers and are not eligible for re-election as Society officers.
- C. Inactive senior membership shall be granted to senior members upon receipt of written request. Inactive senior members will no longer receive a subscription to the Journal. Inactive senior members are not required to pay annual dues nor are they allowed to sponsor new member applications or papers and presentations submitted to the Annual Meeting. Inactive senior members may become active senior members by requesting in writing reactivation and paying all back dues or three times the current year's dues.
- D. Honorary membership shall be granted to individuals at the discretion of the Executive Council. Honorary members pay no dues and are not eligible for election as VESS officers.
- E. Candidate membership shall be granted to participants who are in good professional standing in an RRC accredited general surgery, vascular surgery residency, or other vascular residency recognized by the Society. Also students in accredited osteopathic and allopathic medical schools can participate in this membership group. Candidate members must be sponsored by an active or senior active VESS member. Candidate members shall have no voting rights. Candidate members can present papers at the Annual Meeting if sponsored by an active member. Candidate members may be promoted to active membership upon completion of their vascular surgery residency (or equivalent) and upon receipt by the society office of a copy of the vascular surgery training certificate (or equivalent). At this time, the newly promoted active member will be bound by the requirements of active membership in the society.
- F. Associate membership shall be limited to non-vascular trained physicians and surgeons with either an MD or DO degree, scientists active in vascular medicine or surgical research, physician extenders in vascular specialties (RN's, PA's, NP's) and vascular technologists. These members shall pay half dues, have no voting rights, cannot be elected as officers of the society, but may submit abstracts and papers to the meetings.

ARTICLE IV – ELECTION OF MEMBERS

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

1. Membership enrollment in the Society shall be completed via electronic application through the website.
2. Completed applications shall be submitted three months prior to any scheduled business meeting, at which time the candidate shall be considered for election. One letter of recommendation from an active society member is required to complete the application.
3. The names of the applicants recommended for membership by the Executive Council shall be submitted to the members at the business meeting.
4. Election to membership shall be by secret ballot, by a three-fourths (3/4) affirmative vote of the membership present.
5. An applicant who fails to be elected at one meeting may be reconsidered at the next two business meetings of the Society.

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ARTICLE V – DUES AND FEES

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

ARTICLE VI – RESIGNATIONS, EXPULSIONS

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

ARTICLE VII – OFFICERS: ELECTIONS AND DUTIES

1. The officers of this Society shall consist of a President, President-Elect, Secretary, Treasurer and Recorder; all to be elected as provided in these Bylaws.
2. The President shall preside at Executive Council meetings and the Annual Meeting. Successors to vacated offices of the Society shall be appointed by the President until the position is filled at the next Annual Meeting.
3. The President and President-Elect of the Society shall be elected for terms of one year each. The Secretary, Treasurer, Recorder and Councilors-At-Large shall be elected for three year terms.
4. The President-Elect, in the absence or incapacity of the President, shall perform the duties of the President's office.
5. In the absence of both the President and President-Elect, the chair shall be assumed by a president pro tem, elected by such members of the Executive Council as are present.
6. The Secretary shall keep minutes at the meetings of the Society and the Executive Council, update the Executive Council on membership database and new applicant files and conduct correspondence of the Society. The Secretary will issue an annual written report at the Annual Meeting.
7. The Treasurer shall receive all monies and funds belonging to the Society, pay all bills, render bills for dues and assessments, and report to the membership at the Annual Meeting. The treasurer will prepare an annual report for audit.
8. The Recorder shall receive all papers presented before the Society. The recorder shall be responsible for assuring prompt editorial review of manuscripts in concert with other Society members.
9. The Councilors-At-Large shall be elected for three-year terms, with election of one councilor occurring annually so as to provide overlapping terms.

ARTICLE VIII – EXECUTIVE COUNCIL

1. There shall be an Executive Council consisting of the President, President- Elect, Secretary, Treasurer, Recorder, Councilors-At-Large, and the two most recent Past Presidents.
2. The Program Committee chairman, the Scholarship Committee chairman, the

VESS Bylaws

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

3. The Executive Council shall be the governing body of the Society and shall have full power to manage and act on all affairs of the Society.
4. Executive Council meetings shall be held at the call of the President of the Society.
5. A majority of the members of the Executive Council shall constitute a quorum for the transaction of business.

ARTICLE IX – COMMITTEES AND REPRESENTATIVES

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

The Nominating Committee shall consist of the current President in office, the President-Elect and the two most recent Past Presidents. Its functions shall be to make up a slate of officers for the Society, and to nominate representatives to affiliated societies to be presented to the Executive Council at the Annual Meeting. The proposed slate shall then be presented for vote during the Annual Member Business Meeting. Representatives shall be appointed by the Nominating Committee in concert with the Executive Council to serve on American College of Surgeons Board of Governors, American College of Surgeons Advisory Council for Surgical Specialties and the Council of the American Association for Vascular Surgery. Each representative shall serve a three-year term unless otherwise noted by the Executive Council at its Annual Meeting. From time to time, other organizations may seek representation from the Society. Additional representatives shall be appointed in the same manner outlined above.

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

The Scholarship Committee shall consist of six members, a chairman, selected by the Executive Council, three Councilors-At-Large and two remaining At-Large committee members selected by the committee chairman. This committee shall serve for two years. Its function shall be to review educational grant award applications and to report award recipients to the Executive Council at the Annual Meeting.

The Fundraising Committee shall consist of ten members. Its function shall be to research and implement comprehensive fundraising campaigns to support the society, organize and sponsor programs to enhance the awareness and treatment of vascular disease, to evaluate diagnostic and therapeutic tools manufactured by industry, and to enhance the rapid and proficient transfer of new knowledge and techniques to its members with assistance from our industry partners. A committee chairman shall be appointed by the Executive Council at the Annual Meeting to serve a three-year term. The chairman will

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also serve on the Executive Council for the duration of the appointed term. Other committee members shall be the President-Elect, the Treasurer, the Secretary and the newly appointed Councilor-At-Large. The committee chairman will select up to four additional Society members to assist with this task. In addition, the current Society President shall be an ex-officio member.

The Bylaws Committee shall consist of three members to serve overlapping terms of three years each. A new member shall be appointed annually by the Executive Council. The most senior member of the Bylaws Committee shall serve as chair. The Bylaws Committee shall review bylaws from time to time as directed by the Council and when appropriate, make recommendations regarding amendments.

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

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

The Communications Committee shall consist of one chair serving a three year term, and is responsible for organizing, coordinating, and implementing all communication to the membership and along with the Secretary will oversee subcommittee functions. The Communication Chair is appointed by the Executive Council for a maximum three year term renewed annually. The Committee shall consist of three subcommittees:

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

The Vascular Resident Education Committee shall consist of four members to serve overlapping terms of two years each. Its function shall be to organize and execute the fellows program and the Technology Forum at the VESS Annual Meeting. Two new

VESS Bylaws

members shall be appointed annually by the Executive Council. The two most senior members of the Vascular Resident Education Committee shall serve as co-chairs. The two out-going co-chairs shall be ex-officio members.

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.
2. The business meeting of the Society shall be conducted during the Annual Meeting.
3. All active members are encouraged to attend the annual meeting one year out of every three years. There is no attendance requirement for any other member category.
4. Special meetings may be called at any time by the president, or a simple majority of the Executive Council.

ARTICLE XI – QUORUM

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

ARTICLE XII – ALTERATIONS, REPEAL

Bylaws may be altered or repealed at the Annual Meeting by a two-thirds (2/3) affirmative vote of the members present.

ARTICLE XIII – PROCEDURE

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

Amended – August, 2012

Amended – February 1, 2013

Amended – January 31, 2014

Amended – February 2, 2016



Notes



Notes

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!