

**Methods:** A retrospective review was undertaken of all endovascular procedures done at our institution over an 18 month period. Radiation exposure was categorized per procedures. Estimated Skin Dose (ESD) (mGy) and Effective Dose (mSv) were calculated. Also, total CT scans were tabulated for patients undergoing aneurysm stent grafting and cumulative ED was estimated. Statistical analyses were done with Kruskal-Wallis tests to detect overall differences, Wilcoxon Rank Sum Exact tests for paired comparisons, and for group comparisons a Bonferroni post hoc test.

**Results:** 2103 interventions in 1111 patients had fluoroscopy times recorded during this period. As expected, the more complex the procedure, the longer the fluoroscopy time and ESD, with patients undergoing atherectomy (ATH) having significantly higher ESD than all groups (1260 (900,1542);  $p < .001$ ) (mGy) which was approaching the skin injury threshold of 2000 (mGy). When measuring ED, Cerebrovascular intervention (CVI) and infrarenal aortic aneurysm (IAA) received the highest ED (120 (100,150), 109(85,151);  $p < .001$ ) (mSv) among other groups. When comparing different aneurysm repairs, TAA patients underwent a greater number of CT scans than IAA ( $7.4 \pm 0.3$  vs  $5.8 \pm 0.2$ ;  $P < 0.004$ ). After tabulating the cumulative ED including procedure and CT scans, IAA patients had significantly higher doses of radiation exposure than TAA ( $217 \pm 5$ ,  $191 \pm 6$ ;  $P < 0.004$ ).

**Conclusions:** With increasing complexity of endovascular interventions, there is increased radiation exposure to all involved with highest doses coming from those undergoing any aneurysm repair. Future innovations should concentrate on reducing the risk of radiation exposure to all personnel and newer imaging modalities.

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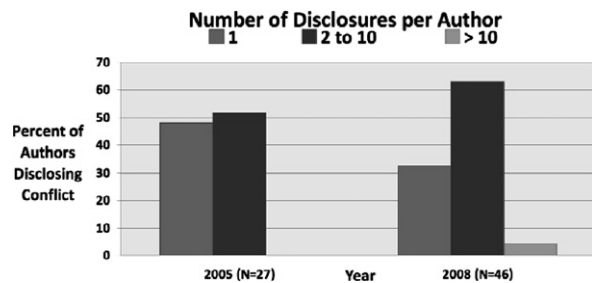
**Conflict of Interest Disclosures in Vascular Surgery**

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**Objectives:** Technological advances in Vascular Surgery have produced a complex relationship between pharmaceutical corporations and surgeons. However, the influence of industry on scientific presentations at national meetings is not known. This study describes the prevalence and patterns of reported *Conflict of Interest* (COI) at the Society of Vascular Surgery (SVS) annual conference.

**Methods:** Data from the programs of the annual SVS meetings from 2005 (when COI disclosure was first required) to 2008 were analyzed.

**Results:** The percentage of authors declaring at least one COI has changed little: in 2005, 23% of authors declared at least one COI, compared to 26% in 2008. However, the number of authors disclosing multiple COI has increased. Of authors disclosing any COI in 2005, nearly half disclosed only one; in 2008, more than two thirds disclosed multiple (*Graph*). Of all scientific papers presented in 2008 at SVS, 21% had at least one author declaring COI; of note, at the PVSS session featuring young vascular surgeons, the incidence was nearly double, 41%.



**Conclusions:** The influence of industry on the SVS conference has increased in the past four years. The frequency of COI disclosures at the PVSS session underscores the importance of endovascular innovation in which young vascular surgeons may be more likely to be involved. It may also reflect an evolving emphasis on the "business" of medicine, a concept to which recently trained surgeons have greater exposure. These results support the establishment of a comprehensive COI management plan to ensure that the scientific integrity of the SVS is not undermined by COI. Further study is needed to determine whether surgeons' relationships with industry affect surgical decision making or patient care.

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**Suboptimal Medical Management in Vascular Patients**

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**Objective:** To assess rates of medication compliance in vascular patients.

**Methods:** A prospective study of consecutive patients seen in Vascular Clinic at a busy tertiary academic center. Patients were interviewed via standardized questionnaire and evaluated co-existing medical conditions and medication use. Optimal medical therapy was defined as the 2006 AHA/ACC Guidelines for Secondary Prevention for Atherosclerotic Vascular Disease.

**Results:** 180 patients were seen in various vascular surgery clinics affiliated in a 4 month period. Co-morbid conditions surveyed included HTN (n=134), DM (n=50), CAD (n=19), hypercholesterolemia (n=84), and ESRD (n=8). 54% of the patients were male. 58% of the patients were insured, 34% were uninsured. 18% were current smokers, 68% were non-smokers. We found that 43% of all patients were receiving inadequate medical therapy for their co-morbid conditions. Uninsured patients were more likely (56%) than insured patients (34%) to receive inadequate therapy. Lack of insurance was a predictor of inadequate treatment of HTN (OR=3.05, C.I. 1.12-8.3,  $p=0.025$ ), hypercholesterolemia (OR=4.5, C.I. 1.4-14.3,  $p=0.007$ ), and any disease overall (OR=2.4, C.I. 1.2-4.7,  $p=0.01$ ) (Fig). Overall, males (49%) were more likely than females (36%) to receive inadequate medical therapy, especially relating to PVD (OR=5.25, C.I. 1.6-17.3,  $p=0.004$ ). The incidence of suboptimal management was 37% for zero to two co-morbid conditions, but increased to 100% for five co-morbid conditions.

**Conclusions:** Uninsured patients were more likely to receive inadequate medical therapy than their insured counterparts. This survey provides sobering statistics regarding medical compliance in a real world medical practice.

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**Techniques, Morbidity and Patency of Portal Vein Reconstruction Using Lower Extremity Vein During Pancreaticoduodenectomy**

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**Background:** Tumor invasion or adherence of the pancreas to the portal vein (PV) complicates pancreaticoduodenectomy. Lower extremity vein (LEV) can provide autogenous conduits for PV reconstruction in such cases. Little data exist, however, describing PV reconstruction techniques, morbidity or patency using LE vein as part of pancreaticoduodenectomy.

**Methods:** We analyzed preoperative imaging, reconstructive techniques, perioperative morbidity related to LEV vein harvest, and reconstruction patency in patients undergoing PV reconstruction during pancreaticoduodenectomy.

**Results:** Thirty-one of 227 patients (14%) undergoing pancreaticoduodenectomy had PV reconstruction using LEV. Mean age was 63 years. Preoperative imaging indicated tumor adherence or invasion of the PV in only 39% of the patients requiring PV reconstruction. Preoperative vein mapping influenced the choice of LEV used for reconstruction by identifying abnormalities in 47%. Reconstruction technique (patch vs. replacement) was determined by extent of PV adherence / invasion. PV patching using greater saphenous vein (GSV) or femoral vein (FV) was performed in 19 cases (61%) and PV replacement using FV was required in 12 cases (39%). Wound complications or ipsilateral DVT occurred in no patients with GSV harvests and in 38% of patients with FV harvests,  $p=0.019$ . Two reoperations were required for wound complications. There was one intraoperative PV thrombosis requiring revision, one occlusion in <30 days and 1 known late occlusion secondary to local disease recurrence. Twelve month patency of PV reconstruction was 96% with a mean follow-up of 5.4 months.

**Conclusions:** Preoperative imaging may fail to confirm PV involvement in patients undergoing pancreaticoduodenectomy. Preoperative vein mapping influences conduit choice in patients requiring PV reconstruction and should be performed prior to pancreaticoduodenectomy. Minimal morbidity is associated with GSV harvest while FV harvest is associated with manageable complications. PV reconstruction with LEV provides excellent