

on the endovascular database at 1, 3, and 12 months and annually thereafter. Changes in these measurements were calculated for each group.

**Results:** Palmaz stent-graft was used during 22 elective and 19 emergency EVARs (17 elective and 10 emergency patients were included for analysis). Throughout follow-up, the suprarenal diameter became greater in the elective group ( $4.65 \pm 5.51$  mm vs.  $2.2 \pm 4.13$  mm;  $p=0.30$ ) as were the top neck ( $5.06 \pm 5.24$  mm vs.  $4.6 \pm 6.02$  mm;  $p=0.76$ ) and bottom neck diameters ( $5.94 \pm 6.53$  vs.  $3.11 \pm 4.26$  mm;  $p=0.34$ ). Aortic sac regression was higher in emergency patients at 12 months ( $3.71 \pm 21.03$  mm vs.  $3.79 \pm 7.02$  mm;  $p=0.82$ ) and at 24 months ( $13 \pm 13.29$  mm vs.  $4.36 \pm 9.61$  mm;  $p=0.23$ ). Open re-intervention occurred in 20% of emergency patients for proximal type 1 endoleaks, with another 20% for stent-graft migrations. Re-intervention in elective patients (18%) was for persistent type 2 endoleaks.

**Conclusions:** The complication rates, particularly in emergencies show that Palmaz stenting provides only a short-term solution in EVAR. This should influence patient selection as secondary procedures are more likely.

### 0603: PERSISTENT SCIATIC ARTERY ANEURYSM: A PLEA FOR ATTENTION AND PROPOSAL FOR MANAGEMENT

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**Aim:** This article reviewed published evidence on the identification and management of persistent sciatic artery aneurysms.

**Methods:** Systematic literature review was undertaken using Medline, EMBASE and Cochrane Database of Systematic Reviews up to December 31<sup>st</sup> 2012. A free text search using “persistent sciatic artery”, “persistent sciatic artery aneurysm”, “complete PSA” and “incomplete PSA” was performed. All papers identified were screened and the search enhanced with manual bibliography review.

**Results:** 49 relevant studies were identified. PSA has an incidence of 0.025%–0.04%. PSA aneurysms, though usually asymptomatic, may present with a gluteal mass or distal embolization and ischaemia. Investigation is most commonly performed by angiography, although non-invasive methods show surgical planning advantages. Management is guided by anatomical determination of the complete or incomplete forms. For the complete forms, where the PSA supplies distal limb blood supply, this entails exclusion of the aneurysm and vascular reconstruction with open or endovascular techniques. Incomplete forms, where the PSA is present with intact normal circulation, normally require simple aneurysmal exclusion only.

**Conclusion:** Vascular specialists should be aware of this rare, often asymptomatic vascular anomaly as it can complicate common vascular emergencies. Timely surgical or endovascular interventions are vital due to the high risk of aneurysmal dilatation.

### 0630: ASSESSING THE QUALITY OF ONLINE INFORMATION FOR PATIENTS WITH CAROTID DISEASE

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**Aim:** Controversy exists relating to carotid endarterectomy (CEA) versus carotid artery stenting (CAS). We aimed to assess the quality of online information relating to both.

**Methods:** The Google™ search engine was searched for “carotid endarterectomy” and “carotid stenting”. The first 50 webpages returned were assessed. The Gunning Fog Index (GFI) and Flesch Reading Ease Score (FRES) were calculated to assess readability. The LIDA tool (Minervation Ltd., Oxford, U.K.) was used to assess accessibility, usability and reliability.

**Results:** Regarding CEA, 20% ( $n=10$ ) of the webpages returned were from peer reviewed sources with 34% ( $n=17$ ) posted by hospitals or health services. Comparatively, for CAS, 40% ( $n=20$ ) were peer reviewed with 16% ( $n=8$ ) posted by hospitals or health services. Regarding CEA, the GFI and FRES indicated poor readability at 14.84 and 42.38 respectively. For CAS web page assessment suggested further reduced readability with a GFI of 15.91 and FRES score of 36.01. The LIDA score demonstrated that reliability and accessibility of information was greater than usability for online users.

**Conclusion:** Websites providing information on carotid disease management must be made more readable, reliable and usable. Online information currently available to patients regarding CAS is significantly more difficult to read and comprehend than CEA.

### 0653: REVIEW OF POST-OPERATIVE ANTICOAGULATION IN THE SURGICAL MANAGEMENT OF ARTERIAL EMBOLIC DISEASE

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**Introduction:** There is no guidance on post-operative anticoagulation after embolectomy. The purpose of this study was to review the use and outcomes of low molecular weight heparin (LMWH) and unfractionated heparin (UFH) following embolectomy.

**Methods:** Retrospective case review of patients undergoing embolectomy from December 2009 - December 2012 was performed.

**Results:** 33 patients were included. 20 femoral, 5 brachial, 4 popliteal, 2 iliac and 2 graft embolectomies were performed. Anticoagulation prior to surgery included heparin ( $n=16$ , 48%), clexane ( $n=4$ , 12%), or nothing ( $n=13$ , 39%). Intra-operatively heparin ( $n=24$ , 73%) or nothing ( $n=9$ , 27%) was given. Post-operatively LMWH ( $n=20$ , 61%), heparin ( $n=9$ , 27%), aspirin/clopidogrel ( $n=3$ , 9%) or nothing ( $n=1$ , 3%) was given. Patients were discharged on warfarin ( $n=21$ , 64%), aspirin ( $n=5$ , 15%), clopidogrel ( $n=2$ , 3%), clexane ( $n=3$ , 9%), rivaroxaban ( $n=1$ , 3%) or nothing ( $n=1$ , 3%). The overall complication rate was 33% (including haematoma, wound infection, amputation, claudication and death), 67% for those on heparin post-operatively compared to 25% on clexane. Mortality was 30% with average time to death of 9½ months.

**Conclusion:** This study has shown that clexane is a suitable and possibly superior alternative to UFH. The authors have been surprised by the mortality in this group of patients.

### 0681: ARE REFERRAL DELAYS CONTRIBUTING TO LIMB LOSS IN DIABETIC PATIENTS?

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A root cause analysis (RCA) was performed for major amputations (MA) in diabetic patients to identify preventable causes for limb loss.

Data was collected retrospectively using HES codes for Diabetes and MA (above knee/through knee/below knee) and analysed using the London Diabetes Network RCA tool for MA.

20 diabetic patients underwent MA between 1st April 2010 and 31st March 2012. Median time from initial onset of symptoms (IOS) to any secondary care review was 12 weeks while median time from IOS to diabetic foot multidisciplinary team (DFMDT) review was 17 weeks. 6 patients (30%) had no DFMDT clinic review before MA. 16 patients (80%) underwent inpatient vascular imaging. Median interval from admission to vascular imaging was 1 day (1–64). 10 patients (50%) underwent revascularisation (Endovascular therapy  $n=4$  / Surgical bypass  $n=3$  / Endovascular Therapy and Surgical Bypass  $n=3$ ) Median time from IOS to revascularisation was 70 days (2–1080) and median time from hospitalisation to revascularisation was 1 day (1–64). The 30-day post-MA mortality was 15%.

Our RCA highlights significant delays in referral to the DFMDT in this cohort with adverse limb salvage outcomes. The need to refer promptly to the DFMDT should be stressed to carers in the community.

### 0781: PATIENT REPORTED OUTCOMES FOLLOWING CRITICAL ISCHAEMIA MANAGEMENT IN THE REGIONAL VASCULAR CENTRE

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**Aims:** Patient Reported Outcome Measures (PROMs) assess the health gain after surgical intervention. Guided by existing PROMs assessments, we designed a survey to review patient satisfaction following treatment of critical limb ischaemia (CLI) at East Kent Hospitals Trust (EKHT).

**Methods:** All patients who underwent treatment for CLI between November 2010 and May 2011 were invited to fill in an 11-question Patient Satisfaction Survey, either by post or over the phone. Fisher's test was used for statistical analysis.