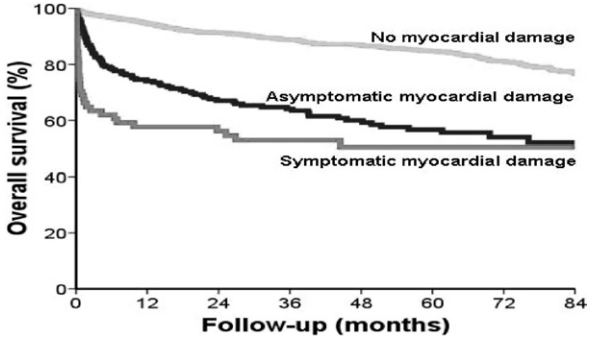


Author Disclosures: O. Schouten, None; **T.A. Winkel,** None; **G.M. Welten,** None; **H. van Urk,** None; **H.J.M. Verhagen,** None; **J.J. Bax,** None; **D. Poldermans,** None.

SS21.

Future of Vascular Surgery is in the Office

Krishna Jain, John S Munn, Mark C Rummel, Sarat K Vaddineni, Chris D Longton. Advanced Vascular Surgery, kalamazoo, MI

Objective: The Practice of Vascular Surgery is under pressure from various specialties and payers. Our group started office based procedures in May of 2007. The purpose of this paper is to study the impact of this change on our case volume, office revenue and the financial impact on healthcare system.

Methods: Between 5/1/06 and 4/30/07 (Period1) and between 6/1/07 and 5/31/08 (Period 2), total of 3041 and 3351 cases were performed respectively. In Period 1 only venous cases could be done in the office. Prior to arteriogram BUN and Creatinine level is obtained. The number of percutaneous cases done in hospital and office setting were analyzed and revenue was calculated based on the 2008 Medicare fee schedule for our region. Thirty day amputation rate and mortality was documented. Hospital DRG payment schedule was obtained.

Results: In Period 1, 670 (22% of total) percutaneous procedures were performed as compared to 1502 (44.8%) in Period 2, a two fold increase. In Period1, 1.5% of total cases were done in office as compared to 31% in Period 2. There was a fivefold increase in revenue from these procedures. There was no mortality or amputation as a result of procedures performed in office. There was no anesthesiologist's expense and minimal pre-procedure expense. Total payment by Medicare, DRG payment to hospital plus physician component is higher in all the cases.

Procedure	*Period1 Hospital*	*Period1 Office*	*Period2 Hospital*	*Period2 Office*	*R/C Hospital*	*R/C Office*	*Hosp. DRG*
Cath Ins.	198		240	146	$ 309	$ 947	$ 1581
Cath Rem	62		38	122	$ 134	$ 160	$ 361
Fist Thro	71		29	113	$ 426	$2,232	$2,655
Fist Angio	94		28	238	$ 460	$2,450	$2,977
Fist Stent	1		5	9	$ 605	$4,900	$5,808
Fist coil				22	$1,170	$2,407	$5,741
Fist	8		11	47	$ 183	$ 633	$ 613
Aor Angio	16		48	33	$ 589	$3,854	$2,977
Aor Run	114		47	104	$ 267	$1,397	$1,895
Aor Stent	7		18	11	$ 719	$5,860	$5,808
Aorta			18	12	$ 204	$1,003	$1,895
EVLT	38	40		132	$ 324	$1,539	$1,695
Micro	13	4		19	$ 423	$ 423	$1,695
Venogram	4		4	8	$ 208	$1,079	$1,895
Total	626	44	486	1016			

Key: Cath-Catheter, Ins-Insert, Fist-Fistulogram, Thro-Thrombectomy, Angio-Angioplasty, Aor-Aortogram, Run-runoff, EVLT-Endovenous laser Therapy, Micro-Microphlebectomy, R/C-Revenue per case.

Conclusions: A Vascular Surgery practice can benefit from office based procedures. Procedures can be done safely. It results in an increase in number of percutaneous procedures and revenue. There are significant savings to health care system. Surgeons can control their schedule. Every vascular surgeon should consider doing these procedures in office.

Author Disclosures: K. Jain, None; **J.S. Munn,** None; **M.C. Rummel,** None; **S.K. Vaddineni,** None; **C.D. Longton,** None.

SS22.

Totally Laparoscopic Aortic Surgery: Experience In A French Academic Center

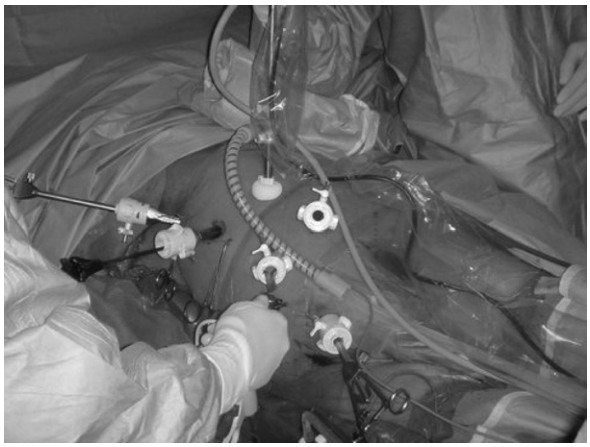
Jérôme Cau, Jean-Baptiste Ricco. Poitiers University Hospital, Poitiers, France

Background: The application of laparoscopic techniques for vascular procedures has been limited by factors such as difficulties in aortic exposure and anastomosis techniques, as well as the concurrent competitive progress of endovascular surgery. The purpose of this study was to review the outcomes for laparoscopic aortic interventions in the endovascular era.

Methods: Retrospective analysis was carried out for a series of 219 patients who underwent a totally laparoscopic aortic procedure for treatment of aortic occlusive disease (AOD; n =127) or abdominal aortic aneurysm (AAA; n=80) and 12 aorto-renal bypass. This series did not include patients operated in others centers (110 aortic bypasses).

Findings: Mean patient age was 61 years and the sex ratio was 3 men for 1 woman. The mean operative time of procedures for AOD was 223 +/− 50 minutes, with a mean clamp time of 56 +/− 21 minutes. 3.6% of the AOD procedures had to be converted to open. For laparoscopic AAA procedures, the mean operative time was 262 +/− 57 minutes and the mean clamp time was 103 +/− 15 minutes. 8 conversions (10%) to open procedure had to be performed in this subgroup. The 30-day mortality rate was 0.9%. Overall mortality rate was 13.4% during a mean follow-up time of 16.2 months. The primary patency rate was 100%.

Conclusions: Totally laparoscopic aortic surgery is feasible and showed promising and satisfactory results in our experience. Precise indications for this kind of surgery, compared to endovascular and open surgery, remain to be determined by randomized studies. Nevertheless, it is a difficult technique. Further development will rely on effective training, advances in technique and instrumentation.



Author Disclosures: J. Cau, None; **J. Ricco**, None.

SS23.

The Incidence of Infectious Complications After Elective Vascular Surgery in the United States

Todd R Vogel, Viktor Y Dombrovskiy, Jeffrey L Carson, Paul B Haser, Stephen F Lowry, Alan M Graham. UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ

Objective: To evaluate the incidence and socio-demographics of postoperative infectious complications after elective vascular surgery, to define vascular procedures with the greatest risk of developing nosocomial infections, and to assess the impact of infection on utilization.

Methods: The Nationwide Inpatient Sample (2002-2006) was utilized to identify major vascular procedures by ICD-9-CM codes. Infectious complications including pneumonia (PNA), urinary tract infections (UTI), postoperative sepsis, and surgical site infections (SSI) were identified. Case mix-adjusted rates for age, race, gender, and comorbidities were calculated using a multivariate logistic regression model with infectious complications as an outcome.