left groin. Over this spartacore crossover wire the Ansel-1 sheath was advanced through the fenestration.

The left renal artery was then accessed from the true lumen and a Atrium iCast stent graft was deployed extending from the true lumen across the false lumen and into the left renal artery. After confirmation of left renal perfusion and false lumen exclusion, a stent graft from the left CIA artery into the external iliac artery was utilized to exclude the distal left renal perfusion and false lumen exclusion, a stent graft from the left across the aortic dissection and normal perfusion into the left kidney. His postoperative studies revealed a normal renal duplex without stenosis and a postoperative creatinine of 1.2 mg/dl.

The Value of a Carotid Duplex Surveillance Program for Stroke Prevention
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Background: Significant controversy exists regarding the natural history of asymptomatic carotid stenosis, and the need and appropriate interval for carotid DU surveillance. The purpose of this study was to determine how often DU surveillance for asymptomatic carotid stenosis or post-CEA resulted in a change in the patient’s clinical management, how many strokes were prevented by DU surveillance, and the cost of the DU surveillance program per stroke prevented.

Methods: We reviewed our vascular surgical database to identify all patients enrolled in a carotid DU surveillance program for asymptomatic carotid stenosis or following CEA between January 1, 2000 and December 31, 2008. The number of Duplex scans and CEAs performed in those patients through March 2010 were determined. The results of the Asymptomatic Carotid Atherosclerotic Study were used to estimate the number of strokes prevented by CEA in the study population. Reimbursement data were reviewed to calculate the cost of each DU and the cost of the DU surveillance program for each stroke prevented.

Results: During the study period, there were 11,594 carotid Duplex scans performed in 3016 patients (mean 3.84 scans per patient) who were enrolled in a DU surveillance program. Carotid endarterectomy for asymptomatic carotid stenosis was performed in 226 patients. The DU surveillance program prevented approximately 12 strokes (974 carotid duplex scans per stroke prevented). The mean allowable cost of each Duplex scan was $332. The total cost of the DU surveillance program approximated $3,850,000 or $321,000 per stroke prevented.

Conclusions: Although a routine DU surveillance program generates substantial revenue, for a vascular surgery practice, its value for stroke prevention is prohibitively modest. These data support elimination of routine postendarterectomy surveillance and implementation of a more selective surveillance process, perhaps targeting patients with carotid stenosis and factors associated with plaque progression and stroke.

Preoperative Thrombus Load/Location and Type II Endoleak and Late Sac Regression/Expansion
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Background: The correlation of type II endoleak (TIE) after endovascular aneurysm repair (EVAR) to aneurysmal sac thrombus load has only been described once. This study will examine the correlation of preoperative thrombus load/location to the incidence of TIE and late sac regression.

Methods: Prospectively collected data from 266 EVAR patients were analyzed. Maximum thrombus thickness (MTT) and percentage of thrombus-lined aneurysm circumference wall coverage (% TLAC) were determined from preoperative CTA at four levels: neck, at maximum AAA diameter (zone B), zone A (between neck and zone B), and zone C (between zone B and aortic bifurcation). The number of aortic side branches (ASB) was also recorded (IMA, accessory rensals, lumbar, and middle sacral). Logistic regression was used to determine the association of TIE with each variable.

Results: Thirty-three (12%) early and 32 (13%) late TIE were noted at a mean follow-up of 22 months (range: 1-87). The mean MTT at zone B was 19.7 in patients without early TIE and 18.8 mm in patients without late TIE vs 14.4 and 17.2 mm in patients with early and late TIE (P = .0187 and .444, respectively). The mean % TLAC was 76% and 75% vs 65% and 64% in patients without vs with early and late TIE (P = 0.0329 and 0.044). There was no correlation of early and late TIE and thrombus location (by zones). IMA was patent in 7% and 7% of patients without early and late TIE vs 16% and 15% with TIE (P = 0.0376 and .077). The mean number of ASB in patients without (early and late) TIE was 5.8 and 5.6 vs 5.8 and 7 with endoleak (P = .952 and .001). Using univariate analysis, the following variables decreased the incidence of early TIE: MTT for zone B (OR 0.79 for 8 mm increased (P = .014), % TLAC wall zone A (OR 0.78, P = .028), MTT zone C (OR 0.82, P = .043), % TLAC (OR 0.88 for 10% increase, P = .036), patent IMA (OR 2.6, P = .043). For late type II endoleak: % TLAC, (OR 0.88, for 10% increase P = .048, Fig 1), ASB (OR 1.39 for each additional vessel, P = .001, Fig 2 and Table). Using multiple regression model, only ASB (OR 1.34, P = .009) was predictor for late TIE (Table). Four out of five patients (80%) with late sac expansion vs 24/208 (12%) without expansion had late TIE (P = .001).

Conclusions: MTT, % TLAC, and number of ASB and patent IMA influence early TIE, however only the number of ASB influenced late TIE.