2.1% (86) pharmacologic alone, and 13.7% (569) no prophylaxis. The incidence of VTE in the high-risk group was 1.3% (54) compared with 0.9% (88) and 0.2% (16) in the medium-risk and low-risk groups, respectively. Of the 54 high-risk patients who developed VTE, 48 (88%) received appropriate prophylaxis as assigned by the risk-assessment model. The incidence of VTE in the high-risk group was greater when mechanical and pharmacologic prophylaxis were both used (50.0%) compared with pharmacologic alone (3.7%), mechanical alone (35.2%), or no prophylaxis (11.1%; $P = .05$; Fig).

Conclusions: Hospital-acquired VTE develops in high-risk patients despite appropriate risk assessment, identification, and prophylaxis with pharmacologic and mechanical methods. Further consideration for more aggressive prophylaxis should be given to this high-risk patient population for VTE prevention.

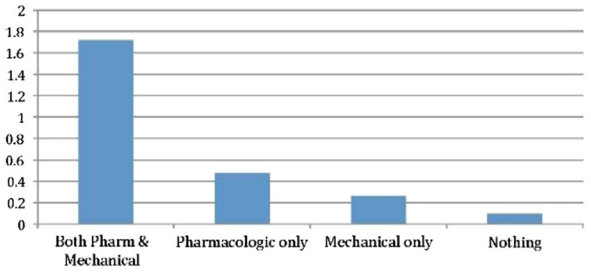

Fig. Incidence of venous thromboembolism (VTE) in all patients based on prophylaxis.

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Prospective Cost Analysis and Implications of Wound Complications in Lower Extremity Vascular Surgery Procedures†

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Objectives: Wound complications (WCs), such as surgical site infection, wound dehiscence, hematoma, and seroma after surgery cause significant morbidity and require additional resources to treat. We sought to quantify the marginal cost of WCs in patients undergoing open lower extremity vascular procedures.

Methods: Hospital administrative accounting cost data from a single tertiary institution were analyzed in patients enrolled in a prospective, randomized trial testing two postoperative wound dressings (gauze vs silver-coated alginate). A Wilcoxon rank sum test was used to assess the incremental cost of WCs at 30 days.

Results: Of the 224 patients who underwent lower extremity vascular surgery procedures, 61 (27.2%) developed WC, 40 (17.9%) of which were a surgical site infection. The mean incremental cost of WCs was $11,973, reflecting a 35% higher cost than non-WC patients ($P = .0112$). Patients with WCs had a longer mean index length of stay (8.2 vs 6.0 days, $P = .0025$), a higher rate of 30-day readmissions (23% vs 6%, $P = .0001$), and a greater mean cumulative 30-day length of stay (10.1 vs 6.2 days, $P = .0001$). The tested dressings showed no efficacy or cost differences.

Conclusions: WCs remain a frequent sequela of open lower extremity vascular surgery, with significant cost and resource utilization. Although the tested dressing did not demonstrate efficacy in reducing WCs, there remains potential cost savings for new and effective products or patient care quality improvements to capture.

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Chronic Mesenteric Ischemia: Outcome Analysis and Predictors of Endovascular Failure†

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Objectives: Outcomes of open (OR) and endovascular revascularization (ER) for chronic mesenteric ischemia (CMI) were analyzed to identify predictors of endovascular failure.

Methods: A multicenter, retrospective study was performed of all consecutive patients with CMI (151 patients/254 vessels) treated from 2008 to 2012. Demographics, comorbidities, etiology, and treatment modalities were compared. Outcomes included technical success, restenosis requiring reintervention, complications, mortality, and hospital length of stay (LOS).

Results: A total of 126 patients were treated with ER (83%) and 25 patients with OR (17%). Average follow-up period was 15.5 months. Overall mortality was 4.6% (7 of 151). A comparison between the two groups is reported in the Table. Among patients treated with ER, 14.3% developed technical and perfusion-related complications vs 20% in the OR group ($P = .464$). A subgroup analysis showed patients with ER requiring reinterventions had a higher incidence of long lesions >2 cm on angiography (55% vs 7%, $P < .05$). Patients crossing over from ER to OR had a significantly higher mortality compared with ER group-only (17.6% [3 of 17] vs 2.5% [3 of 119]), $P = .007$).

Conclusions: ER has similar mortality and shorter hospitalization but higher rate of restenosis requiring reintervention compared with OR. Patients with ER who require reintervention appear to have longer lesions on angiography. Patients who crossed over from ER had a higher mortality than primary OR or ER patients. These findings may guide treatment selection in patients with CMI undergoing ER or OR.

Table. Comparison of patients treated with endovascular revascularization (ER) and patients treated with open revascularization (OR)

Variable	*ER*	*OR*	P
Age, mean years	73 ± 8	64 ± 11	.0003
Comorbidities, %	62	38	.0026
Vessels treated	1.23 ± 0.42	1.59 ± 0.5	.0032
Restenosis, %	25	4	.029
Hospital LOS, days	5 ± 6	13 ± 10	.012
Mortality, %	4.8	4	.868

LOS, Length of stay.

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Comparison of Risk Factors for Length of Stay and Readmission Following Lower Extremity Revascularization◇

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Objectives: Recent initiatives have created incentives to reduce length of stay (LOS) and decrease readmission rates. We sought to elucidate the risk factors for both outcomes and to clarify the relationship between them in patients undergoing lower extremity bypass (LEB).

Methods: Peripheral arterial disease patients (PAD) who underwent LEB were identified from the 2007 to 2010 California State Inpatient Database. Logarithmically transformed LOS and risk factors were analyzed using linear regression. Risk factors for 30-day readmission were analyzed using logistic regression.

Results: Of 6558 patients who underwent LEB, 1541(24%) were readmitted. The average index LOS was 8.3 days for those who were

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