Objectives: The aim of this study was to evaluate the impact of smoking cessation on the progression of thromboangiitis obliterans (Buerger’s disease). The impact of various comorbidities on limb amputation was also evaluated.

Methods: A retrospective analysis of the cross-sectional National Inpatient Sample (2000-2011) was used to identify patients with a diagnosis of Buerger’s disease (International Classification of Diseases, Ninth Revision, 44.31). Patients who underwent extremity amputation were characterized according to smoking status and comorbidities, including renal failure, diabetes, coagulopathy, hypertension, heart disease, and chronic obstructive pulmonary disease, and compared with those who did not undergo amputation. Odds ratios were calculated for all statistically significant ($P < .05$) differences identified using the Fisher exact test and Student $t$-test.

Results: A total of 4,489 patients with Buerger’s disease were identified in the United States between 2000 and 2011, of which 193 (4.3%) underwent limb amputation. A total of 1908 (42.5%) patients were smokers. Smoking was slightly more common among patients who underwent amputation (46.1% vs 42.3%; $P = .30$; 95% confidence interval, −0.11 to 0.03). Of the comorbidities evaluated, renal failure was two times more common among patients who underwent amputation (6.2% vs 3.2%; OR, 2; $P = .02$; 95% confidence interval, −0.06 to −0.004). Patients who were former smokers were just as likely to require limb amputation (9.3% vs 11.5%; $P = .35$).

Conclusions: Although the association between smoking and Buerger’s disease is well understood, whether smoking leads to the limb amputation from this disease is unclear. This study demonstrates that the primary factor associated with limb amputation from Buerger’s disease is end-stage renal disease, not smoking. Further, smoking cessation does not appear to prevent progression to limb amputation in Buerger’s disease.

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PS126.

Vascular Surgeons Can Improve the Cardiovascular Health of Patients With Clinical Atherosclerotic Cardiovascular Disease by Implementing an Intensive Lipid-Lowering Regimen and Providing Smoke Cessation Counseling

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Objectives: To assess the impact of a vascular surgery-led program to improve the cardiovascular risk of patients with clinical atherosclerotic cardiovascular disease (ASCVD) by implementing an intensive lipid-lowering regimen and providing smoke cessation counseling.

Methods: The records of all patients seen in a single-center vascular surgery clinic over a 1-month period in November 2013 were retrospectively reviewed till October 1, 2011, when the vascular surgery service implemented a cardiovascular risk reduction program in patients with clinical ASCVD.

Results: Included were 144 consecutive patients with a median follow-up of 315 days (range, 0-740 days). Pre-intervention, the baseline median low-density lipoprotein (LDL) was 86 mg/dL (range, 39-197 mg/dL) and 96 patients (71.1%) had an LDL >70 mg/dL. Fifty-two patients (37%) were current smokers, 41 (71%) smoked heavily (more than one pack per day). Fifty-five percent of patients had documentation that this intervention was administered at the initial vascular surgery encounter after this program was started. The mean lag time to the first vascular surgery encounter with intervention documentation was 117 days (median, 0 days; range 0-721 days). At the latest follow-up, 92 (72%) of the encounters by a vascular surgeon documented that the intervention was administered, final median LDL was 79 mg/dL (range, 31-198 mg/dL), 80 patients (62%) had an LDL >70 mg/dL, and 60 patients (47%) had a decrease in their LDL. Patients who had no observed decrease in their LDL had a significantly lower mean level at baseline (82.3; standard deviation, 28.7; range 39-197 mg/dL) compared with those with an observed decrease in LDL (mean, 98.8; standard deviation, 32.8; range, 42-187 mg/dL; $P = .003$). At the latest follow-up, 41 patients (31.5%) were currently smoking, 21 (43.7%) of whom smoked heavily (more than one pack per day).

Conclusions: Vascular surgeons can improve the cardiovascular health of their patients by implementing a program of intensive lipid control and smoking cessation in patients with clinical ASCVD. Further studies are needed to determine the impact on cardiovascular event rates.

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PS128.

Defining and Reporting Academic Activity: The Academic RVU Can Justify the Mission

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Objectives: The academic mission is under strain. Although clinical activity is easily quantified by the Relative Value Units (RVU), there are multiple ad hoc measures of academic activity. This study reports the use of academic RVU (aRVU) derived for all nonclinical activities to justify nonclinical protected time of individual faculty, prioritize divisional activities, and drive the academic.

Methods: All nonclinical activity for divisional faculty were correlated and subjected to a defined scoring system. The system was set up in five modules (publications, presentation, clinical trial, grants educational, administration and community). Each module was
assigned a set of academic effort values and a series of modulators to describe the strength and weakness of an activity. Only ongoing productive activities were measured, and no allowances were made for tenure or previous achievements.

**Results:** All activities had effort apportioned to them. Publications were modulated by type, author position, and journal impact factor. Presentations were modulated by level of participation, meeting type and continuing medical education credit. Grants were weighted by funding source, annual income, and investigator classification, whereas clinical trials were assessed by status of recruitment and financial reimbursement. Teaching was based on defined activities, contributions to the curriculum, and learner scores. When faculty members were assessed and their budgeted time allocations compared, all the faculty exceeded their effort requirements. Examples of the system applications to a clinician, clinician administrator, clinician educator and clinician researcher will be shown.

**Conclusions:** Adoption of a universal system of measuring academic performance is necessary to facilitate faculty focus and development and allow for a rational budgeting of academic time and effort. Production and validation of the aRVU will allow for constructive and appropriate recognition of activity and contributions to the academic mission.

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**PS130.**
Clinical Feasibility and Financial Impact of Same-Day Discharge in Patients Undergoing Endovascular Aortic Repair (EVAR) for Elective Infra-Abdominal Aortic Aneurysm (AAA)
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**Objectives:** To evaluate the potential feasibility and financial impact of same-day discharge after elective endovascular aneurysm repair (EVAR) for abdominal aortic aneurysm (AAA).

**Methods:** All elective EVAR patients from January 2012 to June 2013 were identified. Demographics, comorbidities, complications, nursing care, financial data, and length of stay (LOS) were analyzed (SPSS 21).

**Results:** The Table presents care received in 67 elective EVAR (70% percutaneous EVAR/61% of AAA). Intraoperative and postoperative complications were type I endoleak, 1.5%; thrombosis, 3%; blood loss requiring transfusion, 4.5%; urinary retention, 4.5%; myocardial infarction, 3%; and hemodynamic/rythym alterations, 37% (evident in 24 [88%] <6 hours; 13% required therapy). Monitoring only was needed in 28 (42%), intensive care unit in 13.4%. Postoperative day 1 discharge occurred in 73%; 9% <30-day readmission. Total hospital costs: $29,479: operating room, 80.3%; anesthesia, 2.2%; preadmission, 1%; postanesthesia unit, 3.1%; intensive care unit, 1.9%; floor, 4.7%; laboratory/diagnostic tests, 1.2%; pharmacy, 1.4%; and other, 4.2%. Total cost was similar for those discharged <24 or >25 hours postoperatively (P = .88) and for monitoring only vs others ($28,146 vs $30,545; P = .12). Costs for pharmacy ($351 vs $509; P = .05) and laboratory ($86 vs $354: P = .01) and diagnostic testing ($3.96 vs $254; P = .02) were lower for uncomplicated cases.

**Conclusions:** Same-day discharge is clinically feasible in >40% of elective EVAR, but requires coordination for adequate postoperative monitoring. Significant savings is unlikely because most cost is operating room- and device-related, and further reduction of costs in uncomplicated cases is unlikely.

**Table.** Postoperative care in elective EVAR patients: Mean number of hours treatment was utilized or time initiated

<table>
<thead>
<tr>
<th>Indicator</th>
<th>(%)</th>
<th>Mean Hours Postop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>98.5</td>
<td>19</td>
</tr>
<tr>
<td>Telemetry</td>
<td>100</td>
<td>12</td>
</tr>
<tr>
<td>Arterial catheter</td>
<td>27.3</td>
<td>6</td>
</tr>
<tr>
<td>Continuous IV</td>
<td>86.4</td>
<td>12.5</td>
</tr>
<tr>
<td>IV fluid bolus</td>
<td>16.7</td>
<td>3.5 (initiated)</td>
</tr>
<tr>
<td>IV medication</td>
<td>52.4</td>
<td></td>
</tr>
<tr>
<td>Indwelling urinary catheter</td>
<td>67.2</td>
<td>19</td>
</tr>
<tr>
<td>Straight catheterization</td>
<td>4.5</td>
<td>14 (initiated)</td>
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<tr>
<td>&lt;3 Laboratory tests</td>
<td>76.2</td>
<td></td>
</tr>
<tr>
<td>Diabetic management</td>
<td>37.3</td>
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</tr>
</tbody>
</table>

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**PS132.**
Mitigating Mortality in Abdominal Aortic Aneurysmal Disease Through the Use of a Risk Register: Indications for EVAR vs Open Repair
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**Objectives:** This study aimed to determine risk factors associated with perioperative mortality in patients undergoing abdominal aortic aneurysm (AAA) repair nationally and use these risk factors to create a scoring system and risk register to determine mortality rate based on risk scores.

**Methods:** A retrospective analysis was completed using the National Inpatient Sample (NIS) from 2000 to 2010. A discriminant analysis was used to predict in-hospital mortality once predictor variables were identified using a multivariate analysis. A risk register was created using established rates of rupture for various AAA sizes and estimating the average mortality for those patients. This risk was then compared with the in-hospital mortality risk using our discriminant analysis to make recommendations on minimizing overall mortality as a function of aneurysm size and predictors of mortality.

**Results:** In the past decade in the United States, 101,978 patients underwent an AAA repair, of which 95,098 survived and 6,780 (7%) died. The following