

effects of H2S on tissue stability and viability, and optimize conditions for transplantation and for the eventual induction of immunotolerance to composite tissue allotransplants.

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PVSS3.

Should Endovenous Ablation of Small Diameter Great Saphenous Veins Be Performed on Patients with Symptomatic Varicose Veins?

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Objectives: The efficacy of radiofrequency ablation (RFA) for symptomatic varicose veins is well established. Alternatively, there is less consensus and little data on outcomes when treating great saphenous veins (GSV) of small diameter (≤ 5 mm). To this point, there are national insurance carriers that deny coverage for endovenous ablation for patients with small GSV citing lack of proven benefit. The purpose of this study is to assess clinical and anatomical outcomes of RFA on small diameter, symptomatic GSV at 3 months.

Methods: A retrospective analysis was performed of our patients who received RFA of incompetent GSV without any concomitant adjunctive procedures between January 2008 and December 2011. Limbs with a maximum GSV thigh diameter ≤ 5 mm on duplex while standing were subject to review. Clinical success was defined as an improvement in Venous Clinical Severity Score (VCSS) at 3 months. Anatomic success was defined as absence of venous flow ≤ 3 cm distal to the saphenofemoral junction (SFJ) on duplex ultrasound examination. Changes in CEAP class were noted.

Results: In 307 patients, 54 limbs in 44 patients met inclusion criteria. Baseline median VCSS was 4 (interquartile range 4, 5). Clinical success was seen in 83% of limbs at 3 months with a median VCSS change of -2 (IQR -3, -1). None of the treated limbs had phlebectomy for symptomatic varicosities prior to 3 month follow-up. One phlebectomy was performed for cosmesis at 78 days post procedure. Anatomic success was achieved in 96% of limbs at 3 months. Baseline median CEAP was 2 (IQR 2, 2). The median CEAP change at 3 months was 0 (IQR -1, 0). The only complication was a thrombus extension into the SFJ at 4 days.

Conclusions: In our experience, RFA of symptomatic small diameter GSV provides comparable clinical and anatomical outcomes to that of current published data. Our findings suggest that these patients benefit clinically from the RFA procedure and should not be denied this treatment based upon vessel diameter alone.

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PVSS4.

Implementation of the Screen for Abdominal Aortic Aneurysms Very Efficiently (SAAAVE) Act: A Five-Year Follow-up

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Objectives: In 2007, Medicare guidelines were established to identify persons at risk for the presence of an abdominal aortic aneurysm (AAA). The purpose of this study was to evaluate the implementation of the SAAAVE Act in identifying patients at risk for AAA within a 5-year period in clinical practice.

Methods: Data was extracted from a regional Veterans Affairs Healthcare Network to identify all veteran males 65-75 years of age who smoked greater than 100 cigarettes during their lifetime. In 2007, a AAA screening mandate was implemented allowing patients meeting screening criteria to be evaluated for AAA as part of the patient's health maintenance. AAA is identified as an aortic diameter size of 3.0 cm or greater. Clinician adherence to screening protocols and timely referral for aneurysms greater than 5.5 cm were also evaluated.

Results: A total of 9788 patients (71.5 ± 5.6 years of age) were screened for an AAA over a 5 year period from January 1, 2007 to December 31, 2011. A total of 698 aneurysms (7.1%) were found (See Table). Timely referrals were made on 44 patients with aneurysms greater than 5.5 cm. A total of 2828 patients (28.9%) were inappropriately screened: 421 patients were too young, 2250 patients were too old, 36 patients were women, and 121 patients without aneurysms had multiple screenings.

Total Aneurysms	698/9,788	7.1%
3.0 - 3.9 cm	460/9,788	4.7%
4.0 - 4.9 cm	146/9,788	1.5%
5.0 - 5.4 cm	47/9,788	0.5%
5.5 cm <	45/9,788	0.5%

Fig.

Conclusions: The long implementation of the AAA screening has allowed greater deviation from Medicare guidelines that increased the number of inappropriate screenings, mandating further AAA screening education for primary care providers.

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