bone marrow then concentrated and injected intramuscularly into the ischemic limb.

Results: BMA patients had a higher incidence of prior smoking (90% vs 43%; $P < .05$) with a trend towards fewer diabetics (47% vs 71%; $P = .07$). In the BMA cohort, 84% had rest pain and 79% had tissue loss. 68% had a prior bypass or endovascular intervention. Mean follow-up was 334 days (±170). A second BMA treatment was performed in 21% due to clinical deterioration. ABI improvement was 0.23 (±0.25). Rest pain improved in 87.5% and completely resolved in 56%. Wound healing occurred in 67%. 3 patients went on to amputation (Freedom from major amputation or death at 1.5 years 89% vs 59% (Fig; $P < .05$).

Conclusions: Bone marrow aspirate injection therapy is a potential option in CLI patients who are not candidates for bypass or endovascular intervention. Limb salvage is unexpectedly high in this population with few other options.

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RR31.

Anatomic Findings and Outcomes Associated With Arteriography and Thrombolysis for Acute Finger Ischemia

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Objectives: Limited evidence exists for management of acute finger ischemia (AFI). We evaluated anatomic findings, procedural management, and amputation-free survival in a cohort of patients with AFI.

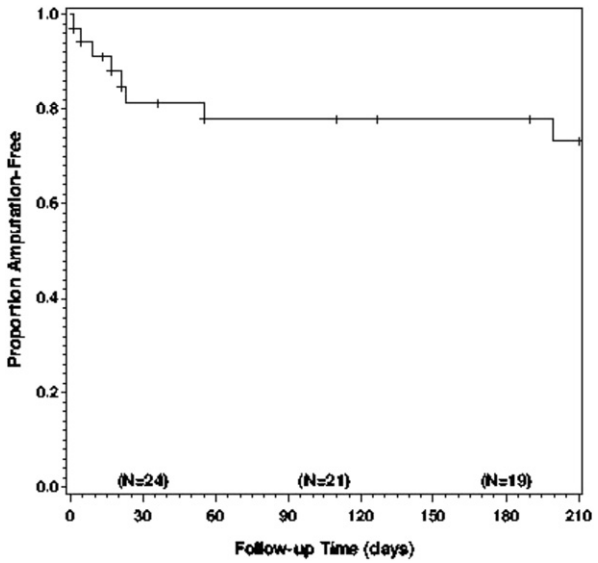

Fig.

Methods: Patients undergoing angiography for AFI were identified. Data were collected from medical records, arteriograms, and patient interviews. Outcomes included anatomic findings, utilization of thrombolysis, complications, and amputation-free survival. Descriptive statistics and survival analysis were used to evaluate results.

Results: 35 patients (Mean age 47.7; 19 women) were analyzed. Symptom duration was 1-28 days; seven patients had gangrene. Mean follow-up was 16 months. Baseline characteristics [n (%)] included: smoking [22 (65)], connective tissue disease [11 (31)], and repetitive hand trauma [10 (29)]. Arterial lesions were most frequently identified distal to the wrist (n = 32), including 8 ulnar/radial aneurysms. Proximal lesions were less common (n = 11). Of 23 patients treated with thrombolysis, 11 (47.8%) had interval anatomic improvement. Eleven patients had subsequent surgical revascularization. Complications included bleeding (n = 3) and pseudoaneurysm (n = 1). Estimated 1- and 6-month amputation-free survival (SE) were 0.81 (0.07) and 0.78 (0.07), with no difference when stratified by use of thrombolysis.

Conclusions: Angiography performed for AFI frequently identifies distal occlusive disease, and selective thrombolysis may expand revascularization options.

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RR32.

Internal Jugular Vein Stenosis in Patients With Thoracic Outlet Symptoms

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Objectives: Traditionally, thoracic outlet syndrome (TOS) has been associated with axillo-subclavian vein stenosis without any mention of the internal jugular (IJ) vein. However, we recently reported a high prevalence of IJ stenosis in 109 patients with TOS in a limited study. To confirm this finding, we analyzed a bigger cohort of patients.

Methods: We retrospectively analyzed 237 consecutive unique patients referred to our practice with thoracic outlet syndrome. From April' 08 to Dec' 12, all patients underwent diagnostic brachiocephalic venograms. Avg age was 49.9 years (r:17 to 81), with 71.8% females and 28.2% male. We looked at the right and left internal jugular veins and the right and left subclavian veins. Stenoses were classified into high (>66%), medium (33%-66%), and low (<33%). We also looked for presence of collaterals around the obstructions. Venogram findings were confirmed by four investigators independently. For the purposes of this analysis, high stenosis was considered significant.Medium and low stenoses were considered significant only if there were visible collaterals.

Results: Left internal jugular vein stenosis, left subclavian vein stenosis, right internal jugular vein stenosis, and right subclavian vein stenosis was seen in 67.5%, 57.6%,