

required per site before the study initiation, group II (n = 142) included the next 3-10 procedures, group III (n = 74) included the next 11-20 procedures, and group IV (n = 76) included ≥ 21 procedures. Variables evaluated include procedure time, total flow reversal time, fluoroscopic time, contrast volume, hospital length of stay, and any major adverse events (death, stroke, transient ischemic events and myocardial infarction through 30 days). P-values based on mixed effects linear model.

Results: Procedure time (minutes) in each group respectively was 105.4 ± 38.6 , 92.2 ± 42.8 , 80.5 ± 37.9 , and 57.5 ± 20.7 ($p < 0.001$). Flow reversal time (minutes) was 18.4 ± 13.4 , 16.1 ± 8.9 , 15 ± 9.7 , and 11.5 ± 7.7 ($p = 0.0028$). Fluoro time (minutes) was 25.5 ± 15.2 , 23.3 ± 17.2 , 19 ± 7.9 , and 15 ± 6.2 ($p = 0.23$). Contrast volume (mL) was 160.3 ± 86.8 , 163.6 ± 99.1 , 126.6 ± 62.8 , 99.7 ± 44.9 ($p = 0.017$). Length of stay (days) was 2 ± 1.6 , 2.2 ± 2.9 , 1.7 ± 2.3 , and 1.8 ± 1.7 ($p = 0.357$). Major adverse events (%) in each group was 1.61, 4.23, 6.76, and 2.63 ($p = 0.4$).

Conclusions: Despite a significant decrease in the total procedure and flow reversal times, with increased experience, there was no impact upon clinical outcomes, establishing the safety of this cerebral protection strategy even among early users.

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RR18.

Open AAA Repair Is Feasible and Can Be Done With Excellent Results in Octogenarians

Edward Y. Woo¹, Brant Ullery¹, Jeffrey P. Carpenter², Grace J. Wang¹, Ronald M. Fairman¹, Benjamin M. Jackson¹. ¹University of Pennsylvania, Philadelphia, PA; ²Coo-per University, Camden, NJ

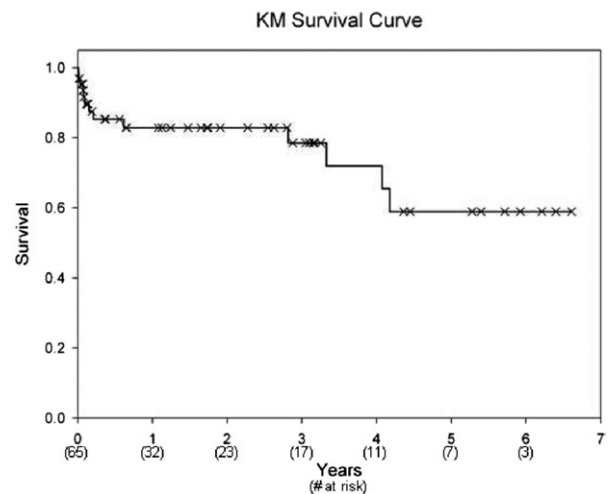
Objectives: To determine the feasibility of open AAA repair in octogenarians during the time of multiple commercially-available endografts where only proximal aneurysms or the most challenging anatomy is not stented.

Methods: A retrospective review was performed. Records for open AAA repair were obtained in patients over 80 from 2003-2009.

Results: Sixty-five patients (27M) had a median age of 82. Mean AAA size was 6.7cm. Morphology consisted of Type IV-19, Suprarenal-14, Pararenal-19, Infrarenal-13. A tube graft was used in 58 and the left renal was reimplemented in 32. Fifty-two required a suprarenal or supraceliac clamp (mean ischemic time-22 minutes). Mean EBL was 1800cc. Mortality was 6% at 30 days. Median ICU and hospital LOS were 3 and 9 days, respectively with 61% of patients discharged directly home. Overall, 28 patients suffered some type of complication, 25% being an arrhythmia. Six patients developed acute renal failure although no patients progressed to dialysis. Mean serum creatinine preoperatively

was 1.3 and at discharge 1.5. Only one patient developed bowel necrosis (sigmoid colon) requiring resection. Follow-up ranged from 1-81 months. Survival is demonstrated in the Figure.

Conclusions: With an increasing population of elderly patients, vascular surgeons are continually confronted with patients over 80 years of age. Our patients consisted of those not amenable to EVAR for anatomic reasons. Despite a predominance of proximal aneurysms our results demonstrate excellent morbidity and mortality. Thus, open AAA can be done safely in octogenarians and age alone should not exclude repair.



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R2: Paper Session II

RR19.

Carotid Artery Disease: Risk Factor Analysis in a Cohort of 3.9 Million Individuals

Giampaolo Greco¹, Natalia N. Egorova¹, K. Craig Kent², Robert M. Zwolak⁵, Andrew Manganaro⁴, Alan Moskowitz¹, Annetine Gelijns¹, Thomas S. Riles³. ¹Mount Sinai School of Medicine, New York, NY; ²University of Wisconsin, Madison, WI; ³NYU Langone Medical Center, New York, NY; ⁴Life Line Screening Inc., Independence, OH; ⁵Dartmouth-Hitchcock Medical Center, Lebanon, NH

Objectives: To develop a risk stratification tool that permits the identification of patients with clinically important carotid artery stenosis (CAS) for medical or surgical intervention.

Methods: In 2003-2008, demographics and risk factors were collected from a uniquely large patient population (3.9 million), who underwent ultrasound screening for CAS by Life Line screening. Using multivariable logistic regression analysis, we identified risk factors and developed a scoring system to predict the presence of CAS (>50%).