

therapy for massive, chronic VLU. Because data demonstrate improved wound closure rates in these large ulcers with STSGs, the price difference becomes negligible and may favor using an STSG.

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#### PS184.

##### **Compression Therapy Is Not Necessary After Endovenous Ablation Therapy for the Treatment of Varicose Veins**

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**Objectives:** Compression therapy is routinely used after endovenous saphenous ablation therapy (EVLT) for the treatment of varicose veins. The rationale for compression therapy is enhancement of vein closure and prevention of superficial thrombophlebitis (STP). A common patient complaint postoperatively is the discomfort elicited by the compression. The present work aims to determine whether compression therapy is necessary as an adjunct to EVLT.

**Methods:** A total of 77 consecutive lower extremities in 62 patients were treated with EVLT. Forty-two of the treated extremities had postoperative compression, and 35 did not. All patients had duplex evaluation at 1 week after EVLT and then were clinically evaluated at 1 and 3 months. Primary end points were status of the treated vein, presence or absence of STP, and the degree of varicose vein resolution.

**Results:** There was no difference between compression and no-compression groups in sex (63% vs 63% female), age (59 vs 55 years), CEAP class (C<sub>2</sub>-C<sub>3</sub>, 81% vs 91%; C<sub>3</sub>-C<sub>4</sub>, 19% vs 9%), extent of varicose veins (<6 mm, 60% vs 66%; >6 mm, 40% vs 34%), type of vein treated (great saphenous vein, 80% vs 66%; small saphenous vein, 9% vs 20%; accessory, 11% vs 14%) and operative variables. There was a 95% follow-up rate at 1 week, and all lower extremities demonstrated saphenous vein closure. Three patients in the compression group and no patients in the no-compression group had STP. No patients had deep venous thrombosis. At 1 month, both groups had the same rate of varicose vein regression and need for secondary procedures.

**Conclusions:** Compression therapy does not add any further benefit to EVLT and therefore consideration should be given to eliminating it, thus simplifying and improving the postoperative recovery.

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#### PS186.

##### **Inferior Vena Cava Placement Utilization Among Over 250,000 Patients: National Trends, Complications, and Relative Contraindications**

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**Objectives:** The aim of this study was to evaluate trends, complications, and risk factors that contribute to morbidity associated with inferior vena cava (IVC) filter placement.

**Methods:** A retrospective analysis of the National Inpatient Sample (NIS), a 20% cross-section of all U.S. inpatient admissions, was completed from 2000 to 2011 by identifying all patients who underwent IVC filter placement (International Classification of Diseases, Ninth Revision [ICD-9] 38.7). Complications including IVC thrombosis (ICD-9 45.32) and death were determined. Variables that were identified for each patient include Agency for Healthcare Research and Quality (AHRQ) standard comorbidities, clinical covariates including age, gender, race, and insurance status. Propensity matching was done to evaluate the effect of IVC filter placement on reducing morbidity and mortality.

**Results:** A total of 251,295 patients (52% female) were identified using the NIS, of which 2262 (0.9%) developed thrombosis of the IVC and 17,566 (7%) died. The average age of admission was 66 years, 14% were elective admissions. The rate of IVC thrombosis has decreased by 38% since 2000, paralleling the 50% decrease in mortality over the same time period. Patients with comorbidities including diabetes, hypertension, obesity, paralysis, chronic obstructive pulmonary disease, renal failure, and heart disease were up to 2.3-times less likely to develop IVC thrombosis or die after receiving an IVC filter. Healthy men aged <66 years were 2.2 times more likely to develop IVC thrombosis after IVC filter placement. Overall, IVC filter placement decreased morbidity from refractory deep vein thrombosis and trauma by 30%.

**Conclusions:** IVC filter placement is effective in reducing morbidity and mortality from deep vein thrombosis and trauma, particularly among patients aged >65 who have significant comorbidities. However, IVC filter placement among young, healthy men is disproportionately associated with complications and its use should be re-evaluated among this population.

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#### PS188.

##### **Open Surgical vs Endovenous Ablation Treatment of Patients with Klippel-Trenaunay Syndrome**

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**Objectives:** To assess safety and efficacy of open surgical treatment (OST) vs endovenous radiofrequency ablation (RFA) in patients with Klippel-Trenaunay syndrome (KTS).

**Methods:** Clinical data of all patients with complex mixed venous malformation treated for chronic venous insufficiency from 2008 to 2013 were reviewed. Perioperative complications and outcome after OST and RFA were compared.

**Results:** Twenty-seven limbs of 26 patients (14 females; mean age, 33 years; range, 15-74) were treated. All had varicose veins, 59% had limb overgrowth, and 63% had capillary malformations. Three had previous