deep venous thrombosis (DVT) or pulmonary embolism (PE). Inferior vena cava (IVC) filter was placed in eight. In group 1, 17 limbs were treated with OST (ligation and stripping/excision of saphenous or lateral embryonic veins); in group 2, 10 limbs were treated with RFA. Phlebectomies were performed in both groups, with thigh tourniquet in 21 limbs. Technical success of saphenous/lateral vein ablation was 100% in group 1 and 90% in group 2. There was no DVT or PE; none had thrombus extension into deep veins after RFA. Perioperative complications occurred in 19% (three of 16) in group 1 (bleeding, wound dehiscence, paresthesia) and in 20% (two of 10, $P = \text{NS}$) in group 2 (bleeding, thrombophlebitis). Follow-up averaged 15 months (range, 1-57 months). No patients reported worsening of symptoms, and none required repeat interventions. Marked improvement in symptoms was reported in 55% in group 1 and in 25% in group 2 ($P = \text{NS}$). All patients continued to wear elastic garments.

Conclusions: Surgical and endovenous treatment in select patients with KTS is safe and can be performed with low rate of complications. More data are needed to justify IVC filter placement. Although symptomatic varicose veins can be removed, residual symptoms due to persistent venous insufficiency are frequent. Lifelong elastic support is warranted.

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PS190.

Operative Explanation of Inferior Vena Cava Filters
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Objectives: Inferior vena cava (IVC) filter placement is not without risk. It has been associated with puncture site bleeding, venous thrombosis, as well as filter migration and perforation. The objective of this study was to assess our experience with open operative explanation of IVC filters.

Methods: After IRB approval, patients were identified from case logs that had transabdominal IVC filter removal between 1994 and 2013. Patient demographics, thromboembolic risk profile, clinical history, operative indication, and outcomes were recorded for each case.

Results: Eighteen patients (9 male; mean age, 49.6 years) were identified. IVC filters (4 permanent, 8 retrievable, 6 unknown) were deployed for a combination of significant thromboembolic events (n = 16), after trauma (n = 3), or after failure of anticoagulation therapy (n = 2). Ten patients had retrievable filters that were not removed percutaneously due to filter strut perforation into surrounding pericaval tissue. Seven patients subsequently presented with abdominal/back pain, hematuria, or sepsis. Midline laparotomy was used for explanation in 11 patients during oncologic resections. A subcostal incision (n = 5) was used for planned explantation alone. One patient had robotic-assisted laparoscopic removal and another had an open transjugular removal. Caval venotomy was primarily closed (n = 15) or patched with bovine pericardium (n = 2). No complications attributed to filter removal were identified in the postoperative period. One patient died of advanced malignancy, and the other 17 patients remain well (mean follow-up, 618 days).

Conclusions: Filter strut caval perforation remains the most significant indication for transabdominal removal. Filter removal is often considered incidentally during oncologic resection. Although operative explantation still remains infrequent, our series suggests that it may be performed safely without significant postoperative complications.


PS192.

Endovascular Venous Ablation in the Setting of Warfarin Anticoagulation: Experience at a Single-Center Institution
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Objectives: To determine the difference in durability of venous ablation in patients on warfarin anticoagulation compared with those without alteration in their coagulation pathway.

Methods: Data were collected from a single-center institution: NYU Medical Center using International Classification of Diseases, Ninth Revision codes for patients who had undergone radiofrequency or laser venous ablation between April 2011 and May 2013. Covidian CF7 7-60 2nd generation VNUS catheters were used for radiofrequency ablation and EVLT NeverTouch kits by Angiodynamics for laser ablation. Patients being concomitantly treated with warfarin were selected for study. Follow-up with venous duplex ultrasound imaging was performed at 1 week, 6 months, and then yearly to check for thrombus extension from the superficial to the deep venous system and document occlusion status of the treated veins.

Results: There were 72 patients: 40 male (55.5%) and 32 female (44.5%), with 94 limbs and 97 procedures performed. Average follow-up time was 142.5 days (range, 7-636 days). Fifty-four procedures (55.7%) were radiofrequency ablations, and 43 (44.3%) were laser ablations. Four veins (4.1%) recanalized within the follow-up time period: one was a radiofrequency ablation (1.9%), and three were laser (7.0%). Two of these occurred ≤1 week, and the other two between 6 and 12 months after the procedure. Nine patients (12.5%) in our study were on aspirin and one (1.3%) was on Plavix, all of whom had successful venous ablations without recanalization within the follow-up time period. None of the patients in our study experienced complications.