8. Does age affect survival in aortic dissection?
15 years single centre experience
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Objective: We identified patients who had surgery for type A aortic dissection and to assess if the outcomes have changed over the years with the increase in experience. We also studied the effect of the patient’s age and technique of repair (open vs. close) in terms of survival, blood products consumption and duration of cardiopulmonary bypass.

Methods: We identified patients who had surgery for type A aortic dissection from a prospectively collected database and theatre logbooks in the period (1998–2013). Details of cardiopulmonary bypass, blood products consumption were provided from perfusion department and blood bank databases. Patients’ long terms survival data obtained by contacting the patients’ GPs. R statistical platform was used for statistical analysis.

Results: A total of 152 patients were identified and 145 patients were included in the analysis. Our results showed that survival has not improved with the increase in centre experience. Older patients at the age of 60 or above had similar survival to younger patients. The use of open vs. closed technique had no significant effect on survival.

Conclusion: Survival following surgery for type A aortic dissection is not affected by age of the patient. Therefore, older patients should not be denied surgical repair based on age alone. Experience did not alter outcome, which indicates that calls for centralization of emergency aortic surgery may not be supported by strong evidence.

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9. Prevalence and impact of carotid disease in adult Saudi patients undergoing isolated coronary artery bypass surgery on early post-operative outcome
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Aim: Assess the prevalence of carotid disease in our Saudi population undergoing coronary artery bypass surgery and determine its impact on stroke and early post-operative outcome.

Materials & Methods: 3197 consecutive adult patients underwent major cardiac surgery in our center between January 2002 and December 2012. 3150 of these had pre-operative duplex scanning, and out of these, 210 patients (6.6%) had significant carotid artery disease defined as >75% stenosis (Group A), while 2940 (94.4%) were free from carotid artery disease (Group B). Both groups were compared for presence of pre-operative risk factors and occurrence of adverse events in the immediate post-operative period.

Results: In univariate analysis, pre-operative risk factors for the presence of carotid artery stenosis were diabetes mellitus (p < 0.0001); hypertension (p < 0.0001); past cerebrovascular accident (p < 0.0001) and peripheral vascular disease (p < 0.0001). All-cause in hospital mortality was high in group A in comparison to group B (3.8% vs 1.56%; p = 0.004). The Morbidity was also high in group A compared to group B in terms of stroke (4.3% vs 1.6%; p = 0.0014), nosocomial pneumonia (16.4% vs 8.9%; p = 0.0015), leg wound infection (14.2% vs 6%; p = 0.0001), sepsis (9.3% vs 4.8%; p = 0.013), acute limb ischemia (1.1% vs 0.4%; p = 0.034), new-onset atrial fibrillation (26.8% vs 16.3%; p = 0.0005), ventricular fibrillation (4.9% vs 1.5%; p = 0.0035) and renal dysfunction (11% vs 4.9%; p = 0.0017).

Conclusion: The Presence of carotid artery disease in Saudi patients undergoing cardiac surgery is associated with increased prevalence of diabetes, hypertension, cerebro-vascular accidents and peripheral vascular disease. It is also a major determinant of adverse outcome after coronary surgery.

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