developed a total of 9 pseudoaneurysms (6.3%: one bilateral), none of which required secondary intervention. Median pseudoaneurysm diameter was 8.4 mm at diagnosis. Median follow up was 24 months. Three pseudoaneurysms had resolved at one year and a further by 2 years. Four patients died at a median of 15 months; none due to pseudoaneurysms.

Conclusion: There is a low rate of pseudoaneurysm formation after fascial closure and no clinical impact in the mid-term. Fascial closure remains a safe and minimally invasive option.

0963: OUTCOMES FOLLOWING ARTERIAL ANGIoplastY IN SYMPTOMATIC INFRApopliteAL DISEASE: A SYSTEMATIC REVIEW OF THE LITERATURE

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Aim: Despite a wealth of research into percutaneous intervention for arterial disease, the role of angioplasty in treating symptomatic infrapopliteal disease remains undefined. Whilst historically, surgical revascularisation has been the cornerstone of its management, angioplasty is recommended for limb salvage where open surgery is contra-indicated. Should non-inferiority be demonstrated, increasing use of endovascular techniques may reduce the morbidity associated with open surgery. This study’s aims are to summarise reported outcomes in endovascular crural disease management.

Methods: A systematic review of the Cochrane Library, OVID/Medline and Pubmed was performed from 1990 to December 2012. Keywords included: ‘infrapopliteal’, ‘angioplasty’, ‘stenoting’, ‘outcomes’. Related article functions were also searched. Clinical and technical success parameters were recorded.

Results: No level 1 evidence exists as to the superiority of bypass over percutaneous transhumal angioplasty (PTA). Two randomised controlled trials (RCT) demonstrated non-superiority of bare-metal stenting over PTA, whilst initial reports from three RCTs suggest a role for sirolimus/everolimus/paclitaxel-eluting stents in improving clinical outcomes.

Conclusions: A level I, intention-to-treat study of angioplasty/stenting vs. bypass will be required before the precise role of infrapopliteal angioplasty can be defined. Drug-eluting stents have shown early promise and may thus facilitate further paradigm shift away from more morbid surgical management techniques.

1009: ROLE OF ANGIOGRAPHIC RUN OFF SCORE AS A TOOL TO PREDICT LONG TERM OUTCOME FOLLOWING LOWER LIMB BYPASS SURGERY

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Objectives: To evaluate the role of peripheral artery run-off scoring as predicted by the SVS/ISCVS system in predicting the fate of infragenual bypass grafts.

Methods: A retrospective cohort study of all patients enrolled in a Duplex-based lower limb graft surveillance programme since January 2007 at a tertiary vascular centre. Outflow vessels were graded according to the SVS/ISCVS Ad Hoc scoring system based on preoperative magnetic resonance angiography. All candidates were followed up for re-intervention or graft occlusion until January 2012 or discharge from the surveillance programme.

Results: 178 patients underwent follow up after infragenual bypass. The primary indication for surgery was: critical limb ischaemia (60%); aneurysm (28%); claudication (10%), and trauma (2%). The median follow up time was 28 months (range, 3-56 months). Primary patency rate was 79.2% at the completion of follow up. Secondary patency rate was achieved in an additional 14.1%. Twelve subjects had graft failure of whom 8 required amputation. Mean run off score in the re-intervention group was 6.0, 6.5 in those resulting in amputation compared to 5.5 in those with primary patency. ANOVA p-value 0.218.

Conclusions: Preoperative run off score did not predict re-intervention or mid-term graft patency.

1032: ULTRASOUND GUIDED FOAM SCLEROThERAPY (UGFS) FOR ACTIVE VENOUS ULCERATION – A 5-YEAR COHORT

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Aim: Ultrasound guided foam sclerotherapy (UGFS) for treatment of CVU (chronic venous ulceration) has demonstrated favourable results in preliminary studies. This study analyses healing and recurrence rates in CEAP6 ulcers treated with UGFS.

Method: Between 2007 and 2012, 60 patients (63 legs) underwent UGFS with sodium tetradecyl-sulphate(STS) for CEAP6 ulcers. All patients were followed up at 2.5 months both clinically and venous duplex was performed before and after treatment. We analysed a prospectively collected database and calculated venous occlusion rates, 12 month healing and recurrence rates.

Results: 63 legs, 43 primary; 20 recurrent. Median time ulcer active 15 months (IQR 9 - 24); range 5 months – 17 years. At a median follow-up 2.5 months 57(90.5%) achieved full occlusion; 3(4.8%) short segment occlusion, 4(4.8%) failed to occlude. 13 required repeat treatment. 2 pts reported thrombophlebitis. 10 patients excluded from outcome analysis. 37(70%) healed at a median time of 4 months; 13(24.5%) at 3 months, 24(45.3%) at 6 months, 30(56.6%) at 12 months. 14(28.3%) significantly reduced and healing; 7 almost healed and discharged; 12 month recurrence rate 2(3.7%).

Conclusions: USFS is a feasible component of the leg ulcer service and a safe and effective means of securing superficial vein occlusion as an alternative to surgery.

1049: GRAFT INFECTION FOLLOWING VASCULAR SURGERY: INCIDENCE, MANAGEMENT APPROACH AND OUTCOMES

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Aim: The aim of this study is to determine the incidence of graft infection in our vascular unit, our management approach and outcome.

Methods: A retrospective study from case notes and a prospective database of 168 patients who underwent vascular surgery with graft insertion from January 2008 to December 2011. Patient demographic, type and site of surgery, CEPOD grade of surgery, antibiotic prophylaxis, onset of graft infection and treatment options were included in the data.

Results: 168 patients were included in our study. Carotid endarterectomy (CEA) was the most performed procedure (48.8%) followed by femoral bypass/endarterectomy (32.8%) and aortic surgery (18.4%). The majority of the operations were elective 78% and 22% were emergency. Cefuroxime, Teicoplanin and Gentamicin were prophylactic antibiotics of choice in our unit. Only 4 (2.38%) cases of graft infection were identified (2 CEA, 1 Aorto-Bifemoral bypass, 1 Femoro-popliteal bypass). All these patients underwent removal of the graft and reconstructive vascular surgery. One patient had an amputation as consequence of graft infection despite reconstructive surgery. There was no mortality.

Conclusion: Our graft infection rate is very low with triple prophylactic antibiotics. Graft removal and reconstructive vascular surgery remain the standard management approach.

1062: SYNCHRONOUS CAROTID ENDARTERECTOMY (CEA) AND CARDIAC SURGERY (CS): A SINGLE CENTRE EXPERIENCE OVER THIRTEEN YEARS

Thomas Hubbard, Marc Bailey, Kathryn Griffin, Julian Scott, Leeds Vascular Institute, Leeds, UK.

Introduction: This study reports rationale for and outcome of synchronous carotid endarterectomy (CEA) and cardiac surgery (CS) over thirteen years in our institution.

Methods: Patients undergoing CEA and CS between 1998-2011 were identified, casenotes retrieved and retrospectively reviewed. Patients were divided into; previously neurologically symptomatic (CEA) and asymptomatic (CEA), and followed up to present day.

Results: 20,320 patients underwent CS during the study period; 64 had CEA. 14 were excluded due to casenote loss or destruction. Twenty seven patients (54%) formed the CEA group (12 completed strokes, 15 TIA) with average Euroscore of 8.23; 23 formed the CEAS group with average Euroscore of 8.33. The rationale for Carotid Doppler Ultrasound in CEAA: carotid bruit in 10 (20%), routine work-up in 11 (22%), re-evaluation of existing carotid lesion in 2 (4%); 80% of CEA were for high grade (70-99%) stenosis, 10 patients (20%) had bilateral disease. Thirty day stroke/death rate was 14% (12% CEAS vs. 16% CEAA, p=0.3). The only predictor of 30
day stroke/death on univariate analysis was preoperative stroke (p=0.02).

**Conclusion:** Rationale for CDUSS in asymptomatic patients pre CS is variable and results in high numbers receiving CEA. National Guidelines for CDUSS and CEA referral pre-CS are required.

**1066: VASCULAR ALLOGRAFTS – THE UK PERSPECTIVE 2008-2012**
Samuel Coulson, Fern Coxon, Dominic Dodd. Vascular Services, Sheffield, UK.

**Introduction:** Cadaveric allografts provide one alternative for conduit formation in peripheral vascular disease when autographs are unavailable and prosthetic grafts pose too great a risk. We aimed to review the use of vascular allografts in the UK to identify reasons for poor uptake.

**Method:** All incidences of vascular allografts in the UK were recorded. Reporting forms at time of operation, then at regular intervals, were sent to the operating surgeon. The forms recorded demographics, comprehensive management information, patient progress and professional opinion.

**Results:** Allografts were used on eighteen occasions, including five femoral–popliteal, three ilio–femoral and two aorto–iliac bypasses. Five are currently in situ and five have been removed. Complications included arterial infection, graft infection and severe limb ulceration. Users found allografts easy to handle and many would utilise again.

**Conclusion:** Vascular allografts have not gained the widespread acceptance they have been afforded in Europe. The current dismal uptake will delay the development of a solid evidence base and threaten the future of the vascular allograft tissue bank. Users reported a good experience, with the ultimate proof being repeated use by four surgeons. Will it take just one exposure to highlight the practicalities of these grafts and encourage further use?

**1080: PERIOPERATIVE COMPLIANCE WITH VSGBI QUALITY IMPROVEMENT FRAMEWORK FOR MAJOR LIMB AMPUTATIONS IN A SINGLE VASCULAR CENTRE**
Matthew Kennedy, Nikhil Sharma, Sobath Premaratne, Anthony Jaipersad, Arun Balakrishna, Catherine Merriman. Royal Shrewsbury and Telford Hospitals NHS Trust, Shrewsbury, UK.

**Aim:** To determine whether our department complies with the quality improvement framework for major amputations formulated by Vascular Society of Great Britain and Ireland (VSGBI).

**Methods:** Retrospective audit of major limb amputations performed during 12 month period until October 2012. Case notes, theatre records and departmental vascular database were analysed and data collected using a proforma formulated upon the VSGBI guideline.

**Results:** 41 patients had major amputations, 30 were male, average age was 70.2 years (range 36-94), 22(54%) below-knee and 17(41.5%) above-knee amputations were performed. All patients were assessed by a vascular surgeon prior to surgery. 97%(39) procedures undertaken during normal working hours. Following the decision to amputate, 73%(30) patients underwent the procedure within 48 hours. All operating surgeons were either senior vascular registrars or performed under consultant supervision. In 71%(29) anaesthesia was administered by a senior anaesthetist. Thromboprophylaxis administered for all patients and prophylactic antibiotic therapy administered in 92%(38) of patients preoperatively. Postoperatively all patients underwent physiotherapist led rehabilitation. In-hospital mortality and 30-day mortality rates were 7.3%(3) and 9.7%(4) respectively.

**Conclusion:** Perioperative management of lower limb amputations according to the quality improvement framework published by VSGBI, can be undertaken in a single vascular centre with acceptable outcome results.

**1149: CATHERET-DIRECTED THROMBOLYSIS IN ILLIO-FEMORAL DEEP VEIN THROMBOSIS**
Hirah Rizki, Abhilash Paily, Gary Picken, Isam Osman, Abdusalam Abu-Own. The Ipswich Hospital, Ipswich, UK.

**Aim:** The importance of thrombus removal through Catheter Directed Thrombolysis (CDT) for acute ilio-femoral DVT is well recognized. The aim of this study was to review outcomes following CDT in our hospital.

**Methods:** A retrospective review of case notes and imaging was undertaken for all cases of CDT from January 2001 to December 2012. tPA was used and administered through the popliteal vein. Patients were thrombolysed for 24-72 hours. No patient had an IVC filter inserted prior to CDT.

**Results:** 20 patients (mean age 36) underwent CDT for iliio-femoral DVTs. Complete radiological clearance was achieved in 40% of patients. May-Thurner Syndrome was identified as the leading cause in 30% of patients. There was no in-hospital PE, cerebral bleeding or deaths. Minor bleeding, from the catheter or cannula site, was noted in 64% of cases. One patient developed recurrent DVT within 3 month and three beyond 3 months. One patient developed a PE 7 months post CDT.

**Conclusions:** In our experience, CDT is a safe and successful treatment option for iliio-femoral DVTs. Our local hospital guidelines for CDT have facilitated the process of safe selection and delivery of this treatment. Our results are in keeping with the findings of published data.