

was 80–89% and the median stenosis on MRA was high grade. Peri-operative stroke rate was 1.2%.

**Conclusion:** Carotid endarterectomy for symptomatic high grade carotid artery stenosis is carried out in our institution with acceptable peri-operative stroke rates and time interval to surgery. The centralisation of acute surgical services and availability of an emergency theatre, timely access to imaging and the availability of a stroke nurse coordinator may have facilitated faster access to surgery. Carotid disease is best managed with a multidisciplinary approach.

### Abdominal Aortic Aneurysm Repair in the Presence of a Stoma

A.S. Galbraith, E.M. Quinn, M.P. McMonagle, K.S. Cross

Department of Vascular and General Surgery, University Hospital Waterford, Ireland

A 67 year old gentleman presented to an emergency department with acute abdominal pain and an underlying diagnosis of known abdominal aortic aneurysm (AAA). Subsequent transfer to a tertiary centre for immediate open aneurysmal repair was undertaken. At the time of surgery a segment of ischaemic bowel extending from mid-transverse to distal sigmoid colon was discovered and no evidence of aneurysmal leakage. Successful left hemi-colectomy was performed, end-colostomy fashioned and aneurysmal repair postponed. Elective open AAA repair of an 8.5cm aneurysm was undertaken eight weeks post initial laparotomy. This patient's postoperative course was unfortunately complicated by Dacron graft infection, the need for explantation of the graft and further surgery following which the patient was successfully discharged home.

We present an interesting case of AAA repair in the presence of a recent colostomy for ischaemic bowel, which poses significant challenges intra and post-operatively for both surgeon and patient. It raises issues including; appropriate timing of procedure, anecdotal reports of aneurysm expansion following laparotomy, difficulties maintaining surgical site sterility, the possible use of extended prophylactic antibiotic administration and the management of the potential dreaded prosthetic graft infection, all in the presence of an imminently life threatening condition.

In conclusion complex major vascular procedures in the presence of concomitant intra-abdominal pathology pose an array of significant dilemmas to which there are no simple solutions.

### Robotic IVC Surgery

M.E. O'Donnell<sup>1,2</sup>, R. Day<sup>2</sup>, C. Velazco<sup>2</sup>, S.M. Cheney<sup>3</sup>, E.P. Castle<sup>3</sup>, W.M. Stone<sup>2</sup>, R.J. Fowl<sup>2</sup>, S.R. Money<sup>2</sup>

<sup>1</sup> Department of Vascular and Endovascular Surgery, Royal Victoria Hospital, Belfast, Northern Ireland

<sup>2</sup> Division of Vascular and Endovascular Surgery, Mayo Clinic, 5777 East Mayo Boulevard, Phoenix, AZ 85054, United States

<sup>3</sup> Division of Urology, Mayo Clinic, 5777 East Mayo Boulevard, Phoenix, AZ 85054, United States

**Introduction:** Robotic surgery has been widely adopted in urological, gynaecological and now colorectal surgery. However, clinicians still remain apprehensive when vascular structures are involved. The objective of this study was to describe our initial experience with robotic surgery of the inferior vena cava (IVC).

**Methods:** All patients who underwent robotic surgery of the IVC between September 2011 and August 2013 were included. Patient data regarding clinical presentation, radiological imaging, operative intervention, treatment pathway and clinical outcome were recorded.

**Results:** Four patients were identified (Male = 3, mean age 51.5 years). Three patients with renal tumours (right = 2) had tumour thrombus extending to the IVC. These three patients were commenced on therapeutic low-molecular weight heparin pre-operatively to minimise tumour thrombus propagation. A fourth female patient presented with a symptomatic IVC filter with associated migration and perforation. All patients proceeded to robotic surgery with careful patient positioning. After creation of the pneumoperitoneum, a 12mm camera port was inserted followed by insertion of the remaining robotic ports under direct vision (5mm x 1, 8mm x 3 and 12mm x 1). The operative procedure was performed in stages which included mobilization of the duodenum and right colon, IVC dissection, vascular control of the IVC with ligatures and Rummel tourniquets, creation of cavotomy, mobilization and removal of the tumour thrombus or IVC filter followed by closure of the cavotomy. Conventional additional dissection was performed for nephrectomy when indicated. Mean operative time was 192 minutes with an IVC clamp time of 78 minutes. Mean total peri-operative intravenous fluid administration was 4167mls with a corresponding urine output of 383mls. All four patients had uncomplicated post-operative courses with mean discharge on post-operative day three. Adjuvant chemotherapy was administered to all renal tumour patients. All patients remain well with mean follow-up of nine (range 1–24) months.

**Discussion:** Our initial experience suggests that robotic IVC surgery is a valid and safe modality providing satisfactory access to the IVC leading to shorter recovery and improved patient quality of life.

### Transatlantic Consensus of Vascular Surgery Consent

M.E. O'Donnell<sup>1,2</sup>, D. McGrogan<sup>1</sup>, C. Velazco<sup>2</sup>, R. Day<sup>2</sup>, S.R. Money<sup>3</sup>, W.M. Stone<sup>2</sup>, R.J. Fowl<sup>2</sup>, M.G. Wyatt<sup>3</sup>, C. Pence-Smith<sup>2</sup>, B. Lee<sup>1</sup>

<sup>1</sup> Department of Vascular and Endovascular Surgery, Royal Victoria Hospital, Belfast, Northern Ireland

<sup>2</sup> Division of Vascular and Endovascular Surgery, Mayo Clinic, 5777 East Mayo Boulevard, Phoenix, Arizona 85054, United States

<sup>3</sup> Northern Vascular Centre, Freeman Hospital and Newcastle University, Newcastle upon Tyne, England, United Kingdom

**Objectives:** Currently, there are no explicit guidelines for informed consent for vascular surgical interventions. The objective of this study was to compare current peer-practice and collate transatlantic consensus relating to vascular surgery patient consent.