abdominal vascular surgery. A total of 388 patients were identified in the year prior to (266) and the year after (122) the intervention was initiated. Thirty-day readmission rates, emergency department (ED) visit rates, and early clinic visit rates (defined as a clinic visit less than 14 days postdischarge) were calculated and compared between the pre- and postintervention periods. Major demographic and comorbidities were then used to create a risk-adjusted logistic regression model examining the effect of the interventions on the outcomes.

Results: Preintervention 30-day readmission rates were 9.8%, compared to 9.0% after the intervention ($P = .81$). The most common reason for readmission were infectious/wound-related (40.5%), and the incidence did not differ between pre- and postintervention time periods; additionally, patients with a positive screen for wound concerns at discharge were more likely to be readmitted ($P = .04$). Postoperative ED visit rates were identical in the postintervention group as compared to the preintervention group, as were the reasons for presentation. Risk-adjusted logistic regression models bore these trends out, though none reached statistical significance.

Conclusions: A callback program did not reduce readmissions or direct patients to clinic rather than the ED in a population of patients undergoing major vascular surgery. A focused process for postoperative wound management may yield the highest decrease in readmissions.

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PS106.

Comparison of Complication Rates of Implantable Venous Access Devices: Percutaneous Versus Cephalic Vein Cut-down Techniques

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Objectives: Indwelling central venous access comprises a significant proportion of vascular surgery cases. We previously compared access techniques and found the cephalic vein cut-down approach a reasonable alternative to percutaneously placed lines. We sought to determine whether utilization of the cut-down technique with smaller catheters reduced complications.

Methods: 307 venous access devices were placed between 2001 and 2007 utilizing a 6.6 F catheter and the cephalic vein cut-down approach. A retrospective study was performed to review complications and operative times for this technique. We compared these cases to prior 9.6 F lines placed by either cut-down or percutaneous techniques. Complications examined included pneumothorax, infection, migration, thrombosis and wound complications. Statistical analysis was performed using the Student t test.

Results: The overall complication rate of lines placed via a cephalic vein cut-down approach utilizing a 6.6 F catheter was 3.9% (11/307), significantly lower compared to 10.8% (16/148) among the 9.6 F lines placed via cut-down technique ($P = .004$) and 15.3% (25/163) among lines placed by percutaneous methods ($P < .0001$). Mean operative time was also significantly lower (38 minutes compared to historical data of 47 minutes; $P < .0001$).

Conclusions: The cut-down approach to the cephalic vein with a 6.6 F catheter provides shorter operative time and fewer overall complications compared to both percutaneous access and cut-down techniques utilizing larger size catheters.

Table. Comparison of complications using cephalic vein cut-down technique with 9.6F vs 6.6F indwelling catheters

Complication	*Historical data (9.6F percutaneous, n = 163)*	*Historical data (9.6F cephalic vein cut-down, n = 148)*	*Current data (6.6 F cephalic vein cut-down, n = 307)*
Migration	4	6	6
Deep vein thrombosis	3	4	2
Wound dehiscence	2	2	1
Wound hematoma	0	1	1
Infection	5	0	1
Pneumothorax	2	0	0

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PS108.

Adrenal Venous Sampling for Hyperaldosteronism: The Vascular Surgeon Experience

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Objectives: Adrenal venous sampling (AVS) is used to distinguish between bilateral hyperplasia and an aldosterone producing tumor in patients with hyperaldosteronism. Successful sampling from both adrenal veins is necessary for lateralization, and may require more than one procedure. AVS has traditionally been performed by interventional radiologists, however our goal was to examine the outcomes when performed by a vascular surgeon.

Methods: All patients over the age of 40 with a diagnosis of hyperaldosteronism were referred for AVS regardless of imaging findings. Cortisol and aldosterone levels were measured in blood sampled from both adrenal veins before and after co-syntropin infusion. Postoperative analysis of intraoperative laboratory values determined successful cannulation and sampling of each vein.

Results: Between 2007 and 2012, 53 patients underwent AVS by one vascular surgeon. The average age was 54 and 63% were male. Our success rate increased with experience, as during the earlier years (2007-2010) primary and secondary success rates were 58 and 68% compared to later years (2011-2012) when primary and secondary success