artery stenosis (CAS) were reviewed. In group 1 symptoms (minor stroke, transient ischemic attack, TIA) occurred ≤14 days; and in group 2 symptoms occurred >14 days before CEA. Primary end points were combined stroke and death; secondary end points were stroke, death, and myocardial infarction (MI).

Results: A total of 231 CEAs were performed in 226 symptomatic patients (32% female; mean age, 72 ± 8.7 years), comprising 58 (25%) in group 1 and 173 (75%) in group 2. Sixty patients (26%) presented with stroke (group1, 19%; group 2, 28%; P = .16). The 30-day stroke and death rate was 2.6% and not significantly different between groups (Table). Three of four early strokes in group 1 occurred in patients with repeated transient ischemic attacks ≥2 days before CEA. Mean follow-up was 3.9 years (range, 30 days-10.8 years). The Table presents 5-year outcomes. In multivariable analysis, patients with symptoms ≤14 days tended to have increased rate of stroke.

Conclusions: CEA can be performed in symptomatic patients with a 30-day stroke and death rate of 2.6%, but there was a trend to increased rate of stroke if the operation was performed ≤14 days after onset of symptoms. Patients with repeated transient ischemic attacks, operated on ≥2 days, had the highest risk of stroke. For this select group of symptomatic patients, outcomes quoted based on prospective randomized trials may not apply.

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C8f: Poster Session—Vascular Medicine; Practice Management; Other

PS122.

Risk Factors for Suboptimal Medical Therapy in Patients Undergoing Revascularization for Symptomatic Peripheral Arterial Disease: A Vascular Study Group of Greater NewYork Initiative


Objectives: The objective of this study is to identify risk factors for suboptimal medical therapy among patients undergoing surgical bypass and percutaneous interventions for symptomatic peripheral arterial disease (PAD).

Methods: The Vascular Study Group of Greater New York (VSGGNY) database was used to identify all patients undergoing percutaneous therapy or surgical bypass for PAD (2011-2013). Bivariate analyses were performed to identify factors associated with preoperative statin use and antiplatelet therapy. Multivariate relative risk regression models were developed to identify patients at risk for suboptimal medical therapy.

Results: A total of 1030 patients underwent endovascular therapy (n = 822 [80%]) or surgical bypass (n = 208 [20%]) for symptomatic peripheral arterial disease (57.2% claudication, 15% rest pain, 27.8% tissue loss). Preoperative statin use was observed in 59%. Antiplatelet therapy was observed in 79% of patients. Bivariate analysis revealed reduced statin use among patients without other cardiovascular risk factors such as hypertension (63% vs 39.3%; P < .0001) and coronary artery disease (CAD) with prior cardiac revascularization (coronary artery bypass grafting [CABG]/percutaneous coronary intervention [PCI]; 75.2% vs 47.4%; P < .0001). Multivariate relative risk regression confirmed increased statin use among patients with other cardiovascular risk factors including hypertension (1.14 [1.02-1.27]; P = .02), and CAD with prior CABG/PCI (1.22 [1.13-1.31]; P < .0001). There was a clear trend towards reduced statin use in patients aged >80 (0.92 [0.84-1.0]; P = .59). By multivariate regression, antiplatelet therapy use was associated with CAD and prior CABG/PCI (1.11 [1.04-1.17]; P = .0015) and prior peripheral revascularization (1.07 [1.01-1.13]; P = .03).

Conclusions: Patients with symptomatic PAD, but without an antecedent cardiovascular history, are less likely to be optimally managed with statins and antiplatelet therapy preoperatively and should be actively targeted for medical optimization by vascular specialists.


PS124.

Smoking Cessation Does Not Impact Limb Amputation Rates in Buerger’s Disease

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Objectives: The aim of this study was to evaluate the impact of smoking cessation on the progression of thromboangiitis obliterans (Buerger’s disease). The impact of various comorbidities on limb amputation was also evaluated.

Methods: A retrospective analysis of the cross-sectional National Inpatient Sample (2000-2011) was used to identify patients with a diagnosis of Buerger’s disease (International Classification of Diseases, Ninth Revision, 44.31). Patients who underwent extremity amputation were characterized according to smoking status and comorbidities, including renal failure, diabetes, coagulopathy, hypertension, heart disease, and chronic obstructive pulmonary disease, and compared with those who did not undergo amputation. Odds ratios were calculated for all statistically significant (P < .05) differences identified using the Fisher exact test and Student t-test.

Results: A total of 4,489 patients with Buerger’s disease were identified in the United States between 2000 and 2011, of which 193 (4.3%) underwent limb amputation. A total of 1908 (42.5%) patients were smokers. Smoking was slightly more common among patients who underwent amputation (46.1% vs 42.3%; P = .30; 95% confidence interval, −0.11 to 0.03). Of the comorbidities evaluated, renal failure was two times more common among patients who underwent amputation (6.2% vs 3.2%; OR, 2; P = .02; 95% confidence interval, −0.06 to −0.004). Patients who were former smokers were just as likely to require limb amputation (9.3% vs 11.5%; P = .35).

Conclusions: Although the association between smoking and Buerger’s disease is well understood, whether smoking leads to the limb amputation from this disease is unclear. This study demonstrates that the primary factor associated with limb amputation from Buerger’s disease is end-stage renal disease, not smoking. Further, smoking cessation does not appear to prevent progression to limb amputation in Buerger’s disease.

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PS126.

Vascular Surgeons Can Improve the Cardiovascular Health of Patients With Clinical Atherosclerotic Cardiovascular Disease by Implementing an Intensive Lipid-Lowering Regimen and Providing Smoke Cessation Counseling

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Objectives: To assess the impact of a vascular surgery-led program to improve the cardiovascular risk of patients with clinical atherosclerotic cardiovascular disease (ASCVD) by implementing an intensive lipid-lowering regimen and providing smoke cessation counseling.

Methods: The records of all patients seen in a single-center vascular surgery clinic over a 1-month period in November 2013 were retrospectively reviewed till October 1, 2011, when the vascular surgery service implemented a cardiovascular risk reduction program in patients with clinical ASCVD.

Results: Included were 144 consecutive patients with a median follow-up of 315 days (range, 0-740 days). Pre-intervention, the baseline median low-density lipoprotein (LDL) was 86 mg/dL (range, 39-197 mg/dL) and 96 patients (71.1%) had an LDL >70 mg/dL. Fifty-two patients (37%) were current smokers, 41 (71%) smoked heavily (more than one pack per day). Fifty-five percent of patients had documentation that this intervention was administered at the initial vascular surgery encounter after this program was started. The mean lag time to the first vascular surgery encounter with intervention documentation was 117 days (median, 0 days; range 0-721 days). At the latest follow-up, 92 (72%) of the encounters by a vascular surgeon documented that the intervention was administered, final median LDL was 79 mg/dL (range, 31-198 mg/dL), 80 patients (62%) had an LDL >70 mg/dL, and 60 patients (47.2%) had a decrease in their LDL. Patients that had no observed decrease in their LDL had a significantly lower mean level at baseline (82.3; standard deviation, 28.7; range 39-197 mg/dL) compared with those with an observed decrease in LDL (mean, 98.8; standard deviation, 32.8; range, 42-187 mg/dL; P = .003). At the latest follow-up, 41 patients (31.5%) were currently smoking, 21 (43.7%) of whom smoked heavily (more than one pack per day).

Conclusions: Vascular surgeons can improve the cardiovascular health of their patients by implementing a program of intensive lipid control and smoking cessation in patients with clinical ASCVD. Further studies are needed to determine the impact on cardiovascular event rates.

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PS128.

Defining and Reporting Academic Activity: The Academic RVU Can Justify the Mission

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Objectives: The academic mission is under strain. Although clinical activity is easily quantified by the Relative Value Units (RVU), there are multiple ad hoc measures of academic activity. This study reports the use of academic RVU (aRVU) derived for all nonclinical activities to justify nonclinical protected time of individual faculty, prioritize divisional activities, and drive the academic.

Methods: All nonclinical activity for divisional faculty was correlated and subjected to a defined scoring system. The system was set up in five modules (publications, presentation, clinical trial, grants educational, administration and community). Each module was