were 97% and 93%. We performed 4 (7%) CP. No significant differences between pre and peri-operative renal function were detected. Mean follow-up was 27 months (range: 6-56). Two (3%) ELIa were observed at 1 month. A significant mean AAA shrinkage of 9±7.2mm was observed (P<.001). Freedom from re-intervention and overall survival at 12, 24 and 36 months were 96%, 93%, 93% and 95%, 95% and 89% respectively. No late ELIa were observed. Intra-operative CP was associated with α-neck angle ≥ 60° (P = .046). Post-operative ELIa was associated with coexisting α-neck angle ≥ 60° and neck calcification/thrombosis (P = .033).

Conclusions: EVAR in AAA with SN using standard suprarenal endograft is feasible and effective with high TS and CS. AAA with SN and α-neck angle ≥ 60° is associated with an increased rate of CP while coexisting α-neck angle ≥ 60° and neck calcification/thrombosis is a risk factor for ELIa.

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PS22.
Endovascular Salvage for Complications of Open Aortic Surgery
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Objectives: Open surgical re-interventions for aortic disease can be technically difficult and associated with increased morbidity and mortality. We report our experience with endovascular interventions as alternative treatments for complications following open aortic surgery.

Methods: A retrospective database was used to identify patients who underwent endovascular interventions to treat complications of open aortic surgery. Records were reviewed for demographics, presentations, details of interventions, and operative outcomes.

Results: Between 2005 and 2011, 20 patients underwent endovascular interventions to treat complications of open aortic surgery. Patients had a male predominance (17) and a mean age of 69.1±1.4 (41-85) years. Initial surgeries included open AAA repair (7), open arch surgery (3), aorto-bifemoral bypass (7), aorto-visceral bypass (2) and primary repair of aorto-duodenal fistula (1). Indications for re-interventions included anastomotic pseudoaneurysm (PAS) (12): proximal-8, distal-4; graft occlusion (5) and aorto-enteric fistula (3). Mean time to re-interventions was 85.3±10.8 (0.6-372) months and consisted of EVAR (12) with splenic (1) or renal (1) embolization, TEVAR (3), or iliac stents (5). Over half of re-interventions were urgent or emergent (11). Technical success was 100%. EBL was 399.0±372.9. There was 1 peri-operative death from hemorrhagic gallstone pancreatitis however, PSA was excluded. There was 1 morbidity of a peri-operative stroke after TEVAR for an ascending aortic PSA (5%). Mean hospital and ICU stays were 6.0±3.7 and 1.1±1.8 days, respectively. Follow-up was 17.1±23.1 (1-72) months. There were no endoleaks, recurrent PSAs, or recurrent stenoses. One patient treated for aortoenteric fistula developed recurrent graft infection requiring excision.

Conclusions: Endovascular interventions for complications following open thoracic or abdominal aortic surgery can be performed with low morbidity and mortality in this high-risk patient cohort.

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PS24.
Evaluation of Aortic Arch Motion In Physician Modified Endografts during TEVAR
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Objectives: Interactions between components of fenestrated thoracic main stent grafts (MSG) and branch stent grafts (BSG) have not yet been evaluated. This study evaluates the cardiac and respiratory effects on interactions between components in the aortic arch.

Methods: Between 2006 and 2011 255 patients underwent TEVAR from 2 institutions. 107 (42%) required coverage of the left subclavian artery. 60 (56%) had coverage, 29 (27%) carotid subclavian bypass, and 18 (17%) had a physician modified endograft for left subclavian artery revascularization. Frames representing the extreme positions of the BSG due to cardiac imposed motion during apnea and through the respiratory cycle were identified. Images were overlaid as layers, using external reference markers common to each image for accurate overlay positioning. BSG’s were traced and magnitudes of horizontal motion compared to CM for the BSG [4.5 ± 0.07 mm (P = .002)]. RM resulted in significant difference in bulk horizontal motion compared to CM for the BSG [4.5 ± 0.07 mm (P = .002)]. RM resulted in significant difference in bulk vertical MSG/BSG system [3.8 ± 0.07 mm (P = .00001)].