

**Methods:** A prospective anonymous online survey was administered to members of the Society for Clinical Vascular Surgery (SCVS) and the Vascular Surgical Society of Great Britain and Ireland (VSS). Each member evaluated general and procedural specific complications for both arterial and venous interventions. Greater than 75% reporting for a specific complication was deemed the threshold for consensus opinion.

**Results:** Overall response rate was 24.8%. The majority of respondents were attending surgeons (81.5% SCVS vs. 85.2% VSS). Both societies considered senior trainees competent to obtain consent. The majority of patients were consented primarily by the attending (67.6% SCVS vs. 90.6% VSS,  $p < 0.01$ ) on a pre-printed consent form (95.1% SCVS vs. 98.7% VSS). Consent was obtained on the day of surgery in the office (35.4%-SCVS) or the day before surgery in the hospital ward (35.1%-VSS) with the provision of additional written documentation (59.2% SCVS vs. 85.4% VSS,  $p < 0.01$ ). Both societies concurred with documentation of general complications including bleeding, cardiac, cerebrovascular, respiratory, thromboembolic and wound infection as well as more specific complications pertaining to aortic aneurysm, carotid endarterectomy, lower limb bypass, amputation and venous surgeries. Although the VSS reported a significantly higher consent training rate (14.1% SCVS vs. 40.8% VSS,  $p < 0.01$ ), both societies stated this mainly involved ad-hoc informal training.

**Conclusion:** Whilst completion logistics of vascular consent vary, both SCVS and VSS members concur on the majority of complications necessary for inclusion in informed vascular consent.

### Ultrasonic Accelerated Thrombolysis of IVC Thrombosis

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**Background:** Inferior vena cava thrombosis (IVCT) remains rare with an incidence of 0.4%. We describe our initial experience with ultrasonic accelerated thrombolysis (UAT) of IVCT.

**Methods:** All patients diagnosed with symptomatic IVCT who were treated with UAT from January 2012 to August 2013 were included. Patient data regarding clinical presentation, thromboembolic risk factors, pertinent imaging, treatment pathway and clinical outcome were recorded.

**Results:** Seven patients (5 males, 2 females, mean age 58.1 years) presented with lower extremity DVT. Four patients had a history of neoplastic disease and two were current smokers. Four patients had a history of previous DVT and 6 patients a history of pulmonary emboli. All seven patients

were previously anticoagulated and had IVC filters in-situ. Pro-thrombotic haematological analyses were negative for all patients. Ultrasound duplex imaging identified proximal lower extremity thrombus in four patients (57%) while cross-sectional imaging confirmed thrombus extending from the iliac veins into the IVC in all seven patients. All patients were initially treated with limb elevation, compression hosiery and systemic heparinisation. Significantly symptomatic patients proceeded to venography and evaluation of clot burden. The thrombus was crossed and bilateral UAT catheters were placed extending into the suprarenal IVC. Combined infusions were commenced of 0.5mg tissue plasminogen activator and 35mls of normal saline coolant via the UAT catheters and 500IU of heparin via the 7-Fr sheath per hour to each limb separately. After twenty-four hours, repeat venography was satisfactory in one patient. The remaining six patients required mechanical thrombectomy and balloon angioplasty if necessary, which resulted in satisfactory flow in five patients. The remaining patient required an additional twenty-four hour UAT infusion followed by further mechanical thrombectomy before satisfactory flow was obtained. All patients are currently well and remain anticoagulated (warfarin = 6, rivaroxaban = 1) with improvement in lower extremity symptomatology and no recurrence of IVCT (mean follow-up 7.6, range 1–20 months).

**Conclusions:** This is the first reported series of UAT for IVCT. These early results suggest this modality may be helpful in treating patients with large IVC thrombus burden and significant clinical symptoms with successful clot dissolution and satisfactory venous flow without significant patient distress or complications.

### Expanding Type 2 Endoleak Interventions: A 12 Year Review

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**Introduction, Aims and Methods:** At present there does not appear to be an agreed best practice for management of expanding type 2 endoleaks following EVAR. Endovascular coiling seems to be the most prominent in recent years. With new methods becoming available we aim to review the outcomes for current practice.

A retrospective case note review of 18 patients was undertaken. PACS, electronic care records & GP notes were used to assess progression in sac dimension & clinical health.

**Results:** 88% (16/18) underwent embolization as a definitive procedure. 3 patients died following rupture of AAA whilst a further 9 died from medical co-morbidities. Mean time to death in ruptures in these patients was 22 months vs 49 months in non-ruptured. Sac size on latest scan was larger in ruptured group (114mm vs 77mm). There was also on average less interventions on ruptured group (1 vs 1.7).

Mean survival of the remaining 6 patients is 72 months (43–105) with an average sac size of 60mm.