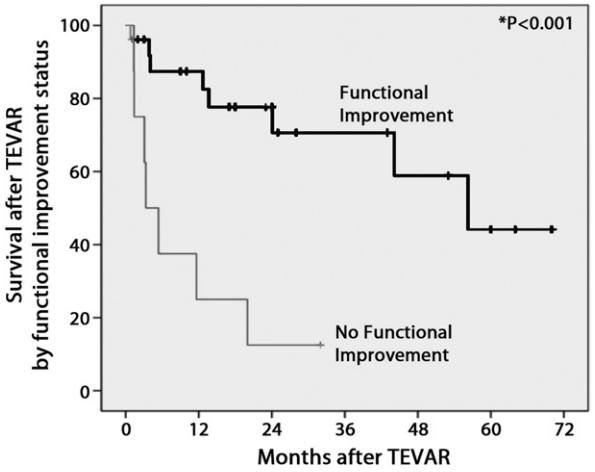

Fig.

mortality was noted when comparing patients with prophylactic vs. post-op drains.

Conclusions: SCI can be a devastating complication after TEVAR and patients without functional improvement have a dismal prognosis. Measures to decrease the rate of SCI and/or mitigate its severity are needed. Timing of drain placement does not appear to have an impact on functional recovery.

Author Disclosures: A. W. Beck: Nothing to disclose; **K. DeSart**: Nothing to disclose; **R. J. Feezor**: Nothing to disclose; **M. Hong**: Nothing to disclose; **T. S. Huber**: Nothing to disclose; **S. T. Scali**: Nothing to disclose.

RR25.

Outcomes following Late Explantation of Aortic Endografts Depend on the Indication

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Objectives: This study compares our experience with explantation of aortic endografts for endoleak versus infection.

Methods: The medical records of 1500 aortic procedures performed at our center were queried from 2002-2011. Relevant data from patients needing explantation of aortic endografts was analyzed.

Results: 36 patients underwent aortic explantation (63.9% male). Mean age was 71.6 years with a mean aneurysm size of 6.6cm (range 3.5 - 10.7cm). Hypertension (97%), hyperlipidemia (77.8%) and smoking (83%) were the most prevalent risk factors. Mean time to explant was 45.3 months (range 2.2- 118.4 months). The primary explant indication was endoleak in 24 (66.7%) and infection in 12 (33.3%) patients. Thirty-day morbidity was 54%(endoleak) and 83%(infection). There were 2 deaths(16.7%) in the infection group within 30 days. Five patients were symptomatic, while 2 patients had ruptured aneurysms. In the endoleak group, there were 9 type Ia, 7 type II, 1 type III, 3 type V, 1 rupture and 3 patients with multiple endoleaks. 78% of patients were alive at a mean follow-up of 17. 4 months.

Conclusions: This is the largest endograft explantation series to date. Patients with an infectious etiology have significantly worse morbidity and mortality than patients requiring explantation for endoleaks.

Table. Peri-operative variables by indication for explant

Peri-operative variable	*Endoleak (n = 24)*	*Infection (n = 12)*
Males (%)	50.0	91.7[a]
ASA class > 3 at explant (%)	50.0	66.7[a]
Supra-mesenteric clamping (%)	4.4	50.0[a]
Re-exploration needed (%)	4.2	41.7[a]
Post-op DIC (%)	0	25.0[a]
30-day mortality (%)	0	16.7
Intra-op blood loss (Liters)	3.3	6.3[a]
Mean PRBCs transfused intra-op (n)	4.3	12.2[a]
ICU length of stay (days)	5.4	10.4
Length of stay (days)	12.2	18.7

ASA, American Society of Anesthesiologists; DIC, disseminated intravascular coagulation; ICU, intensive care unit
[a]P<0.05

Author Disclosures: S. Arya: Nothing to disclose; **D. M. Coleman**: Nothing to disclose; **E. Criado**: Nothing to disclose; **J. L. Eliason**: Nothing to disclose; **K. Gallagher**: Nothing to disclose; **P. K. Henke**: Nothing to disclose; **J. Knepper**: Nothing to disclose; **J. E. Rectenwald**: Nothing to disclose; **G. R. Upchurch**: Nothing to disclose.

RR26.

Primary Balloon Angioplasty of Small (≤2 mm) Cephalic Veins Shortens Maturation Time, Decreases Reinterventions and Improves Mid-term Patency of Arteriovenous Fistulae

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Objectives: To evaluate the novel technique of Primary Balloon Angioplasty (PBA) of cephalic veins with diameter ≤2mm on patency of radio-cephalic arteriovenous fistulae (AVF) before performing the anastomosis.

Methods: Forty patients, all candidates for distal radiocephalic fistula, with a cephalic vein ≤2 mm, were randomized to undergo dilatation of the cephalic veins with two different techniques, before performing the anastomosis: A) PBA of a long cephalic vein segment from the wrist up to the elbow (n=19); B) hydrostatic dilatation (HD) of a short venous segment (5cm) at the level of the anastomosis (n=21). PBA was performed using a Pacific Extreme