(PTA) or thromboendarterectomy (TEA) and 1 bypass infection) versus 15 patients (32%) with bypass related complications in the IAOD group (4 bypass infections, 2 wound infections, 8 stenoses or occlusions requiring PTA/TEA (n=7) or removal (n=1) and 1 ischemic leg) (P < .05).

Conclusions: Femorofemoral bypasses have comparable patency rates for aneurysmal and occlusive disease. However, bypass related complications are more often seen in IAOD patients.

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PS114.

The Retrogeniculate Popliteal Artery Is Valid Territory For Stenting

Objectives: The retrogeniculate popliteal artery (RGP) is conventionally regarded as unsuitable for stenting due to a perceived risk of accelerated restenosis and fracture. This study sought to evaluate the efficacy of angioplasty (PTA) alone compared to PTA and stenting in management of atherosclerotic disease of the RGP.

Methods: Patients who underwent RGP angioplasty with or without stenting were drawn from a prospectively-maintained database of patients undergoing lower extremity intervention. Disease characteristics were obtained from angiogram and chart review. Primary and secondary patencies as well as limb salvage were calculated using Kaplan-Meier analysis.

Results: From 2004-2011, 74 isolated RGP lesions were identified that were primarily treated with PTA. Mean follow-up was 15.8±15 months. TASC B, C, and D classification was 51, 33, and 16% respectively. Procedural success (<30% residual stenosis) was 57% with angioplasty alone. Overall, 47 lesions were treated with PTA alone and 27 required adjunctive stenting. No significant differences were found between PTA and PTA+S at any time point for primary, primary assisted, or secondary patencies or for rates of limb salvage.

Conclusions: The retrogeniculate popliteal artery has historically been considered a poor location for stent placement in the treatment of atherosclerotic occlusive disease because of a perceived high risk of complication and accelerated restenosis. We show, however, that stent placement in this location confers no decrease in patency or limb salvage compared to angioplasty alone.

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PS116.

Major Limb Amputation Is Higher in Regions with Limited Access to Cardiovascular Specialists
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Objectives: To analyze the rate of major limb amputations in North Carolina in relation to physician density and comorbidities including diabetes (DM), end stage renal disease (ESRD), peripheral vascular disease (PVD), and lower extremity ulcers.

Methods: Using the NC Hospital Inpatient Discharge Database, the rate of hospital discharges with DM, ESRD, PVD, lower extremity ulcer, or major amputation from 2006-2009 was calculated. The NC Health Professions Data System was used to define cardiovascular specialist (CVS; surgeons, cardiologists, nephrologists, radiologists)
by county from 2006-2009. Counties were designated as urban or nonurban as defined by the US Office of Management and Budget.

Results: From 2006-2009, the rate of patients hospitalized with comorbidities increased but major amputation decreased (Table). Total major amputations decreased from 2476 to 2160 per year. Amputation rates decreased in both urban and nonurban counties. However, no CVS worked in 43% of nonurban counties in 2006-2009. Counties achieving fewer amputations had a higher frequency of CVS (67%) than counties experiencing an increased number of amputations (36%).

Conclusions: Despite a more acute patient population in NC, major limb amputations have decreased. However, there are underserved areas in the state that have not seen this decline. This data suggests that access to CVS is related to limb preservation.

Table. Rate of hospitalization based on condition (per 1000 discharges)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Rate in 2006</th>
<th>Rate in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>186</td>
<td>192</td>
</tr>
<tr>
<td>ESRD</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>PVD</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Lower extremity ulcer</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Major amputation</td>
<td>2.45</td>
<td>2.10</td>
</tr>
</tbody>
</table>

PS118.

Extent of COPD Is Associated with Short and Long-term Adverse Outcomes in Patients Undergoing Elective AAA Repair

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Objectives: Although COPD is implicated as a risk factor for AAA rupture, its impact on surgical repair remains undefined. Consequently, variation in practice persists. The purpose of this study was to analyze the impact of clinically significant COPD on patients undergoing AAA repair.

Methods: We reviewed a regional registry of 3156 patients undergoing elective AAA repair in New England from 2003-2011. COPD was defined as mild (diagnosis only) vs. severe (medication/oxygen). Endpoints included major post-operative adverse events (MAEs), extubation in the operating room (eOR), and long-term survival. Predictors of endpoints were determined by multivariate logistic regression and Cox-Proportional Hazards.

Results: Over the study interval, 1752 patients underwent EVAR while 1404 patients underwent open AAA (oAAA) with nearly equal prevalence of COPD (35% EVAR, 36% oAAA). COPD was associated with increased MAE (Fig). While COPD did not impact eOR (96.3% vs. 97.9%, P = .2) in the EVAR group, it was associated with lower eOR (56.6% vs. 73.6%, P < .001) in the oAAA cohort. Five-year survival was reduced among all patients undergoing AAA repair with COPD (none-79%, mild-75%, severe-65%; P < .001). By multivariate analysis, severe COPD was independently associated with in-hospital death (O.R. 2.01 C.I. 1.0-4.0 P = .04) and diminished 5-year survival (H.R. 1.5 C.I. 1.2-1.8 P < .001).

Conclusions: COPD is associated with higher MAE and diminished long-term survival among patients undergoing elective AAA repair. Accordingly, careful evaluation of COPD severity should be done before recommending elective AAA repair.


PS120.

Regional Primary Care Utilization Impacts Readmissions after Complex Vascular Surgery

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Fig.