PP7.
Pharmacological Management During Carotid Endarterectomy
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Introduction: The peri-operative use of antiplatelet, anticoagulant and other drugs for patients undergoing carotid endarterectomy (CEA) is unclear and consensus is lacking. This study aimed to assess the current practice of European vascular surgeons with respect to antiplatelet and other medications.

Methods: An online survey was conducted of members of the vascular Society of Great Britain & Ireland and European Society for Vascular Surgery in 2008. Surgeons were asked about their preferences for the peri-operative administration of various medications for patients undergoing carotid endarterectomy.

Results: Responses were received from 399 surgeons with a collective annual throughput of >11500 CEA procedures. For symptomatic and asymptomatic patients, 54/399 (14%) and 94/399 (24%) of surgeons would stop aspirin before surgery and 205/399 (52%) and 263/399 (66%) of surgeons would stop clopidogrel. Of surgeons who would stop clopidogrel, 84/205 (40%) and 121/205 (60%) would do so >7 days before surgery for symptomatic and asymptomatic patients respectively. 12/399 (3%) of surgeons would routinely use intraoperative platelets.

Conclusions: There are wide variations between vascular surgeons in the pharmacological management of patients undergoing carotid endarterectomy. Further clinical studies may help clarify the optimum management strategy in this patient group.

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PP9.
Endovascular Management of Chronic Mesenteric Ischemia

Objectives: Chronic Mesenteric Ischemia often presents in patients who are malnourished and nutritionally compromised, often exacerbated by a delay in diagnosis. This condition may predispose these patients to increased surgical risks in open surgery. We present our results of Endovascular management with percutaneous techniques in a large series of patients.

Methods: A retrospective review of all patients diagnosed with chronic mesenteric ischemia was performed. All procedures were performed in a single group practice setting. Diagnoses was made by physical examination, patient history and ultrasound examination. Patients were treated between October 2003 through November 2008. Patients with acute mesenteric ischemia were excluded. Follow up was performed both in office and with ultrasound. Analysis consisted of patient demographics, failure of treatment, need for re-intervention as well as morbidity and mortality.

Results: Between October 2003 and November 2008 138 mesenteric arteriograms were performed for patients in whom chronic mesenteric ischemia was suspected. Twenty one patients had normal arteriograms, 112 patients and 128 vessels were treated with either angioplasty alone or with stenting. Patient age ranged from 31 to 90 years old. Average age was 70. Seventy-five percent of the patients were women. No deaths occurred within the first 30 days. Six patients died within the first year, 2 from acute mesenteric ischemia, 3 from unrelated causes and 1 from unknown cause. Seventeen patients were lost to followup. Eight patients after initial endovascular treatment were eventually converted to an open procedure. None of the patients required bowel resection.

Conclusions: Patients with chronic mesenteric ischemia can be managed effectively with endovascular techniques. Many patients do require reintervention to maintain patency, however this can be accomplished with minimal morbidity. Follow-up consisting of regular office visits and surveillance ultrasound is an important adjunct in the management of these complex patients.

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PP10.
Preoperative Clinical Determinants of Response to Renal Artery Stenting: Who Will Benefit?
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Objective: Renal artery stenting (RAS) is the most common method of treatment for symptomatic renal artery stenosis despite few evidence-based guidelines to aid in patient selection. The goal of this study was to identify predictors of blood pressure (BP) and renal function response that will aid in patient selection for RAS.

Methods: The clinical outcomes of 149 patients who underwent primary RAS between 2000 and 2008 were examined. A modification of AHA guidelines defined individual patient responses to RAS: 1) BP responder = BP < 160/90 on a reduced number of anti-hypertensive medications (MEDS) or reduction in diastolic BP < 90 mm Hg on the same MEDS; 2) Renal function responders = ≥ 20% increase in eGFR. Median follow-up was 19 months.

Results: As a group, the cohort had a significant decrease in systolic and diastolic BP with RAS (baseline vs. follow-up systolic BP: 155.6 ± 2.5 vs. 139.7 ± 2.3 mm Hg, P < 0.0001; baseline vs. follow-up diastolic BP: 79.1 ± 1.5 mm Hg vs. 72.3 ± 1.1 mm Hg, P < 0.0001) with no change in MEDS (median number of MEDS at baseline vs. follow-up: 3 vs. 3; P = 0.95). The cohort had no change in renal function with RAS (median creatinine [CR] at baseline vs. follow-up: 1.4 vs. 1.3 mg/dL, P = 0.50). Using rigorous criteria to determine individual responses to RAS, only 48 of 149 (32.2%) patients were BP responders and 22 of 149 (14.8%) patients were renal function responders. Logistic regression analysis identified the number of baseline MEDS (Odds Ratio [OR] 4.0, 95% CI 2.4-6.7, P < 0.0001) and diastolic BP<90 mm Hg (OR 13.3, 95% CI 4.0-44.0; P < 0.0001) as independent predictors of a positive BP response. The BP response stratified by number of MEDS, is provided (Table) to assist with patient selection for RAS. Preoperative CR ≥ 1.5 mg/dL was the only independent predictor of renal function response (OR 5.3, 95% CI 1.7-16.6; P = 0.04), although only 23.0% of patients with a CR ≥ 1.5 mg/dL were renal function responders.