the number of varicosities before and after the tourniquet Trendelenburg test was recorded. All patients underwent EVA of the GSV under local anaesthetic without stab avulsions. At 6-weeks post-EVA, the number of residual varicosities were recorded and compared to the pre-operative findings.

**Results:** The mean number of varicosities observed pre-EVA was 5.7 (range 1–11) before and 1.5 (SD 1.4) after the Trendelenburg Test, versus 1.4 (SD 1.2) post-EVA. Mean difference between the pre-EVA and post-EVA groups was -0.2 (95% CI -0.7 - 0.4); p=0.55 (paired T-test). The Trendelenburg test showed a positive correlation in predicting the number of varicosities post-EVA (pearson coefficient: 0.64; p=0.001).

**Conclusions:** The tourniquet test is a valuable bedside tool in determining the outcome post-EVA and the need for stab avulsions.

**0753: RUPTURED ABDOMINAL AORTIC ANEURYSMS: DECREASING INCIDENCE MAY AFFECT THE IMPACT OF SCREENING**

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**Background:** Ruptured Abdominal Aortic Aneurysm (AAA) is a significant cause of death and recent evidence has shown that screening is beneficial in reducing mortality.

**Aim:** The aim of this study was to evaluate the number of ruptured AAs, and the associated mortality, that presented to a tertiary vascular surgery unit each year.

**Methods:** A retrospective review of operative records from 1987–2009 was conducted.

**Results:** 888 Patients (Male 728, Female 158) were identified. The number of ruptures remained constant from 1987-2001, with a mean of 43.4 ruptures a year (95% CI 40.1-46.7). This decreased to a mean of 29.63 per annum (95% CI 24.3-34.6) in 2002-2009. The average mortality was 39.8% and showed no significant decrease; a mean of 41.1% (95% CI 38-44.2) in 1995-2001 and 38.6% (95% CI 33.4-43.8) during the period 2002-2009.

**Conclusion:** This data series showed patients that reach hospital have a significant mortality which has not decreased during the study period. This study further suggests that the incidence of ruptured AAs is decreasing. These results suggest that AAA screening may not be as beneficial and cost effective as previous studies have shown.

**0808: ENDOVENOUS RADIOFREQUENCY ABLATION IN OCTOGENARIANS – SAFE, EFFECTIVE AND RECOMMENDED**

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**Aim:** Varicose vein surgery aims to reduce venous ulcer recurrence and encourages healing to those resistant to compression therapy. However, it is often avoided in elderly populations due to multiple co-morbidities. This often results in chronic ulceration and impaired quality of life.

We report our experience of varicose vein radiofrequency ablation (RFA) under local anaesthesia (LA) in an octogenarian population.

**Method:** All patients aged >80 undergoing endovenous RFA between 2009 and 2011 were identified from a prospective database. Patient demographics, co-morbidities, indications for surgery, mode of anaesthesia, complications and outcomes at follow-up were documented.

**Results:** 35 patients (Median age 84.5, M:F=1:1.33) had endovenous RFA, with an ASA grade 2 (57%, n=20) and 3 (43%, n=15). 12 patients had active ulcers and 7 had ulcers previously. The majority of operations (69%, n=24) were performed under LA (1 Spinal,10 GA). There was no operative mortality or morbidity. All 12 ulcers were healed by the end of the follow-up period (Median 51 days. Range–8-220). Only 5 patients had oedema and 1 had residual varicosities post-treatment. No ulcer recurrence was identified.

**Conclusions:** Endovenous RFA under local anaesthesia is safe, effective and recommended in patients aged over 80 in units with suitable endovenous expertise.

**0814: PEAK OXYGEN CONSUMPTION IS AN INDEPENDENT PREDICTOR OF MORTALITY FOLLOWING ABDOMINAL AORTIC ANEURYSM SURGERY**

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**Aims:** We examined whether peak oxygen consumption (VO2peak) was an independent predictor of long-term outcome after abdominal aortic aneurysm (AAA) repair.

**Methods:** Between 02/2007 and 09/2009, 115 patients (mean age 74.8±years) underwent static echocardiography and cardiopulmonary exercise testing before AAA surgery. Lee scores were calculated for each patient. Mortality data were determined from our database; median follow-up was 932days. Using Cox-regression analysis the associations between VO2peak, anaerobic threshold (AT) and all-cause mortality were examined.

**Results:** 59 open and 56 endovascular AAA repairs were performed. 30-day mortality was 3.5% and 12-month mortality was 11.3%. 25 patients had died by 05/2011 giving a long-term series mortality of 21.7%.

The unadjusted hazard ratio (HR) for all-cause mortality was 0.89(95% confidence intervals(CI)=0.82-0.97) for every ml/kg/min reduction of VO2peak(p=0.008). This remained significant when adjusted for age, sex, Lee score and performance on static echocardiogram (HR 0.90(CI=0.82-0.99),p=0.033).

The association between AT and mortality was not statistically significant(HR 0.91(CI=0.80-1.04), p=0.187). The association between left ventricular function and mortality was not statistically significant (HR 2.1(CI=0.91-4.71),p= 0.080).

**Conclusion:** VO2peak is an independent predictor of all-cause mortality following AAA repair. A dynamic exercise test to volitional exhaustion adds value in risk stratification prior to AAA surgery.

**0828: PREVALENCE OF AAA IN NORTH CENTRAL LONDON – FIRST YEAR RESULTS**

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**Aim:** The National Health Service Abdominal Aorta Aneurysm Screening Programme (NAAAASP) was announced in January 2008. North Central London was approved in the first phase of AAA screening implementation and commenced screening in September 2010.

**Method:** Men aged 65 years resident in North Central London were invited for screening. Data collected from 01 December 2010 for 12 months are reported.

**Results:** 11785 men were invited, this included first and numerous recall invitations; 4496 (38%) attended while 1620 (13%) declined to be screened and 5082 (43%) did not attend. Forty (0.9%) aneurysms were detected: with one man requiring surgery; this was performed endovascularly and is alive 4 months postoperatively.

**Conclusion:** In North Central London the prevalence of screened AAA (0.9%) is far lower than the rate in the MASS trial (4.9%). Possible reasons for this are the younger age screened as compared to those recruited to the MASS trial. The high DNA rates may hide the true prevalence of aneurysms. It is noted, however that nationally the prevalence of AAA remains low. Further work is needed to improve attendance rates for aneurysm screening in London and this may well provide a more accurate AAA prevalence rate.

**0849: ENDOVENOUS LASER ABLATION FOR SMALL SAPHENOUS VARICOSE VEINS: EVALUATION OF OUTCOMES OVER TWO YEAR FOLLOW-UP**

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**Aim:** To evaluate the safety and efficacy of endovenous laser ablation (EVLAb) as an alternative to conventional surgery for small saphenous vein(SSV) incompetence.

**Methods:** Patients with symptomatic, unilateral, primary saphenopopliteal junction(SPJ) incompetence with SSV reflux receiving EVLA(810 nm diode laser) treatment were included. Patients were assessed at baseline and at 1,6,12,52 & 104 weeks. Outcome measures included: Venous Clinical Severity Score(VCSS); Quality of life(generic-SF36, EQ5D and disease specific-AVQV) measures; complications and recurrence rates.

**Results:** 62 patients(37 women), mean age 46.3±(s.d. 13.3) years were assessed. Initial technical success was 100% in all limbs. SPJ incompetence was abolished in 83% & 85%; and treated SSV occluded in 83 % & 84% at 1 and 2 years respectively. Clinical recurrence over same period was 11% with 6(4.6%) developing recanalisation [median(i.q.r.) laser density 94(90-103)]cm]. Venous severity (CEAP and VCSS), AVQV, SF36, EQ5D