

sive calcification were observed more frequently in asymptomatic patients (43 vs 22%; $P = .014$). IPH is significantly higher in symptomatic plaque regardless of the time since the neurologic event. For FCR difference between symptomatic and asymptomatic are significant only during the first 15 days following the neurological event.

Conclusions: Carotid MRI can identify plaque features that are associated with symptomatic presentation and may be indicative of plaque vulnerability. These features may ultimately be utilized in the management of extracranial carotid stenosis.

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RR23.

A Stroke/Vascular Neurology Service Increases the Volume of Urgent CEAs Performed in a Tertiary Referral Center

Hernan A. Bazan, Gentry Caton, Sharzad Talebinejad, Ross Hoffman, Taylor Smith, Elizabeth Holt, Gabriel Vidal, Kenneth Gaines, W. Charles Sternbergh III. Ochsner Clinic, New Orleans, LA

Objectives: Patients presenting with carotid-related acute neurological symptoms are at heightened risk of stroke. Urgent CEA (uCEA) during the index hospitalization is indicated in select patients. We aimed to determine the effect of a dedicated vascular neurology team on the volume of uCEAs and assess outcomes.

Methods: CEAs ($n=436$) performed at a tertiary center between 2005-2011 were analyzed. Chi-square was used to compare the uCEA volume pre- (June 2005-Aug. 2008) and post- (Sept. 2008-Nov. 2011) implementation of a vascular neurology service. Fisher's exact and t-tests were used to analyze perioperative outcomes.

Results: The proportion of uCEAs performed increased significantly after initiation of a vascular neurology

service (4.1% [7/172] vs. 22.2% [49/221], $P < .0001$). Per annum, uCEAs increased from 5.3% (4/75) in 2005 to 39.6% (25/63) in 2011 (Fig). uCEA indications were stroke-in-evolution 10% (5/49), crescendo TIAs 6% (3/49), acute stroke 45% (22/49), and cerebral/ocular TIAs 39% (19/49). Mean National Institutes of Health Stroke Scale (NIHSS) was 3.5 (0-24); mean TIA score was 5 (1-8). A trend towards a higher combined stroke/death rate in the urgent compared to the elective symptomatic CEA group was present (7.1% [3/49] vs. 2% [1/49]; $p = .36$); however, patients undergoing uCEA with an NIHSS < 10 had no perioperative complications.

Conclusions: Collaboration with a vascular neurology team increased the volume of uCEAs over a three year period. In patients with mild strokes (NIHSS < 10), uCEA outcomes approximate those for electively-performed CEAs.

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RR24.

Fate of Patients with Spinal Cord Ischemia (SCI) Complicating Thoracic Endovascular Aortic Repair (TEVAR)

Kenneth DeSart, Salvatore T. Scali, Michael Hong, Robert J. Feezor, Thomas S. Huber, Adam W. Beck. University of Florida, Gainesville, FL

Objectives: SCI is a devastating complication of TEVAR with varying degrees of disability. Here we review the outcomes of patients with SCI after TEVAR.

Methods: Patients with SCI after TEVAR, defined by any lower extremity neuro deficit over baseline, were evaluated. A database query and chart review/phone interviews with patients/family were used to determine outcomes and functional status after discharge. Patients were analyzed based on functional recovery and timing of their CSF drain placement (prophylactic or post-op for symptoms).

Results: 609 TEVARs were performed in the study period, and 57 patients developed SCI (9.4%). In-hospital mortality with SCI was 7.0%. 54 patients (95%) had a CSF drain placed with the majority placed post-op (54%). Complete data were available for 34 patients (60%) of whom 27 (47%) were alive at follow-up [median 11.8 mos]. Of these 34 patients, 26 (76%) had functional improvement, with 12 (35%) reporting return to baseline. Survival was worse in patients with no functional improvement (NI) when compared to patients with improvement (WI). Median survival for WI patients was 56 mos compared to 3 mos ($P < .001$) in NI patients. No difference in functional improvement or

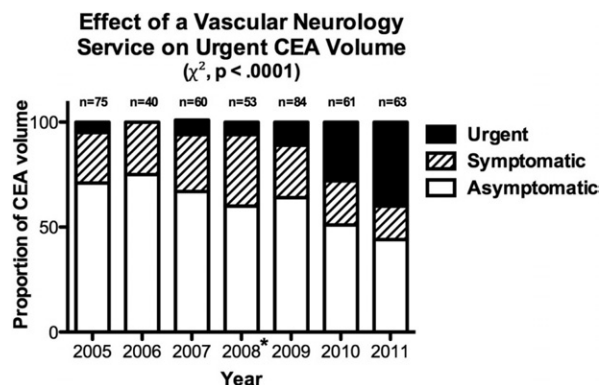


Fig. *September 2008: Vascular neurology service implementation