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Peripheral Vascular Surgery Society
Officers
2012 - 2013

President
Ruth L. Bush, MD, MPH
Texas A & M Health Science Center
Round Rock Campus, Suite N404H
3950 No. A. W. Grimes Boulevard
Round Rock, TX 78665
T: 512-341-4929
E: rbush@medicine.tamhsc.edu

President-Elect
W. Darrin Clouse, MD
University of California, Davis
Vascular & Endovascular Surgery
4860 Y Street
ACC Building, Suite 3400
Sacramento, CA 95817-2026
T: 916-734-2022
E: wdclouse@ucdavis.edu

Secretary
Sean P. Roddy, MD
The Vascular Group, PLLC
43 New Scotland Avenue, MC-157
Albany, NY 12208
T: 518-262-8720
E: roddys@albanyvascular.com

Treasurer
Vikram S. Kashyap, MD
University Hospitals - Case Medical Center
Vascular & Endovascular Surgery
11100 Euclid Avenue, MS LKS 7060
Cleveland, OH 44106
T: 216-844-1631
E: Vikram.Kashyap@UHhospitals.org

Recorder
Thomas Maldonado, MD
New York University
530 First Avenue, Suite 6F
New York, NY 10016
T: 212-263-7311
E: thomas.maldonado@nyumc.org

Councilor-At-Large
Peter R. Nelson, MD, MS
University of Florida College of Medicine
PO Box 100128
Gainesville, FL 32610
T: 352-273-5484
E: peter.nelson@surgery.ufl.edu

Councilor-At-Large
Jonathan L. Eliason, MD
University of Michigan
Section of Vascular Surgery
1500 E. Medical Center Drive, SPC 5867
CVC 5463
Ann Arbor, MI 48109
T: 734-936-5786
E: jonaellia@med.umich.edu

Councilor-At-Large
James H. Black, III, MD
Johns Hopkins Hospital
Vascular & Endovascular Surgery
Harvey 611
600 North Wolfe Street
Baltimore, MD 21287
T: 410-955-1708
E: jhblack@jhmi.edu
12 - ‘13 Committees

Program Committee
Ravi Veeraswamy, MD, Chair
Jean Bismuth, MD
Mark Conrad, MD
Brian DeRubertis, MD
Katherine Gallagher, MD
Ravi Rajani, MD

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Rabih Chaer, MD
Benjamin Pearce, MD
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Carlos Bechara, MD
Kellie Brown, MD

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Rabih Chaer, MD
Brian DeRubertis, MD

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Eric Adams, MD
Kakra Hughes, MD

Military Liaison
Niten Singh, MD, Chair
Zachary Arthurs, MD

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Vikram Kashyap, MD
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Ankur Chandra, MD
Jonathan Elason, MD
Robert Feezor, MD
Peter Nelson, MD

Correspondence
Brian Nolan, MD, Chair
Rajeev Dayal, MD
James Reeves, MD
Accreditation

Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the Peripheral Vascular Surgery Society. The American College Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™
The American College of Surgeons designates this live activity for a maximum of 14.00 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learning Objectives
This activity is designed for peripheral vascular surgeons. Upon completion of this course, attendees should be able to: (1) Define criteria for re-intervention in lower extremity arterial disease; (2) Understand the optimal method of screening for carotid artery disease; (3) Know and prevent radial artery access complications and; (4) Establish simulation based training.

Disclosure Information
In compliance with ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.

Marketing Acknowledgement
The Peripheral Vascular Surgery Society wishes to recognize and thank the following companies for their ongoing support through marketing:

Abbott Vascular
Medtronic Vascular
## Past Meetings & Presidents

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>President</th>
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<tbody>
<tr>
<td>1976</td>
<td>Chicago, IL</td>
<td>Organizational Meeting</td>
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<tr>
<td>1977</td>
<td>Dallas, TX</td>
<td>Steven M. Dosick, MD</td>
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<td>1978</td>
<td>San Francisco, CA</td>
<td>Robert G. Scribner, MD</td>
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<td>1979</td>
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<td>William S. Gross, MD</td>
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<td>1980</td>
<td>Chicago, IL</td>
<td>Charles A. Andersen, MD</td>
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<td>1981</td>
<td>Dallas, TX</td>
<td>Larry H. Hollier, MD</td>
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<td>1982</td>
<td>Boston, MA</td>
<td>G. Edward Bone, MD</td>
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<td>1983</td>
<td>San Francisco, CA</td>
<td>Robert C. Batson, MD</td>
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<td>1984</td>
<td>Atlanta, GA</td>
<td>Lee C. Bloemendal, MD</td>
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<td>1985</td>
<td>Baltimore, MD</td>
<td>George J. Collins, Jr.</td>
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<td>1986</td>
<td>New Orleans, LA</td>
<td>Jonathan B. Towne, MD</td>
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<td>1987</td>
<td>Toronto, Canada</td>
<td>Thomas S. Riles, MD</td>
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<td>1988</td>
<td>Chicago, IL</td>
<td>Paul T. McDonald, MD</td>
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<td>1989</td>
<td>New York, NY</td>
<td>Anthony J. Comerota, MD</td>
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<td>1990</td>
<td>Los Angeles, CA</td>
<td>John W. Hallett, Jr., MD</td>
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<td>Paul M. Orecchia, MD</td>
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<td>David L. Rollins, MD</td>
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<td>Frank T. Padberg, Jr., MD</td>
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<td>Peter G. Kalman, MD</td>
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<td>Joseph L. Mills, MD</td>
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<td>Gary Giangola, MD</td>
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<td>Thomas F. Lindsay, MD</td>
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<td>R. Clement Darling, III, MD</td>
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<td>Jeffrey L. Ballard, MD</td>
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<td>Samuel R. Money, MD</td>
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<td>Lewis B. Schwartz, MD</td>
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<td>Robert A. Cambria, MD</td>
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<td>William D. Jordan, Jr., MD</td>
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<td>W. Charles Sternbergh, III, MD</td>
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<td>Denver, CO</td>
<td>Tina R. Desai, MD</td>
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<td>2010</td>
<td>Boston, MA</td>
<td>Karl A. Illig, MD</td>
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<td>2011</td>
<td>Chicago, IL</td>
<td>Marc A. Passman, MD</td>
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<td>2012</td>
<td>Baltimore, MD</td>
<td>Martin R. Back, MD</td>
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Schedule-At-A-Glance

Thursday, January 31, 2013

7:00 am - 9:00 am  Executive Committee Meeting
7:00 am - 5:00 pm  Registration
9:00 am - 12:30 pm  FELLOW LUMINARIES
10:30 am - 11:00 am  Coffee Break
12:45 pm - 1:30 pm  FEATURED SPEAKER LUNCHEON
           Norman M. Rich, MD, Col, MC, LISA (Ret)
           F. Edward Hebert School of Medicine, USUHS, Bethesda, MD
1:30 pm - 4:30 pm  SOCIETY FOR MILITARY VASCULAR SURGERY
               SCIENTIFIC PROGRAM
SVMS SCIENTIFIC SESSION I
           Opening Remarks: W. Darrin Clouse, MD
1:35 pm – 1:45 pm  M1
           Evaluating the Degree of Carotid Artery Stenosis Utilizing
           CT Angiography Versus Duplex Ultrasound and Digital
           Subtraction Angiography
           Douglas R. Stoddard*, Niten N. Singh, Charles A. Kitley*,
           Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA
1:45 pm – 1:55 pm  M2
           Consequences of Cross Clamping the Aorta: A Histologic
           and Inflammatory Perspective
           Steven Satterly, Shashikumar Salgar*, Matthew Martin*, Niten
           Singh - Madigan Army Medical Center, Tacoma, WA
2:00 pm – 2:10 pm  M3
           Fishing For a Safe and Effective Vascular Closure Device: A
           Single Institution’s Experience With the Femoral Introducer
           Sheath and Hemostasis (FISH™) Device
           Gregory Skerrett*, Gilbert Aidinian, Llewellyn Lee, Patrick Cook
           - William Beaumont Army Medical Center, El Paso, TX
2:10 pm – 2:20 pm  M4
           Pharmacologic Attenuation of the Hyperdynamic
           Response After Aortic Occlusion
           Wayne Causey*, Seth Miller*, Matthew Martin*, Niten Singh -
           Madigan Hospital, Tacoma, WA
2:20 pm – 2:30 pm  M5
           A Process Improvement Project To Improve IVC Filter
           Retrieval
           Leo J Daab*, Paul W White, Scott R Golarz, David R Whittaker,
           Robert M Craig, Charles J Fox - Walter Reed National Military
           Medical Center, Bethesda, MD
Schedule-At-A-Glance

2:30 pm – 3:00 pm  Coffee Break

SVMS SCIENTIFIC SESSION II

3:00 pm – 3:10 pm  M6  
Resuscitative Endovascular Balloon Occlusion of the Aorta For Hemorrhagic Shock: A Review of the Literature With Implications For Modern Practice  
Sahar T Leazer**, Jonathan J Morrison J Morrison1, Zackary M Arthurs*, Jeremy W Cannon**, Jonathan L Elaiason2, Todd E Rasmussen1  - 1US Army of Surgical Research, Fort Sam Houston (San Antonio), TX; 2University of Michigan, Michigan, TX

3:10 pm – 3:20 pm  M7  
Feasibility of Carotid Stenting Through Brachial Access In Difficult Arch Anatomy  
Patrick Neville, Brian Santin, Patrick Muck, Matthew Recht, Sophia Afridi, Pryze Smith*, Joann Lohr - Good Samaritan Hospital, Cincinnati, OH

3:20 pm – 3:30 pm  M8  
Repair of Aberrant Right Subclavian Artery Entirely Via A Supraclavicular Approach  
Aaron C Baker1, Brodus Atkins2, W. Darrin Clouse2, Robert Noll2, James Sampson2, Timothy Williams2 - 1University of California Davis Medical Center, Sacramento, CA; 2David Grant Medical Center, Travis Air Force Base, CA

3:30 pm – 3:40 pm  M9  
A Case of Subclavian Vein Thrombosis With Poland Syndrome  
Steven Satterly*, Charles Andersen, Niten Singh - Madigan Army Medical Center, Tacoma, WA

3:40 pm – 3:50 pm  M10  
Common Femoral Endovenectomy With Inline Iliac Vein Stenting: A Hybrid Solution To Daunting Problem  
Mel J Sharafuddin, Rachael M Nicholson, Sara Mijal*, Adonis J Lysandrou* - University of Iowa Carver College of Medicine, Iowa City, IA

3:50 pm – 4:00 pm  M11  
Case Report of An Anterior Trans-Abdominal Approach To A Type II Endoleak Repair  
Douglas R. Stoddard*, Niten N. Singh, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA

4:00 pm – 4:30 pm  Discussion

4:30 pm  Meeting Adjourns

5:00 pm – 7:00 pm  WELCOME RECEPTION
## Schedule-At-A-Glance

**Friday, February 1, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>6:00 am – 7:00 am</td>
<td>Continental Breakfast</td>
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<tr>
<td>6:00 am – 9:30 am</td>
<td>Registration</td>
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</tbody>
</table>
| 7:00 am – 9:15 am| **SCIENTIFIC SESSION I**  
                      Moderators: Mark Conrad, MD & Katherine Gallagher, MD  
                      Opening Remarks: Ruth L. Bush, MD, MPH, President |
| 7:00 am – 7:15 am| **1**  
                      Comparison of Acute Versus Chronic Dynamic Intimal Flap Movement In Stanford Type B Aortic Dissections (ATBD) and the Effects of Thoracic Endovascular Stent Grafting  
                      Frank R Arko, III, Aaron H Hurd*, Tzvi Nussbaum*, Christopher Boyes*, Stephen G Lalka*, Timothy S Roush - Sanger Heart and Vascular Institute, Charlotte, NC |
| 7:15 am – 7:30 am| **2**  
                      Results of Routine Adjunctive Spinal Drainage and/or Left Subclavian Artery Bypass In Thoracic Endovascular Aortic Repair  
                      Dean J. Arnaoutakis*, George J. Arnaoutakis*, Robert J. Beaulieu*, Christopher J. Abularrage*, James H. Black, III - The Johns Hopkins Hospital, Baltimore, MD |
| 7:30 am – 7:45 am| **3**  
                      Acute Complications After Balloon Assisted Maturation of AVF's  
                      Anil Hingorani, Enrico Ascher*, Natalie Marks*, Andrea Carollo*, Pamela Boniviscage* - Lutheran Medical Center, Brooklyn, NY |
| 7:45 am – 8:00 am| **4**  
                      Restenosis and Symptom Recurrence After Endovascular Therapy For Claudication: Does Duplex Ultrasound Correlate With Recurrent Claudication?  
| 8:00 am – 8:10 am| **5 (RF)**  
                      Paroxysmal Nocturnal Hemoglobinuria: A Red Clot Syndrome  

RF - Rapid Fire
Schedule-At-A-Glance

8:10 am – 8:20 am  6 (RF Video)
Videoscopic Basilic Vein Harvest For the Creation of
Transposed Brachial-Basilic AV Fistulas: A Novel Protocol
John P Leone*, Alexander Glaser*, Rick Hufstetler*, Karl
Illig1 - 1Tampa General Medical Group, Tampa, FL; 2Tampa
General Hospital, Tampa, FL; 3University of South Florida/
Tampa General Hospital, Tampa, FL

8:20 am – 8:30 am  7 (CR)
IVUS As A Novel Tool For the Diagnosis of Endofibrosis
Danielle Campbell*, Katherine A Gallagher, Shipra Arya*, Tina
Chen*, Dawn Coleman, Peter Henke, Jon L Eliason, John
Rectenwald - University of Michigan, Ann Arbor, MI

8:30 am – 8:45 am  8
Post-Discharge Care Matters: The Relationship Between
Quality of Diabetic Care, Readmission and Survival For
Lower Extremity Revascularization
Benjamin S Brooke*, Randall R DeMartino*, Kristina A Giles*,
Richard J Powell, David H Stone, Brian W Nolan, Philip P
Goodney - Dartmouth-Hitchcock Medical Center, Lebanon, NH

8:45 am – 9:00 am  9
Surgical Complications of Radial Artery Catheterization
Karan Garg, Brittny S Williams-Howell, Stephanie Saltzberg,
David Dexter, Todd L. Berland, Thomas S Maldonado, Caron B
Rockman - NYU Langone Medical Center, New York, NY

9:00 am – 9:15 am  10
Surgical Site Infections and Complications Following
Vascular Groin Procedures
SreyRam Kuy*, Anahita Dua, Bhavin Patel*, Nader Tondravi*,
Gary R Seabrook, Kellie R Brown, Brian D Lewis, Cheong J Lee,
Peter J Rossi - Medical College of Wisconsin, Milwaukee, WI

3:00 pm  Registration Re-Opens

3:30 pm – 4:00 pm  Coffee/Snacks – Visit Exhibitors

4:00 pm – 6:00 pm  SCIENTIFIC SESSION II
Moderator: Jean Bismuth, MD

4:00 pm – 4:15 pm  11
Open Mesenteric Interventions Are Equally Safe As
Endovascular Interventions and Offer Better Long-Term
Patency
Shipra Arya, Stephanie Kingman*, Jordan Knepper, Jonathan L
Eliason, Peter K Henke, John E Rectenwald - University of
Michigan, Ann Arbor, MI

CR - Case Report
Schedule-At-A-Glance

4:15 pm – 4:30 pm  12
Preliminary Experiences With Early Primary Closure of Foot Wounds Following Lower Extremity Revascularization
Neal R Barshes, Carlos F. Bechara, George Pisimisis, Panos Kougiou - Baylor College of Medicine, Houston, TX

4:30 pm – 4:45 pm  13
Do PSVR Ratios Correlate With ABI Value and Symptoms After SFA Intervention? Lessons From the VIBRANT Trial
Patrick Geraghty1, Mark W. Mewissen*2, Gary M Ansel*3, Michael R Jaff*4 1Washington University Medical School, Saint Louis, MO; 2St. Luke’s Hospital, Milwaukee, WI; 3Riverside Methodist Hospital, Columbus, OH; 4Harvard Medical School, Massachusetts General Hospital, Boston, MA

4:45 pm – 5:00 pm  14
Retrograde Popliteal Access Is Safe and Effective - It Should Be Added To the Vascular Surgeon's Portfolio

5:00 pm – 5:10 pm  15 (RF)
Supervised Exercise Programme Improves Aerobic Fitness In Patients Awaiting Abdominal Aortic Aneurysm Repair
Hashem Barakat*, Yousef Shahin, Peter McCollum, Ian Chetter - Academic Vascular Surgical Unit, Hull York Medical School, Hull, United Kingdom

5:10 pm – 5:20 pm  16 (CR Video)
Use of the Artis-Zeego iGuide Program To Perform A Translumbar Glue Embolization of A Type-2 Endoleak: A Video Case Report
Mikel Sadek*, Todd L Berland, Thomas S Maldonado, Firas F Mussa, Caron B Rockman, Genn R Jacobowitz, Patrick J Lamparello, Mark A Adelman, Frank J Veith, Neal S Cayne - New York University Langone Medical Center, New York, NY

5:20 pm – 5:30 pm  17 (CR)
Pulmonary Emboli and Internal Jugular Vein Aneurysm In A Patient With Neurofibromatosis 1
Brian Santin, Sara McKeever*, Chris Paprzycki*, Matt Recht* - Good Samaritan Hospital, Cincinnati, OH

5:30 pm – 5:45 pm  18
Heparin Bonding Does Not Improve Patency of PTFE Arteriovenous Grafts
Matthew T Allemand*, Brian Schmotzer*2, Virginia L. Wong*1, Alex Chang*1, Ryan Lakin*1, Kenneth Woodside*1, John Wang*1, Vikram S. Kashyap*1 1University Hospitals Case Medical Center, Cleveland, OH; 2Case Western Reserve University, Cleveland, OH
Schedule-At-A-Glance

5:45 pm – 6:00 pm  
19  
Is There Benefit To Universal Carotid Artery Duplex Screening Prior To Cardiac Surgery?  
Brian C Adams*, Ross M Clark*, James M Goff, Jr.1,2.  
1University of New Mexico School of Medicine, Albuquerque, NM; 2Raymond G. Murphy VA Medical Center and the University of New Mexico School of Medicine, Albuquerque, NM

6:00 pm – 6:30 pm  
PVSS MEMBER BUSINESS MEETING  
(Members Only)

6:30 pm -  
Free Evening

Saturday, February 2, 2013

6:00 am – 7:00 am  
Continental Breakfast

6:00 am – 9:30 am  
Registration

7:00 am – 9:00 am  
SCIENTIFIC SESSION III  
Moderators: W. Darrin Clouse, MD & Ravi Rajani, MD

7:00 am – 7:15 am  
20  
The Impact of Gender On Angioplasty and Primary Stenting For Femoropopliteal Occlusive Disease: Results of the DURABILITY II Trial  
Rami O Tadros1, Peter L. Faries1, Krishna J Rocha-Singh2, Sung Yup Kim3, Victoria Teodorescu1, Sharif H Ellozy1, Michael L Marin1, Ageiliki G Vouyouka1 - 1The Mount Sinai Medical Center, New York, NY; 2St. John’s Hospital, Springfield, IL

7:15 am – 7:30 am  
21  
Patient-Centered Outcomes and Risk-Adjusted Hospital Mortality In Major Vascular Surgery  
Micah E Girotti*, Jonathan L Eliason, Justin B Dimick*, Peter K Henke* - University of Michigan, Ann Arbor, MI

7:30 am – 7:45 am  
22  
Use of Anti-Xa Levels To Monitor Heparin Therapy - A Failed Trial In A Hospitalized Population  
Joann M Lohr, Thomas Panke, Thomas Imhoff, Janice Miller, Angela N Fellner* - Good Samaritan Hospital, Cincinnati, OH

7:45 am – 8:00 am  
23  
Outcome Predictors of Limb Salvage In Traumatic Popliteal Artery Injury  
Anahita Dua*, Jaecel O Shah, Robert E Lasky, Kristofer Charlton-Ouw, Ali Azizzadeh, Anthony Estrera, Hazim J Safi, Sheila M Coogan - University of Texas-Houston, Houston, TX
Schedule-At-A-Glance

8:00 am – 8:10 am  24 (RF)  The Endovascular Management of Arterial Injuries Associated With Posterior Knee Dislocation  Zachary K. Baldwin, Rishi Roy*, Andrea Barker - University of Mississippi Medical Center, Jackson, MS

8:10 am – 8:20 am  25 (RF)  Assessment of Initial Wound Healing Following Amputations  Amani D Politano*, Jennifer Wang*, Mehul S Patel*, Kenneth J Cherry*, Gilbert R Upchurch*, Jr.*, Margaret C Tracci* - University of Virginia, Charlottesville, VA

8:20 am – 8:30 am  26 (RF)  When To Call It A Day: Incremental Risk of Amputation After Multiple Revascularization  Alexander T. Hawkins*, Maria J. Schaumeier*, Ann D. Smith*, Nathanael D. Hevelone*, Louis L. Nguyen* - Brigham and Women's Hospital, Boston, MA

8:30 am – 8:45 am  27  A Cost-Effectiveness Analysis of Revascularization For Limb Salvage Among Patients With Marginal Baseline Functional Status  Neal R. Barshes1, Panos Kougias1, C. Keith Ozaki2, George Psimisis1, Carlos F. Bechara1, Helene K. Henson*1, Michael Belkin2 - 1Baylor College of Medicine, Houston, TX; 2Brigham and Women’s Hospital, Boston, MA

8:45 am – 8:55 am  28 (CR)  Re-Entry Device Aided EVAR In Patients With AAA and Unilateral Iliac Artery Occlusion  Jason T Lee, George K. Lee, Vinit Varu*, Shu Chang* - Stanford University Medical Center, Stanford, CA

8:55 am – 9:05 am  Introduction of the President

9:05 am – 9:35 am  PRESIDENTIAL ADDRESS  I Have But One Candle of Life To Burn…  Ruth L. Bush, MD, MPH

12:00 pm – 1:00 pm  SKI-IN/SKI-OUT LUNCH

3:00 pm  Registration Re-Opens

3:30 pm – 4:00 pm  Coffee/Snacks  Last Chance To Visit Exhibitors

RF - Rapid Fire; CR - Case Report
Schedule-At-A-Glance

4:00 pm – 6:00 pm  SCIENTIFIC SESSION IV
Moderators: Peter Nelson, MD & Brian DeRubertis, MD

4:00 pm – 4:15 pm  29
Concomitant Intracranial Aneurysm and Carotid Artery Stenosis: An Institutional Review of Patients Undergoing Carotid Revascularization

4:15 pm – 4:30 pm  30
Endovascular Popliteal Artery Aneurysm Repair: A Decade of Experience
Jeffrey Jim, Enjae Jung, Brian G Rubin, John A Curci, Luis A Sanchez, Patrick J Geraghty - Washington University in St. Louis, St. Louis, MO

4:30 pm – 4:45 pm  31
Disparate Preoperative Surveillance and Rupture of Abdominal Aortic Aneurysm For the Elderly Poor
Matthew W Mell, Laurence C Baker*, Mark A Hlatky* - Stanford University, Stanford, CA

4:45 pm – 5:00 pm  32
Postoperative and Long-Term Outcomes Following Open Repair of Ruptured Abdominal Aortic Aneurysms In Octogenarians
Hashem M Barakat*, Yousef Shahin, Ian Chetter, Peter McCollum - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

5:00 pm – 5:10 pm  33 (CR)
Endovascular Management of Middle Aortic Syndrome With Associated Saccular Aneurysm In A Newborn
Siddharth Patel, Dennis Kim*, Ravi Veeraswamy - Emory University, Atlanta, GA

5:10 pm – 5:20 pm  34 (CR)
Coil Embolization of Ascending Aortic Pseudo-Aneurysm Post Open Repair of Type A Aortic Dissection
Vikalp Jain*, Luis Gruberg*, Thomas V Bilfinger*, Apostolos K Tassiopoulos, Shang A Loh - Stony Brook University Medical Center, Stony Brook, NY

5:20 pm – 5:30 pm  35 (RF)
A Novel Approach To EVAR Simulation Using Patient Specific Modeling
Gavin R Davis, Murray L Shames, Karl A Illig, George Yang*, Thu -Hoai Nguyen* - USF, Tampa, FL

RF - Rapid Fire;  CR - Case Report
Schedule-At-A-Glance

5:30 pm – 5:45 pm  36
Validated Assessment Tool Paves the Way For Standardized Evaluation of Trainees On Anastomotic Models
Cassidy Duran1, Murray L Shames2, Jean Bismuth1, Jason T Lee3, APDVS Committee for Education and Simulation - 1The Methodist DeBakey Heart & Vascular Center, Houston, TX; 2University of South Florida Health, Tampa, FL; 3Stanford University School of Medicine, Stanford, CA

5:45 pm – 6:00 pm  Q & A, Discussion

7:00 pm – 10:00 pm  PRESIDENT’S DINNER
All attendees are welcome to purchase tickets to attend this separate subscription event.

Sunday, February 3, 2013

6:30 am – 7:00 am  Continental Breakfast
6:30 am – 9:00 am  Registration

7:00 am – 9:00 am  SCIENTIFIC SESSION V
Moderators: Ravi Veeraswamy, MD & Christopher Smolock, MD

7:00 am – 7:15 am  37
Risk Factors Associated With the Abdominal Aortic Aneurysm Diagnosis In Patients Screened At A Regional Veterans Affairs Health Care System
Kevin C Chun*, Kai Y. Teng**, LeAnn A. Chavez***, Elyse N. Van Spyk*, John G. Carson***, Eugene S. Lee***, 1VA Northern California Health Care System, Mather, CA; 2University of California, Davis, Sacramento, CA

7:15 am – 7:30 am  38
Mini-Incision Thoracobifemoral Bypass In the Endovascular Era
Amy E Reppert*, Omid Jazaeri*, Ashok Babu*, Mark Nehler*, Brett T Reece* - University of Colorado, Aurora, CO

7:30 am – 7:45 am  39
CEAP Classification Relationship To VLU Closure: A Retrospective Analysis of A Prospective Randomized Controlled Trial of VLU Treatment With A Novel Spray-Applied Cell Therapy
Jamie A Schwartz*, Cynthia Gendics*, Robert S Kirsner**, Herbert B Slade**, John C Lanits, III** - 1St Luke’s- Roosevelt Hospital Center, New York, NY; 2University of Miami, Miami, FL; 3University of North Texas Health Science Center, Fort Worth, TX
# Schedule-At-A-Glance

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Title</th>
<th>Authors</th>
<th>Institution</th>
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</thead>
<tbody>
<tr>
<td>7:45 am – 8:00 am</td>
<td>40</td>
<td>Does Pulse Volume Recording Aid In Peripheral Arterial Disease Stratification?</td>
<td>Benjamin A Eslahpazir*, Matthew T Allemang*, Ryan O Lakin*, John C Wang*, Teresa L Carman, Virginia L Wong, Henry R Baele, Vikram S Kashyap - Case Western Reserve University School of Medicine, Cleveland, OH; University Hospitals Case Medical Center, Cleveland, OH</td>
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<tr>
<td>8:00 am – 8:10 am</td>
<td>41 (CR)</td>
<td>Endovascular Management of Chronic SVC Syndrome With SVC Occlusion</td>
<td>Robert W Fincher*, Magdiel Trinidad* - University of Arizona, Tucson, AZ</td>
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<tr>
<td>8:10 am – 8:20 am</td>
<td>42 (CR)</td>
<td>Percutaneous Retrieval of An Inferior Vena Cava Filter Causing Right Ureter Obstruction</td>
<td>Kristina Thornburg*, Amber Batool*, Melissa Obmann, Shivprasad Nikam*, David Mariner* - Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA</td>
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<tr>
<td>8:20 am – 8:30 am</td>
<td>43 (RF)</td>
<td>- Unable To Attend Meeting - Isolated Axillary Artery Aneurysm In A Patient With A Patent Ipsilateral Arteriovenous Fistula</td>
<td>Yan T. Ortiz-Pomales*, Jennifer B Smith*, Jeffrey S Weiss, Kevin Casey - Naval Medical Center San Diego, San Diego, CA</td>
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<tr>
<td>8:30 am – 8:45 am</td>
<td>44</td>
<td>Short- and Mid-Term Results of Iliac Artery Flush Occlusion Stenting With the Assistance of An Occlusive Contralateral Iliac Artery Balloon</td>
<td>Carlos F Bechara, Neal R Barshe, George Psimisis, Peter H Lin, Panagiotis Kougias - Baylor College of Medicine, Houston, TX</td>
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<tr>
<td>8:45 am – 9:00 am</td>
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<td>Q &amp; A/Discussion</td>
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<td>9:00 am</td>
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<td>Winter Annual Meeting Adjourns</td>
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Full Program & Abstracts

Thursday, January 31, 2013

7:00 am - 9:00 am  Executive Committee Meeting
7:00 am - 5:00 pm  Registration
9:00 am - 12:30 pm  FELLOW LUMINARIES
10:30 am - 11:00 am  Coffee Break
12:45 pm - 1:30 pm  FEATURED SPEAKER LUNCHEON
                       Norman M. Rich, MD, Col, MC, USA (Ret)
                       F. Edward Hebert School of Medicine, USUHS, Bethesda, MD
Full Program & Abstracts

1:30 pm - 4:30 pm  SOCIETY FOR MILITARY VASCULAR SURGERY
SCIENTIFIC PROGRAM

SVMS SCIENTIFIC SESSION I
Opening Remarks: W. Darrin Clouse, MD

1:35 pm – 1:45 pm  M1
Evaluating the Degree of Carotid Artery Stenosis Utilizing
CT Angiography Versus Duplex Ultrasound and Digital
Subtraction Angiography
Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: The purpose of this study is to examine the accuracy and
correlation between computed tomographic angiography (CTA), duplex ultrasonography
(DUS), and digital subtraction angiography (DSA) in patients with carotid artery stenosis (CAS).

Methods: A retrospective review of prospectively collected data was performed on all patients
who underwent carotid DUS, CTA and DSA between January 2007 and June 2012. Standard
duplex criteria were utilized and all axial CTA images were reviewed by an independent
radiologist. Data was evaluated using the intra-class correlation to determine the overall degree
of consistency in measurement among the three imaging modalities. Pearson’s correlation
coefficient was employed to identify the relationship between each individual imaging
modality.

Results: Fifty-five carotid arteries in 44 patients (72.7% male, mean age 69.4 years, range 43.4 to
86.2 years) were evaluated using all three modalities. In 20 of 55 vessels (36.4%), CAS correlated
in all three imaging modalities. In 32 of 55 vessels (58.2%), DUS correlated with DSA. In 28 of 55
vessels (50.9%), CTA correlated with DSA. In 11 of 55 vessels (20.0%), DUS and DSA were
consistent with each other but discordant with CTA. The intra-class correlation between all
three imaging modalities was 0.685. Degree of stenosis was underestimated in 70.4% of the
vessels by CTA.

<table>
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<th>Imaging</th>
<th>Pearson Correlation (r)</th>
<th>p-value</th>
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<tbody>
<tr>
<td>DUS and CTA</td>
<td>r (55 studies) = 0.697</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>DUS and DSA</td>
<td>r (55 studies) = 0.691</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>CTA and DSA</td>
<td>r (55 studies) = 0.689</td>
<td>&lt;0.01</td>
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<table>
<thead>
<tr>
<th>Imaging</th>
<th>Intra-class Correlation</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>DUS, CTA, and DSA</td>
<td>0.685 (95% CI: 0.560 - 0.789)</td>
<td>&lt;0.01</td>
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</table>

Conclusion: Our results suggest that there is a moderate degree of correlation between all
three imaging modalities, CTA does not add significantly to the data provided by DUS, and CTA
underestimates the percent stenosis compared to both DUS and DSA.
Introduction & Objectives: Massive abdominal trauma and subsequent hemorrhagic shock can require heroic life-saving intervention via aortic cross clamp. The survivability from degree of injury and subsequent supraceliac cross-clamping is typically poor. Multi-organ failure and death is common following survival of the initial insult despite resuscitation and restoration of perfusion. Blood products are limited in an austere environment similar to a military deployment. We sought to model consequences of supraceliac aortic cross-clamping in the setting of hemorrhagic shock and no available blood products.

Methods: 7 porcine models were utilized for the experiment, 3 control animals and 4 animals for the experimental group. Control pigs were splenectomized. The experimental group was subjected to Class III (35%) hemorrhagic shock and subsequent cross-clamping of the supraceliac aorta for 50 minutes. Resuscitation goal was for mean arterial pressure (MAP) of ≥ 40 mmHg for 6 hours following intervention. Serum lab values were taken during the experiment. Histologic samples from the kidney and liver were obtained immediately following course of resuscitation.

Results: Epinephrine requirement to maintain mean arterial pressure ≥40 mmHg was significantly increased in cross-clamp animals compared to control (3052±850μg; n=4). Mean lactate levels in treated groups were significantly (P<0.05) higher than in sham group (2.1±1.5). Liver injury/function biomarkers (Alkaline phosphatase, Alanine amino transferase, Gamma glutamyl transferase, Glucose) varied significantly (P>0.05) between cross-clamp and control groups. Liver injury scores of 1.5±0 and 2.25 ± 0.95 in control and cross-clamped groups, respectively. Kidney injury scores were 1±0 and 1.75±0.96 in sham and cross-clamp groups. Inflammatory markers HIF-1α, eNOS, iNOS2, and iNOS3 were markedly upregulated in the kidney from treated groups compared to control.

Conclusions: Supraceliac aortic cross-clamp dramatically increases both the inflammatory cascade as well as renal and hepatic tissue injury following isotonic fluid resuscitation in Class III shock.
Fishing For A Safe and Effective Vascular Closure Device: A Single Institution’s Experience With the Femoral Introducer Sheath and Hemostasis (FISH™) Device
Gregory Skerrett*, Gilbert Aidinian, Llewellyn Lee, Patrick Cook
- William Beaumont Army Medical Center, El Paso, TX

Introduction & Objectives: A number of vascular closure devices (VCD) are available for use by endovascular providers with the intent to decrease access site complications and shorten time to ambulation. The objective of this study is to determine the safety and efficacy of the newly FDA approved Femoral Introducer Sheath and Hemostasis (FISH™) device. The FISH™ is a novel closure mechanism that deposits a plug of bioresorbable extracellular matrix known as small intestinal submucosa (SIS®) which gets remodeled into the arterial wall and serves as a scaffold around which the artery heals itself.

Methods: Between December 2009 and August 2012, 57 arteriotomies underwent closure with the FISH™ device at our institution. A retrospective review of each patient’s medical record was performed and pertinent data was compiled to include, indication for procedure, anticoagulation status, vessel accessed, device failure, and time to hemostasis.

Results: A total of 36 males and 20 females underwent vessel closure with the FISH™. Twenty-seven were anticoagulated at the time of closure. Hemostasis was obtained in under 2 minutes in all but 2 patients. In the two patients with prolonged bleeding 1 was due to a device failure requiring pressure to be held for 20 minutes and the other patient had a prophylactic FemoStop™ device placed due to active disseminated intravascular coagulation. In follow up that extends up to 2 years there have been no access site complications. The overall success rate for the FISH™ is 96%.

Conclusions: The FISH™ vascular closure device has proven to be effective and safe in a variety of patients. Further research needs to be conducted on a larger number of patients to assess the true risk profile and to make an accurate comparison to the other available closure devices.
Pharmacologic Attenuation of the Hyperdynamic Response After Aortic Occlusion

Wayne Causey*, Seth Miller*, Matthew Martin*, Niten Singh - Madigan Hospital, Tacoma, WA

Introduction & Objectives: Aortic occlusion is accompanied by a hyperdynamic cardiovascular response secondary to increased systemic vascular resistance and increased cardiac output. This can contribute to increased myocardial stress and possibly fatal arrhythmias. This study was designed to determine if pharmacologic medications are able to attenuate the adverse hyperdynamic response occurring with hemorrhage and a supraceliac aortic cross clamp in a porcine model.

Methods: In a validated porcine model demonstrating a significant hyperdynamic response to a 50 minute supraprenal aortic cross clamp following 35% blood volume hemorrhage. In our experiment, 8 experimental swine (ES) were given hydrogen sulfide at 4mg/min during aortic cross clamp and compared to 5 controls (C).

Results: 13 swine were length and weight matched. Time intervals were divided every 15 minutes during the course of the aortic cross clamp. At cross clamp, mean arterial pressure (MAP) was 60mmHg in the C compared to 65mmHg in the ES but H2S administration attenuated this response at 15 minutes (103 vs. 141mmHg, p=0.21), 30 minutes (125 vs. 150 mmHg, p=0.15), 45 minutes (120 vs. 149 mmHg, p=0.043), with equal pressure 10 minutes after CC release when H2S infusion was complete (80.8 vs. 80.6mmHg). Heart rate was not significantly decreased at CC application, 15 minutes, 30 minutes, or 45 minutes (all P>0.1), but was decreased upon cross clamp release (144 vs. 183 bpm, p=0.011). There was not a significant change in invasive hemodynamic parameters to include cardiac output, systemic vascular resistance, pulmonary vascular resistance, and stroke volume.

Conclusions: The administration of H2S during the time of supraceliac aortic cross clamp causes decreases in mean arterial blood pressure and decreased heart rate after cross clamp release without significant changes in invasive hemodynamic parameters. As demonstrated in this study, targeted pharmacologic therapy is possible to minimize adverse invasive hemodynamic parameters with aortic occlusion.
Introduction: The American Association for the Surgery of Trauma has recently focused attention on temporary IVC filter (T-IVCF) removal following reports of low retrieval rates in urban trauma centers. Despite vigilant follow up in the military, a similarly low retrieval rate has prompted us to establish a registry and track T-IVCFs placed at Walter Reed National Military Medical Center (WRNMMC) to improve retrieval rates.

Methods: The Peripheral Vascular Surgery Service at WRNMMC initiated an IVC filter registry in July 2012 as a process improvement project. All patients receiving an IVC filter are entered into a database. Monthly, this database is reviewed. Indications for filter placement are reviewed. Patients no longer requiring an IVC filter are scheduled for removal. Data from this registry from July 2012 through December 2012 is being collected and will be presented. This data will be compared to previously published data.

Results: The results of the aforementioned data review will be presented to highlight the effects of focusing on IVC filter retrieval as a process improvement project at WRNMMC.

Conclusions: Previously reported rates of IVC filter retrieval of 18-21% have improved after the implementation of dedicated follow-up and filter registries. We have previously reported our 18% retrieval rate at Walter Reed Army Medical Center. A large number of filters were not retrieved because of ongoing indications for a filter. By reviewing these patients monthly, we hoped to increase our retrieval rate. We will present the results of this strategy at WRNMMC.
Introduction: Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) is an emerging technique for aortic control in the setting of torso hemorrhage. It provides inflow control in addition to after-load support. Our aim is to summarize the available evidence in order to assess the utility of REBOA in contemporary clinical practice.

Methods: "REBOA" and related keywords were used to search the Pubmed Database for all English language animal and human studies published between 1953 to 2012.

Results: The search identified 49 publications; 35 in a clinical setting and 14 in large-animal studies. The majority (60%) of clinical studies were published after 1997 (post FDA approval of the first endografts) and are represented by the following specialties: vascular surgery (52%), trauma surgery (17%), spine surgery (17%), obstetrics (11%) and general surgery (3%). Within these specialties, REBOA was used emergently in 79% of the studies and electively in 21%. Electively, REBOA was predominantly used in the infrarenal aorta to control blood loss during sacral tumor resection. Emergently, REBOA has utility in severe postpartum hemorrhage as well as in the proximal control of ruptured abdominal aortic aneurysms. Within the trauma setting, REBOA has been used to achieve thoracic and infrarenal control. REBOA has been examined in numerous animal studies, predominantly in the thoracic aorta (80%), comparing the technique to open operative approaches as well as the metabolic consequences. REBOA has been demonstrated to increase central aortic pressure, while limiting hemorrhage in several injury models, although this does incur a metabolic burden which is recoverable with appropriate critical care.

Conclusion: REBOA is a promising technique which has utility in the control of the aorta in a number of settings. Further clinical studies and improved endovascular balloon technologies are required to advance this adjunct in the setting of hemorrhagic shock.
Full Program & Abstracts

3:10 pm – 3:20 pm  M7
Feasibility of Carotid Stenting Through Brachial Access In Difficult Arch Anatomy
Patrick Neville, Brian Santin, Patrick Muck, Matthew Recht, Sophia Afridi, Pryze Smith*, Joann Lohr - Good Samaritan Hospital, Cincinnati, OH

Introduction & Objectives: Carotid artery stenting (CAS) has been reported to be an alternative to carotid endarterectomy (CEA) for carotid artery stenosis due to the improvements of stents and embolic protection devices. However, the transfemoral route can be unavailable or high risk, in cases of difficult arch anatomy. We assessed the feasibility, safety, and efficacy of CAS through the right brachial approach in patients with difficult arch anatomy.

Methods: The charts of all patients undergoing carotid stenting from a right brachial approach were retrospectively reviewed. In this report, the charts of 6 patients who underwent CAS using the right transbrachial approach were reviewed. Charts were reviewed for patient demographics, radiographic results as well as procedural results. Neurologic results and access site complications were examined.

Results: 2 males and 4 females were treated. 1 right ICA, 3 left ICAs and 2 left CCAs and were treated. Technical success was 100%. Patient follow-up ranged from 16 days to 804 days. The morbidity and mortality were both 0%. No strokes were encountered. Major and minor local complications at the puncture site were not encountered.

Conclusions: Difficult arch anatomy may increase carotid artery stenting (CAS) procedural difficulties and complications through the transfemoral route. We suggest that CAS via transbrachial route is an effective and safe treatment for carotid stenosis in the setting of difficult arch anatomy. Carotid stenting in difficult arch anatomy can be safely done by transbrachial route depending upon operator’s experience.
Full Program & Abstracts

3:20 pm – 3:30 pm  M8
Repair of Aberrant Right Subclavian Artery Entirely Via A Supraclavicular Approach
Aaron C Baker¹, Brodus Atkins², W. Darrin Clouse³, Robert Noll³, James Sampson³, Timothy Williams³ - ¹University of California Davis Medical Center, Sacramento, CA; ²David Grant Medical Center, Travis Air Force Base, CA

Introduction & Objectives: Aberrant right subclavian artery is a known arch variant, only rarely requiring surgical intervention. Traditionally, patients presenting with dysphagia lusoria undergo repair via a supraclavicular approach in conjunction with a thoracotomy, or hybrid endovascular techniques more recently. We report a case performed entirely via a right supraclavicular approach.

Methods: A 78-year-old man with chronic cough and hoarse voice presented with progressive dysphagia to solids and liquids. Barium swallow demonstrated a filling defect of the thoracic esophagus with proximal dilation (Figure1). CT scan revealed an aberrant right subclavian artery without aneurysmal degeneration. He was subsequently taken to the operating room for repair. A right supraclavicular incision was performed with division of both heads of the sternocleidomastoid muscle. The right subclavian artery was identified and dissected out posterior to the esophagus. The artery was divided and the proximal portion over sewn (Figure2). A subclavian-to-carotid transposition was then performed with preservation of the vertebral artery (Figure3). The sternocleidomastoid was re-approximated.

Results: The patient did well postoperatively with complete resolution of dysphagia. A postoperative duplex ultrasound demonstrated a widely patent anastomosis with good flow to the subclavian and carotid arteries distally. Direct laryngoscopy showed normal cord function bilaterally.

Conclusions: Dysphagia lusoria from a non-aneurysmal aberrant right subclavian artery can successfully be approached via a single neck incision safely, obviating the need for additional incisions or adjunctive endovascular techniques.
Figure 1: Upper GI barium swallow shows an indentation on the thoracic esophagus caused by the aberrant retroesophageal right subclavian artery.

Figure 2: The aberrant right subclavian artery was dissected out posterior to the esophagus via a supraclavicular incision, divided and proximally over sewn.
Figure 3: Subclavian carotid artery transposition with preservation of the vertebral artery.
Introduction & Objectives: 38-year-old female presented with several days of a painful, swollen and edematous left upper extremity. She stated several months of intermittent positional swelling prior to presentation. Patient’s medical history was notable for congenital absence of the left breast requiring repeat reconstructive surgery and implants. The patient was otherwise healthy. Duplex ultrasound revealed a thrombosis of the left subclavian vein. Subsequent invasive venogram revealed a similar finding. Patient underwent catheter directed thrombolytics through the basilic and cephalic vein for 48 hours. Repeat venogram revealed resolution of thrombosis. A temporizing angioplasty of the involved segment of subclavian vein was performed. Patient was maintained on therapeutic levels of Lovenox as an outpatient with complete resolution of symptoms after one week. Anterior scalenectomy with first rib resection via supra- and infra-clavicular incisions was completed. Hypertrophied subclavius and costochondral tissue with a thickened 1st rib were decompressed. Surgery and 2 weeks of anticoagulation resulted with complete resolution.

Poland syndrome is comprised aplasia or hypoplasia of breast tissue, nipple, and the sternocostal portion of the pectoralis major muscle, and also absence of the costal cartilages. Venous thoracic outlet syndrome occurs in approximately 3% of all thoracic outlet cases. We present the first case of Paget-Schroder’s Syndrome and the second case of documented Thoracic Outlet Syndrome in a patient with a history of Poland syndrome.

Methods: A literature search of “PubMed,” “Medline,” “Ovid” for articles using the following key words: “Paget-Schroeder,” “Paget-Schroetter,” “Disease,” “Syndrome,” “Venous Thoracic Outlet Syndrome,” “Effort Induced Thrombosis,” and “Poland Syndrome.”

Results: A single case of neurogenic Thoracic Outlet Syndrome and Poland Syndrome.

Conclusions: Poland syndrome is a rare risk for development of acute subclavian vein thrombosis. Inherent congenital hypoplasia or subsequent reconstructive surgery on or near the thoracic outlet may lead to a higher risk of developing ‘Paget-Schroeder’ syndrome.
Introduction & Objectives: Iliac vein stenting can be a beneficial intervention in patients with venous hypertensive symptoms. However, it may not be feasible when the common femoral vein is involved in the occlusive process. We report our experience with a 61 y.o. active man who presented with chronic left iliofemoral DVT complicating abdominal surgery 3-months prior. He had debilitating leg pain and swelling not responsive to compression therapy. Duplex sonography and MR venography revealed left iliac vein occlusion with extensive synchial occlusive disease involving the common femoral vein extending to a short segment of the adjacent femoral vein.

Methods: The patient underwent groin exploration with thrombo-endovenectomy of the severely diseased common femoral vein and adjacent femoral vein and the ostium of the profunda femoris vein. The longitudinal venotomy was patch-closed using contralateral greater saphenous vein. The adjacent long-segment occlusion of the iliac vein was then endolumenally recanalized and stented. Post-operatively he was placed on full anticoagulation. Large hematoma with compression of the common femoral vein developed on POD-1, and was managed by evacuation and mechanical thrombectomy.

Results: The patient eventually did very well with resolution of his venous hypertensive symptoms. He was able to resume his prior active life style with normal duplex sonography on follow-up nearly two years later.

Conclusions: This hybrid approach towards iliac venous disease involving the common femoral vein may offer a viable option to the management of this very challenging group of patient. It is also feasible in cases of chronic femoral vein occlusion, provided outflow from the limb can be maintained via the greater saphenous and profunda veins.
Full Program & Abstracts
Case Report of An Anterior Trans-Abdominal Approach To A Type II Endoleak Repair
Douglas R. Stoddard*, Niten N. Singh, Reagan W. Quan - Madigan Army Medical Center, Tacoma, WA

Introduction & Objectives: We describe the case of a successful anterior abdominal wall approach to the repair of a type II endoleak.

Methods: The patient is a 65 year old man who underwent an endovascular repair of a 5cm infrarenal abdominal aortic aneurysm four years ago with a Cook Zenith device. An enlarging type II endoleak was discovered post operatively that increased in size to 7.5cm over a two year period. During this time, the patient underwent an unsuccessful attempt at endoleak repair via a trans-arterial approach. Given his slender body habitus and the anterior location of his aneurysm sac, an anterior trans-abdominal approach under ultrasound guidance was used to repair the endoleak. The sac was injected anteriorly, feeding vessels were coil-embolized using microcoils, and an Amplatzer plug was used to secure the access site.

Results: The patient tolerated the procedure well, and there was no evidence of endoleak on subsequent six month follow-up.

Conclusions: In this patient, an anterior trans-abdominal approach to repair of a persistent type II endoleak was successful.
**Full Program & Abstracts**

**Friday, February 1, 2013**

6:00 am – 7:00 am  Continental Breakfast

6:00 am – 9:30 am  Registration

7:00 am – 9:15 am  **SCIENTIFIC SESSION I**  
Moderators: Mark Conrad, MD & Katherine Gallagher, MD  
Opening Remarks: Ruth L. Bush, MD, MPH, President

7:00 am – 7:15 am  1  
**Comparison of Acute Versus Chronic Dynamic Intimal Flap Movement In Stanford Type B Aortic Dissections (ATBD) and the Effects of Thoracic Endovascular Stent Grafting**  
Frank R Arko, III, Aaron H Hurd*, Tzvi Nussbaum*, Christopher Boyes*, Stephen G Lalka*, Timothy S Roush - Sanger Heart and Vascular Institute, Charlotte, NC

**Introduction & Objectives:** To compare the intimal flap of the visceral aorta of acute and chronic Stanford Type B (TBD) dissections prior to and following TEVAR.

**Methods:** Nineteen patients with TBD, 11 chronic and 8 acute were evaluated with IVUS. Aortic flap movement at the SMA during one RR-interval of the ECG was recorded pre/post TEVAR. Flap movement index (FMI) and flap area index (FAI) were defined with measurements of the minimum and maximum aortic diameters (ADmin, ADmax), minimum and maximum true lumen diameters (TDmin, TDmax), and true lumen areas (TAmin, TAmaj). FMI was defined as [(TDmax/ADmax-TDmin/ADmin)/TDmin/ADmin x 100(%)], FAI was defined as TAmaj-TAmin/TAmajx100.

**Results:** Table I demonstrates all measurements. There was a significant increase in the TD and TA following TEVAR in the visceral aorta in those with acute compared to chronic. Furthermore, following TEVAR the FMI was significantly decreased by 8.9 +/-1.2% in acute compared with 4.9 +/-1.9% in chronic dissections (p=0.002). The FAI was significantly increased in acute at 76.8 +/- 17% compared to 17.6 +/- 4.3% with chronic (p=0.0001). All 8 patients had complete thrombosis of the false lumen, while those with chronic dissections had continued retrograde perfusion of the distal landing zone.
Full Program & Abstracts

Conclusions: This is the first study to compare and characterize the dynamic aortic flap movement of the visceral aorta and the effects of TEVAR in TBD. Aortic morphologic changes occur immediately after stent graft placement in those with acute TBD with little change in the flap in those with chronic TBD. Early intervention was associated with complete thrombosis of the false lumen which may be a result of the acute changes seen with the flap after TEVAR.

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<th>PRE Thoracic Stent</th>
<th>Post Thoracic Stent</th>
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<tr>
<td>TD min (mm)</td>
<td>11.25 +/- 1.7</td>
<td>16.00 +/- 1.8</td>
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<td>TD max (mm)</td>
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<td>19.25 +/- 2.2</td>
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<td>TA min (cm2)</td>
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<td>2.97 +/- 0.33</td>
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<td>TA max (cm2)</td>
<td>2.70 +/- 0.42</td>
<td>3.53 +/- 0.22</td>
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<td>AD min (mm)</td>
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<td>22.75 +/- 1.5</td>
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<td>P=0.947</td>
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<td>AD max (mm)</td>
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<td>24.75 +/- 2.2</td>
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<td>P=0.81</td>
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<td>CHRONIC (n=8)</td>
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<td>TD min (mm)</td>
<td>11.3 +/- 3.5</td>
<td>12.0 +/- 3.61</td>
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<td>P=0.6933</td>
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<td>TD max (mm)</td>
<td>21.0 +/- 6.6</td>
<td>22.67 +/- 5.0</td>
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<td>P=0.5774</td>
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<td>TA min (cm2)</td>
<td>1.1 +/- 1.3</td>
<td>1.4 +/- 1.3</td>
<td></td>
<td>P=0.6515</td>
</tr>
<tr>
<td>TA max (cm2)</td>
<td>1.45 +/- 1.2</td>
<td>1.6 +/- 1.2</td>
<td></td>
<td>P=0.8062</td>
</tr>
<tr>
<td>AD min (mm)</td>
<td>26.75 +/- 1.89</td>
<td>26.17 +/- 1.92</td>
<td></td>
<td>P=0.945</td>
</tr>
<tr>
<td>AD max (mm)</td>
<td>28.55 +/- 2.8</td>
<td>28.75 +/- 2.6</td>
<td></td>
<td>P=0.81</td>
</tr>
</tbody>
</table>
2
Results of Routine Adjunctive Spinal Drainage and/or Left Subclavian Artery Bypass In Thoracic Endovascular Aortic Repair
Dean J. Arnaoutakis*, George J. Arnaoutakis*, Robert J. Beaulieu*, Christopher J. Abularrage*, James H. Black, III - The Johns Hopkins Hospital, Baltimore, MD

Introduction & Objectives: The adjunctive use of a preoperative cerebrospinal fluid (CSF) drain or left subclavian artery (LSA) bypass for thoracic endovascular aortic repair (TEVAR) to minimize neurologic complications remains controversial.

Methods: A retrospective review of a prospective database of patients undergoing TEVAR from 4/2005 through 8/2012 was conducted. CSF drainage was routinely performed under local anesthesia in a staged fashion prior to TEVAR. When possible, LSA bypass was performed prior to TEVAR. Adjunctive procedures were not performed for patients in emergent operations. Preoperative characteristics, operative variables, outcomes, neurologic complications, and survival status were recorded.

Results: Ninety patients underwent TEVAR at our institution during the study period. Mean age was 67.3 years (SD 13.8) and 48 (53%) were male. One (1%) patient had a connective tissue disorder. Sixty-six (73%) presented with degenerative aneurysm, 13 (14%) with chronic Type B dissection, 6 (7%) with pseudoaneurysm, and 5 (6%) with traumatic aortic pathology. Fourteen (16%) had acute ruptures. Sixty-seven (74%) patients underwent adjunctive procedures for TEVAR including a CSF drain (n=48, 53%), LSA bypass (n=7, 8%), or both (n=12, 13%). CSF drain placement was uncomplicated. Cerebral ischemia due to device migration occurred in 2 (2%) patients with resolution in both by common carotid stent. One (1%) patient developed hemispheric stroke but recovered. Delayed spinal cord ischemia (SCI) occurred in 3 (3%) patients and was reversed with hypertensive therapy in 2. The 30-day mortality was 4% and overall median survival was 23 months (IQR 8-90).

Conclusions: Our strategy of adjunctive procedures for TEVAR demonstrates better SCI results than prior reports of selective CSF drainage. This suggests routine adjunctive use of a CSF drain and/or LSA bypass in TEVAR patients is an effective means of reducing SCI and stroke. Furthermore, preoperative drain placement allows rapid therapy for SCI, and should be considered for all.
Objective: Balloon assisted maturation (BAM) of A-V fistulae is a fairly new procedure used to accelerate the process of maturation. As with any procedure complications do arise. In this retrospective analysis of 336 office based BAM procedures, five major acute complications were analyzed and categorized as: formation of wall hematoma, extravasation/rupture, spasm, thrombosis, and formation of puncture site hematoma.

Methods: Data collected from 5/14/09-3/30/11 used to assess 336 office-based duplex-guided BAM procedures. Access site puncture and cannulation with short sheath, wire and balloon advancement and inflation were guided by duplex only. Vascular injuries were classified based on duplex assessment. All patients had follow-up duplex scans within a week after BAM.

Results: Of the 336 procedures the most common injury was formation of wall hematoma (135/336), followed by extravasation/rupture (31/336), spasm (26/336), formation of puncture site hematoma (13/336), and thrombosis (5/336). The injuries were further classified based on balloon size, ranging from 3mm-12mm [total amount: 3mm-6, 4mm-22, 5mm-54, 6mm-71, 7mm-69, 8mm-64, 9mm-27, 10mm-20, 11mm-0, 12mm-3]; entry position, retrograde (177 total) versus anterograde (159 total); and type of fistula, radial-cephalic (232 total), brachial-cephalic (64 total), or brachial-basilic (33 total). Injuries were nearly equal in all cases regardless of anterograde or retrograde insertion. Balloon sizes ranging from 5mm-10mm and 6mm-8mm accounted for 92.86% and 61.90% respectively, of all injuries combined.

Conclusion: The data suggest that office-based BAM procedures are fairly safe, but do carry a small percentage of complications. Except for wall hematoma formation (40.19%), all of the injuries occur in less than 10% of the procedures; extravasation/rupture (9.22%), spasm (7.74%), thrombosis (1.49%), and formation of puncture site hematoma (3.87%). None of the identified factors correlated with these acute complications.

Full Program & Abstracts

3

Acute Complications After Balloon Assisted Maturation of AVF's
Anil Hingorani, Enrico Ascher*, Natalie Marks*, Andrea Carollo*, Pamela Boniviscage* - Lutheran Medical Center, Brooklyn, NY
Restenosis and Symptom Recurrence After Endovascular Therapy For Claudication: Does Duplex Ultrasound Correlate With Recurrent Claudication?


INTRODUCTION AND OBJECTIVES: After peripheral endovascular therapy (ET), surveillance duplex ultrasound (DUS) to detect restenosis guides clinical decisions and defines treatment failure. Prior reports have defined DUS-based criteria for failure based on angiography as the “gold standard” however, the correlation between DUS and symptom recurrence remains unclear. Accordingly, our objective was to examine the association between determination of treatment failure by DUS and symptom recurrence after ET for claudication.

METHODS: Retrospective review of a prospectively maintained institutional database identified patients undergoing ET for lifestyle-limiting claudication. From 2007-2010, patient-reported symptoms were paired with contemporaneous post-intervention surveillance DUS. The association between systolic velocity ratio (SVR) and symptom recurrence was assessed (t-test, Receiver Operating Characteristic curve analysis) and the appropriateness of threshold values analyzed (frequency distribution, Pearson chi-square).

RESULTS: 287 patients underwent 366 interventions for claudication. 183 post-operative clinic visits had clear documentation of clinical status and concomitant DUS after interventions in the femoropopliteal (62%) or iliac (38%) arteries. After femoropopliteal intervention, SVR (mean +/- SD) was higher in patients with symptom recurrence compared to asymptomatic patients (4.50 +/- 2.85 vs 2.07 +/- 1.25; p<0.001). After femoropopliteal intervention, elevated SVR or occlusion correlated with symptom recurrence (area under ROC curve [AUC] = 0.82 [95% CI 0.74-0.89]; P < 0.0001), and SVR > 2.5 was 71% sensitive and 72% specific for symptom recurrence (Table). DUS after iliac intervention was weakly associated with recurrent claudication (AUC = 0.597).

CONCLUSIONS: After femoropopliteal ET for claudication, DUS-detected restenosis is highly associated with clinical deterioration; in the majority of patients, sustained patency is necessary to prevent recurrent claudication. These findings not only support post-intervention surveillance DUS to identify restenosis, but also validate objective criteria for treatment failure with respect to patient-centered outcomes such as symptom recurrence.

<table>
<thead>
<tr>
<th>SVR</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>97.9</td>
<td>40</td>
<td>54.7</td>
<td>96.3</td>
</tr>
<tr>
<td>2</td>
<td>87.5</td>
<td>55.4</td>
<td>59.2</td>
<td>85.7</td>
</tr>
<tr>
<td>2.5</td>
<td>70.8</td>
<td>72.3</td>
<td>65.4</td>
<td>77</td>
</tr>
<tr>
<td>3</td>
<td>50</td>
<td>87.7</td>
<td>75</td>
<td>70.4</td>
</tr>
<tr>
<td>3.5</td>
<td>47.9</td>
<td>93.8</td>
<td>85.2</td>
<td>70.9</td>
</tr>
</tbody>
</table>

AUC 0.815

PPV, positive predictive value; NPV, negative predictive value
Paroxysmal nocturnal hemoglobinuria (PNH) is a rare, acquired, non-malignant disorder of hematopoetic stem cells characterized by hemolysis, diminished hematopoiesis and thrombophilia. We describe the case of a 65 year-old woman with known PNH who presented with ischemic rest pain and non-healing foot ulcers. This case highlights four key concepts relevant to managing surgical patients with PNH: 1. predisposition for arterial and venous thromboses; 2. hypercoagulability despite standard anti-coagulation regimens; 3. role of eculizumab (a monoclonal antibody against complement protein C5) in significantly reducing thrombotic complications; and 4. complications associated with eculizumab. PNH patients with limb threatening ischemia require aggressive anticoagulation, close monitoring of hemolysis and immunosuppression, more frequent surveillance post-surgical bypass and an awareness of potential complications associated with medical management of PNH.
Introduction & Objectives: Due to the extensive dissection required during the standard transposed brachial-basilic arterial venous fistula (BB-AVF) procedure and the potential for postoperative complications, many surgeons shy away from performing BB-AVFs. Less invasive videoscopic-vein harvesting has been described with good results, but this approach remains rarely used. We present our protocol for videoscopic BB-AVF creation.

Methods: We began a videoscopic-assisted BB-AVF protocol in selected patients at our institution in 2006. Vein harvesting from the antecubital fossa to the level of the axilla is performed by an experienced surgical technician under the guidance of a dialysis access surgeon. Peri-operative data and post-operative outcomes were retrospectively reviewed after IRB approval.

Results: From 2006 to 2011, we performed videoscopic-assisted BB-AVF in 21 selected patients. Median age was 59 years and median BMI 30; women comprised 52% of the cohort. Previous vascular access procedures had been performed on 81% of patients. Of the 21 attempts with the video-assisted approach, only 1 required conversion to a standard open procedure. There were no significant intra-operative or post-operative surgical complications, median operative time was 159 minutes, and maximum length of stay was one night. Maturation sufficient for cannulation and use occurred in 80% of patients, with the median time to first access in patients who matured being 60 days. At 3 years follow up, 47% of fistulas that matured were still functional, with 33% lost to death or successful renal transplantation.

Conclusions: Videoscopic assisted transposition of the basilic vein is a reasonable option for BB-AVF placement. The procedure can be performed in an acceptably expeditious fashion with near elimination of infection, wound breakdown, lymph drainage and nerve injury and satisfactory maturation (80%) and patency rates. Technicians experienced in lower extremity vein harvest can perform this procedure successfully and assist the surgeon during the procedure.
8:20 am – 8:30 am  7 (CR)  
**IVUS As A Novel Tool For the Diagnosis of Endofibrosis**  
Danielle Campbell*, Katherine A Gallagher, Shipra Arya*, Tina Chen*, Dawn Coleman, Peter Henke, Jon L Eliason, John Rectenwald  - University of Michigan, Ann Arbor, MI

**Objectives:** Endofibrosis involves hypertrophy of the iliac vessels in endurance athletes and results in claudication with exercise. Given the rise of high-intensity sport athletes and the paucity of literature on endofibrosis, we describe a novel adjunctive technique to aid in diagnosis.

**Methods:** A 41 yo female triathlete presents exercise-limiting claudication. Her work-up for chronic compartment syndrome was negative. She had palpable pedal pulses on exam. ABI’s were 1.0 bilaterally but decreased to .66 on the left at 1 min (10% incline/8mph). Lower extremity MRA was performed to evaluate for cystic adventitial disease (CAM) involving the popliteal/femoral vessels and this was negative. Provocative non-invasive testing with dorsiflexion and knee hyperextension that was negative. An angiogram was performed which suggested mild narrowing of the left external iliac artery. A drop in pressure across the subtle stenosis could not be obtained with papaverine. (Figure 1A) IVUS was used across the area of interest to determine if there was disease present. IVUS delineated a abnormal segment of proximal external iliac artery with medial hypertrophy. (Figure 1B) The patient underwent left external iliac replacement with a reversed saphenous interposition graft via a retroperitoneal approach without complication.

**Results:** Post-operative duplex demonstrated a patent bypass with no elevated velocities. Pathology demonstrated circumferential subendothelial fibrosis consistent with endofibrosis. (Figure 1C,D)

**Conclusions:** Endofibrosis is an uncommon disease and there is little literature describing optimal methods for diagnosis. Findings of endofibrosis on angiogram are subtle and easily missed. Creation of pressure gradients across suspected lesions with administration of vasodilators is inconsistent and not reliable in this group of athletes. IVUS provides a definitive diagnostic modality allowing for proper planning and operative treatment of these patients.
Full Program & Abstracts

Figure 1.
A.

B.

C.

D.
Post-Discharge Care Matters: The Relationship Between Quality of Diabetic Care, Readmission and Survival For Lower Extremity Revascularization
Benjamin S Brooke*, Randall R DeMartino*, Kristina A Giles*, Richard J Powell, David H Stone, Brian W Nolan, Philip P Goodney - Dartmouth-Hitchcock Medical Center, Lebanon, NH

Introduction & Objectives: While quality improvement initiatives have placed considerable emphasis on the in-hospital management of diabetes, the effect of variation in the quality of diabetic care on post-discharge outcomes remains uncertain. We examined relationships between outpatient quality of diabetic care, readmission rates, and one-year survival following lower extremity revascularization.

Methods: We studied Medicare diabetics with critical limb ischemia (CLI) undergoing open and endovascular lower extremity revascularization (2004-2007), linked to HEDIS diabetic care quality measures (annual serum cholesterol and HgA1C). We divided all 306 U.S. hospital referral regions into quartiles, based on the region’s quality of diabetic care. We then used regression models to examine the associations between quality of diabetic care, readmission, and survival.

Results: Overall, 84,653 diabetic patients (52% male, 15% black, mean age 76 years) with CLI underwent revascularization between 2004 and 2007. Annual rates of diabetic testing varied from 59% in low quality regions to 86% in high-intensity regions (p<0.001). Patients in regions with high-quality diabetic care were significantly less likely to be readmitted within 30-days (20.6% low vs. 22.5% high; P<0.001) or 1-year (61.9% low vs. 64.4% high; P<0.001). One-year survival was improved in regions with high-quality diabetic care (Figure, 84.5% in high-quality regions, log-rank <0.001). Even after adjusting for differences in gender, age, race, and comorbidities, patients in regions with high-quality diabetic care were 7% less likely to be readmitted (OR:0.93;95%CI:0.88-0.98;P<0.05) and 11% (OR:0.89;95%CI:0.83-0.96;P<0.05) decreased 1-year mortality following their revascularization procedure.

Conclusions: Vigilant diabetic care was associated with decreased readmission rates and 1-year mortality. This data support the value of intensive diabetic care and may serve as an important quality improvement initiative for vascular surgery.
Surgical Complications of Radial Artery Catheterization
Karan Garg, Brittny S Williams-Howell, Stephanie Saltzberg, David Dexter, Todd L. Berland, Thomas S Maldonado, Caron B Rockman - NYU Langone Medical Center, New York, NY

Introduction: Cannulation of the radial artery is frequently performed for invasive hemodynamic monitoring, and now increasingly as access for coronary interventions. Complications arising from cannulating the radial artery are well described and can be broadly divided into ischemic and infections. However, their surgical management is not well reported. We reviewed our institutional experience in treating this clinical entity and propose an algorithm for managing such complications.

Methods: We conducted a retrospective review to identify patients who underwent surgical intervention for complications from radial artery cannulations from 1997 to 2011.

Results: We identified 31 patients who underwent interventions - 16 patients for ischemia and 15 with infections (3 for arterial thrombosis with abscess, 10 with pseudoaneurysms, and 2 with abscesses alone). Three patients required reinterventions; all in individuals initially presenting with ischemia developed recurrent thrombosis. There were no amputations in this series. The mortality in these series was 38.7%, none related to surgery itself, reflecting the severity of illness in this patient cohort.

Conclusion: Complications of radial artery cannulation are uncommon, however, not entirely inconsequential. These complications arise in a sicker cohort of patients with a high overall mortality, so the patient’s clinical presentation should ultimately drive goals of care. Unstable patients may be best served with damage control. While majority of patients will tolerate sacrifice of the radial artery, the challenge lies in identifying those who will not. Therefore, intervention should aim to restore blood flow when feasible. In the presence of infection and sepsis, source control supersedes revascularization and may involve debridement/drainage along with intravenous antibiotics. Patients whose radial artery is sacrificed should be monitored closely for development of ischemia.

<table>
<thead>
<tr>
<th>Table 1. Non-Ischemic Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Presentation (N)</td>
</tr>
<tr>
<td>Pseudoaneurysms (8)</td>
</tr>
<tr>
<td>Ruptured pseudoaneurysms (2)</td>
</tr>
<tr>
<td>Thrombosis with abscess (3)</td>
</tr>
<tr>
<td>Abscess (2)</td>
</tr>
<tr>
<td>I&amp;D Incision and Drainage</td>
</tr>
</tbody>
</table>
Introduction & Objectives: To evaluate the incidence, epidemiology, and contributing factors of post-operative surgical site complications following vascular operations involving femoral artery exposure.

Methods: Retrospective cohort study of 118 patients who underwent femoral endarterectomy or extra-anatomic bypass at a tertiary referral hospital. Primary outcome was surgical site complications (infection, hematoma or seroma). Length of stay, reoperation, discharge disposition, and 30-day mortality were evaluated. Independent variables included patient demographics and operative variables (procedure type, transfusion, preoperative antibiotics, intraoperative vasopressors). Statistical analysis included log-rank testing and Wilcoxon models.

Results: Of the 118 patients who underwent femoral artery surgery, 28 (23.7%) developed surgical site complications; 61.9% were male, mean age was 62.4 years, 92.4% had elective procedures, and 5.9% had prior surgery at the surgical site. Comorbidities included hypertension (90.0%), dyslipidemia (62.7%), coronary artery disease (39.8%), and diabetes (23.7%). Most patients were smokers (47.5% active smokers and 32.2% former smokers). Procedures performed included femoral endarterectomy (56.8%) and extra-anatomic bypass (43.2%). Preoperative antibiotics, administered to 97.5%, included cefazolin (75%), clindamycin (15.3%) or vancomycin (3.4%). Mean length of hospital stay was 10.7 days (SD 8.5, range 1-43). The overall 30 day reoperation rate was 17.8% and 30 day mortality was 11%. Intraoperative vasopressors were administered to 48.3%. 23.7% required blood transfusion, mean 3 units (SD 2.3, range 1-12). Tissue flaps were raised in 5.1%. Factors significantly associated with surgical site infection or complications were advanced age, use of intraoperative vasopressors and use of statins use.

Conclusions: The overall incidence of surgical site infections or complications following vascular groin procedures is 23.7%, and significantly associated with the use of intraoperative vasopressors, advanced age, and statin usage. The use of intraoperative vasopressors is a modifiable perioperative factor that is associated with surgical site infections, and further studies of this relationship are warranted.
Full Program & Abstracts

4:00 pm – 6:00 pm  SCIENTIFIC SESSION II
Moderator: Jean Bismuth, MD

4:00 pm – 4:15 pm  11
Open Mesenteric Interventions Are Equally Safe As
Endovascular Interventions and Offer Better Long-Term
Patency
Shipra Arya, Stephanie Kingman*, Jordan Knepper, Jonathan L
Eliason, Peter K Henke, John E Rectenwald - University of
Michigan, Ann Arbor, MI

Introduction: Endovascular techniques have been recently advocated as the preferred method for mesenteric interventions. This study compares our experience with treatment of mesenteric ischemia using endovascular and open techniques.

Methods: The medical records of open and endovascular mesenteric procedures performed at a single center were queried from 2002-2012. Demographic, peri-operative and follow-up data were extracted and analyzed.

Results: Thirty-eight patients underwent endovascular mesenteric interventions while 77 patients underwent open revascularization. The demographic and peri-operative characteristics for patients were similar (Table 1). Majority of the endovascular procedures (89.2%) comprised stenting while open procedures included 25 (32.1%) antegrade bypasses, 38 (48.7%) retrograde bypasses, 8 (10.3%) thromboembolectomies, 7 (9%) transaortic endarterectomies. Postoperative complications, overall 30-day morbidity and mortality were not significantly different in the open and endovascular groups for acute (AMI) or chronic mesenteric ischemia (CMI). Thirty-day mortality in AMI (N=34) was 38.2% (Endovascular: 45.5% vs open 34.8%; p-value=NS). There was no 30-day mortality in either group for CMI patients. Mean follow-up was much longer for the open procedures (34.9 vs 12.7 months, p=0.004). Primary and secondary patencies were better for open revascularization for CMI patients (Figure 1).

Conclusion: Open revascularizations are equally safe as endovascular interventions in similar patient populations for acute and chronic mesenteric ischemia. Patency of open revascularization for CMI is better than endovascular procedures.
Table 1. Demographic and peri-operative variables for mesenteric interventions.

<table>
<thead>
<tr>
<th>Variable</th>
<th>All (N=115)</th>
<th>Endovascular (N=38)</th>
<th>Open (N=77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>64.0 +/- 1.6</td>
<td>68.9 +/- 2.0</td>
<td>61.6 +/- 2.1*</td>
</tr>
<tr>
<td>Body mass index (BMI) in kg/m²</td>
<td>24.0 +/- 0.6</td>
<td>25.1 +/- 1.2</td>
<td>23.3 +/- 0.7</td>
</tr>
<tr>
<td>Active smokers</td>
<td>52 (46.9%)</td>
<td>13 (32.4%)</td>
<td>39 (54.1%)</td>
</tr>
<tr>
<td>Coronary artery disease (CAD)</td>
<td>51 (45.1%)</td>
<td>18 (48.7%)</td>
<td>33 (43.4%)</td>
</tr>
<tr>
<td>Congestive heart failure (CHF)</td>
<td>15 (13.4%)</td>
<td>7 (18.9%)</td>
<td>8 (10.7%)</td>
</tr>
<tr>
<td>Chronic renal insufficiency (CRI)</td>
<td>17 (15.0%)</td>
<td>8 (21.6%)</td>
<td>9 (11.8%)</td>
</tr>
<tr>
<td>COPD</td>
<td>36 (31.9%)</td>
<td>10 (27.0%)</td>
<td>26 (34.2%)</td>
</tr>
<tr>
<td>ASA class&gt; 3</td>
<td>39 (38.2%)</td>
<td>16 (43.2%)</td>
<td>23 (35.4%)</td>
</tr>
<tr>
<td>Prior interventions</td>
<td>34 (29.6%)</td>
<td>8 (21.6%)</td>
<td>26 (33.3%)</td>
</tr>
<tr>
<td>Indication- CMI</td>
<td>81 (70.4%)</td>
<td>26 (68.4%)</td>
<td>55 (71.4%)</td>
</tr>
<tr>
<td>Emergency cases</td>
<td>30 (26.1%)</td>
<td>10 (27.0%)</td>
<td>20 (25.6%)</td>
</tr>
<tr>
<td>Presence of ischemic bowel</td>
<td>11 (9.6%)</td>
<td>3 (8.1%)</td>
<td>8 (10.3%)</td>
</tr>
<tr>
<td>Mesenteric territory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celiac artery</td>
<td>13 (11.3%)</td>
<td>6 (16.2%)</td>
<td>7 (9.0%)</td>
</tr>
<tr>
<td>Superior mesenteric artery (SMA)</td>
<td>63 (54.8%)</td>
<td>26 (70.3%)</td>
<td>37 (47.4%)</td>
</tr>
<tr>
<td>Multiple arterial territories</td>
<td>35 (30.4%)</td>
<td>3 (8.1%)</td>
<td>32 (41.0%)</td>
</tr>
</tbody>
</table>

*p<0.05 (comparison for endovascular and open group)  
COPD: Chronic obstructive pulmonary disease, ASA: American Society of Anesthesiologists,  
AMI: Acute mesenteric Ischemia, CMI: Chronic mesenteric ischemia.
Full Program & Abstracts

Figure 1: Primary and secondary patency of open and endovascular interventions for chronic mesenteric ischemia (CMI).
Preliminary Experiences With Early Primary Closure of Foot Wounds Following Lower Extremity Revascularization
Neal R Barshes, Carlos F. Bechara, George Pisimisis, Panos Kougias - Baylor College of Medicine, Houston, TX

INTRODUCTION AND OBJECTIVES: The annual costs associated with local wound care averages $20,000, and previous work has suggested that early closure of foot wounds can be a source of cost-savings following revascularization for limb salvage. We sought to determine the safety and effectiveness of attempts to primarily close chronic foot wounds early after revascularization.

Methods: We reviewed the outcomes of patients in whom primary wound closure was attempted during the same hospitalization in which a successful limb revascularization (surgical bypass or endovascular intervention) was performed during the study period between August 2010 and August 2011.

Results: Seven patients underwent an attempt at early primary wound closure during the study period (Table 1). Five patients were diabetic, and six had been treated for active infection of the wound at some point prior to revascularization. Wounds were primarily closed at a median of 6 days (range, 3-8 days) following revascularization. Wound closure techniques included the use of toe/forefoot amputations (n=5), skin grafting (n=1), and pedicled rotational toe flaps (n=2) [see examples, Figure 1]. Three remained completely healed. Three remained partially healed, each with small residual open wounds that remained uninfected. One patient underwent above-knee amputation six weeks after revascularization.

Conclusions: An attempt to achieve primary wound closure early after revascularization appears safe and may be effective in reducing post-operative wound care needs and costs.
Full Program & Abstracts
Full Program & Abstracts
### Full Program & Abstracts

**Table 1: Patient characteristics, management and outcome.**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age and Gender</th>
<th>Diabetes</th>
<th>Initial Foot Wound</th>
<th>Revascularization</th>
<th>Debridement &amp; Closure (no. stages)</th>
<th>Interval between revascularization and primary closure attempt, days</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>M 55</td>
<td>No</td>
<td>Non-healing 1st toe ulcer amputation site</td>
<td>Femoral to anterior tibial artery bypass using greater saphenous vein (GSV)</td>
<td>Completion of first toe amputation (one stage)</td>
<td>6</td>
<td>Completely healed, alive</td>
</tr>
<tr>
<td>Patient 2</td>
<td>M 73</td>
<td>Yes</td>
<td>Abscess overlying metatarsal heads 3-5</td>
<td>Femoral artery reconstruction, Femoral to below-knee artery bypass using GSV</td>
<td>Completion of transmetatarsal amputation with pedicled rotational flap closure (one stage)</td>
<td>6</td>
<td>Partially healed, alive</td>
</tr>
<tr>
<td>Patient 3</td>
<td>M 68</td>
<td>Yes</td>
<td>Infected medial heel ulcer Non-healing 1st toe ulcer</td>
<td>Femoral to dorsalis pedis artery bypass using GSV</td>
<td>First toe amputation, skin grafting of ulcer (one stage)</td>
<td>8</td>
<td>Completely healed, alive</td>
</tr>
<tr>
<td>Patient 4</td>
<td>M 62</td>
<td>Yes</td>
<td>Abscess overlying 4th metatarsal head</td>
<td>Popliteal to dorsalis pedis artery bypass using lesser saphenous vein</td>
<td>Completion of 5th toe amputation</td>
<td>4</td>
<td>Partially healed, alive</td>
</tr>
<tr>
<td>Patient 5</td>
<td>M 60</td>
<td>Yes</td>
<td>Planter foot ulcer Abscess on ulcer puncture wound</td>
<td>Percutaneous balloon angioplasty of posterior tibial artery</td>
<td>Foot debridement, amputation of 2nd &amp; 3rd toes</td>
<td>3</td>
<td>Partially healed, alive</td>
</tr>
<tr>
<td>Patient 6</td>
<td>M 66</td>
<td>No</td>
<td>Abscess overlying 4th metatarsal head</td>
<td>Femoral to tibial posterior tibial artery bypass using GSV</td>
<td>Completion of transmetatarsal amputation with pedicled rotational flap closure (one stage)</td>
<td>7</td>
<td>Above-knee amputation, alive</td>
</tr>
<tr>
<td>Patient 7</td>
<td>M 55</td>
<td>Yes</td>
<td>Non-healing 1st toe ulcer with osteomyelitis</td>
<td>Femoral to posterior tibial artery bypass using GSV</td>
<td>1st toe amputation (one stage)</td>
<td>3</td>
<td>Completely healed, alive</td>
</tr>
</tbody>
</table>
Full Program & Abstracts

4:30 pm – 4:45 pm

Do PSVR Ratios Correlate With ABI Value and Symptoms After SFA Intervention? Lessons From the VIBRANT Trial

Patrick Geraghty¹, Mark W. Mewissen²*, Gary M Ansel³*, Michael R Jaff⁴* - ¹Washington University Medical School, Saint Louis, MO; ²St. Luke’s Hospital, Milwaukee, WI; ³Riverside Methodist Hospital, Columbus, OH; ⁴Harvard Medical School, Massachusetts General Hospital, Boston, MA

Introduction & Objectives: Following superficial femoral artery implantation, nitinol stents (NS) develop diffuse in-stent restenosis, whereas stent-grafts (SG) develop focal edge stenoses. Sonographic restenosis is currently characterized by elevated peak systolic velocity ratio (PSVR) within the treated segment. Given the different patterns of restenosis between devices, we interrogated the VIBRANT trial database to evaluate whether increasing PSVRs within NS and SG accurately correlate with ankle-brachial index (ABI) and patient-reported symptoms from the Intermittent Claudication Questionnaire (ICQ).

Methods: The multicenter VIBRANT trial randomized participants with complex SFA disease to NS implantation (n=76) or SG implantation (n=72). PSVR within treated arterial segment, ABI, and ICQ scores (ICQ range: 0=best, 100=worst) were collected at 1, 6, 12, 24, and 36 months post procedure. All complete patient follow-up visits were included. We grouped PSVR values into three categories (PSVR <2.0, 2.0-3.0, or >3.0). Within each ascending PSVR category, we analyzed differences in ABI and ICQ scores between study arms.

Results: No significant differences in ABI or ICQ score were noted between study arms for participants with PSVR<2.0 or PSVR 2.0-3.0. However, NS recipients with PSVR>3.0 experienced a significant decline in ABI in comparison to those receiving SG (Table), and a trend toward worsening (increased) ICQ scores, 20 ± 19.3 for SG versus 33 ± 20.8 for NS.

Conclusions: As PSVRs increase above 3.0, ABI values and quality of life scores worsen in NS recipients, but remain stable in SG recipients. PSVRs accurately characterize the worst focal stenosis within a treated arterial segment, but fail to accurately quantify the hemodynamic and symptomatic impairment caused by long-segment disease that may accompany focal stenosis, as in the case of failing NS.
# Full Program & Abstracts

## PSVR Effect on ABI Values

<table>
<thead>
<tr>
<th></th>
<th>Viabahn</th>
<th>Nitinol Stent</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSVR &lt; 2.0</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>139</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>ABI (StDev)</td>
<td>0.99 (0.13)</td>
<td>1.00 (0.15)</td>
<td>0.379</td>
</tr>
<tr>
<td><strong>PSVR 2.0-3.0</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>29</td>
<td>25</td>
<td></td>
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<tr>
<td>ABI (StDev)</td>
<td>0.96 (0.11)</td>
<td>0.94 (0.150)</td>
<td>0.690</td>
</tr>
<tr>
<td><strong>PSVR &gt; 3.0</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>ABI (StDev)</td>
<td>0.94 (0.15)</td>
<td>0.79 (0.210)</td>
<td>0.005</td>
</tr>
</tbody>
</table>
Full Program & Abstracts

4:45 pm – 5:00 pm  14

Retrograde Popliteal Access Is Safe and Effective - It Should Be Added To the Vascular Surgeon’s Portfolio


Introduction & Objectives: The aim of the study is to review the outcomes of superficial femoral artery (SFA) interventions with retrograde popliteal access approach after failed antegrade recanalization.

Methods: A database of patients undergoing endovascular treatment of the SFA between 2008-2011 was retrospectively queried, and those with transpopliteal artery retrograde access were analyzed. Outcomes were determined by Kaplan-Meier survival analyses, and the Cox proportional hazard model was used for time-dependent variables.

Results: Total of sixteen patients (75% men; mean age 61 ± 9 years) underwent retrograde popliteal access after failed antegrade attempts. Patients had the multiple CV co-morbidities with a modified cardiac index was 3 ± 1.9. The reason for intervention was claudication in 81% cases and tissue loss in the remainder. Retrograde ultrasound guided puncture of the popliteal artery was successful in all of cases. Recanalization was successful in 88% cases. One uncomplicated perforation (7%) was encountered during attempted recannulization. There was no perioperative morbidity or 30 days mortality. The MACE, MALE and 30day amp rate were 0%. On long term follow up 14% of patients developed restenosis and 7% occlusion. The primary patency was 66±9%, assisted patency 81±9% and secondary patency 87±8% at 2years. 94% of patients reported improvement of symptoms. Limb salvage was 100% with 14% of patient requiring either a digit or transmetatarsal amputation.

Conclusions: For failure of antegrade recanalization of SFA occlusions, the retrograde popliteal access is a safe and successful technique with good long term results.
Supervised Exercise Programme Improves Aerobic Fitness In Patients Awaiting Abdominal Aortic Aneurysm Repair
Hashem Barakat*, Yousef Shahin, Peter McCollum, Ian Chetter - Academic Vascular Surgical Unit. Hull York Medical School, Hull, United Kingdom

Introduction & Objectives: Aerobic fitness is an important predictor of postoperative outcomes in major surgery. In this study we aimed to assess the effect of a period of preoperative exercise on aerobic fitness as measured by Cardiopulmonary exercise testing (CPET) in patients scheduled for AAA repair.

Methods: Patients listed for AAA repair were enrolled in a supervised exercise programme of 4 week duration. Treadmill CPET parameters were measured before and after the period of exercise preoperatively. CPET parameters measured were: peak oxygen uptake (VO2 max), anaerobic threshold (AT), and ventilator equivalents for oxygen and carbon dioxide (VE/VO2 and VE/VCO2 respectively). Total exercise time and the time at which AT was achieved were also recorded.

Results: Some 16 patients with AAA (13 men, mean age 75.7 +/- 4.8) were included in this study.

50% had a past history of ischaemic heart disease, 25% of obstructive airway disease and 19% had cerebral vascular events. 69% were previous smokers, 19% are current smokers and 12% never smoked. 94% of patients were on both Aspirin and Statins.

Median (IQR) VO2 max at baseline was 18.1 (14.9-19.9) ml/kg/min, and after exercise 20.0 (17.3-22.4) (p=.002). Median AT at baseline was 11.65 (9.9-12.8), and 12.57 (11.6-14.3) after exercise (p=.02). Time of exercise tolerated also improved from a median of 419 seconds to 603 seconds (p=.003). No significant changes were seen in ventilator equivalents of Oxygen (VE/VO2), carbon dioxide (VE/VCO2) or the time at which AT was achieved.

Conclusions: This study shows that cardiopulmonary aerobic fitness improves after a period of supervised exercise programme in patients scheduled for AAA repair. This is justification for a randomised trial to assess whether this affects morbidity and mortality following AAA repair.
Introduction & Objectives: Translumbar access may be utilized for the treatment of Type-2 endoleaks (T2E) in expanding aneurysms following endovascular aortic aneurysm repair. This study sought to assess the safety and efficacy of the Artis-Zeego iGuide program for performing translumbar embolization of T2Es.

Methods: This was a retrospective review of consecutive patients treated for T2Es using the iGuide program from 6/2011-8/2012. Non-contrast rotational imaging was performed using the Zeego system, and the image was aligned with the preoperative contrast image using bony landmarks. The iGuide program was used to generate a digital line that originated at the patient’s skin and terminated within the nidus of the endoleak (Figure). The translumbar needle was directed into the endoleak using the pathway generated by the iGuide program. Treatment was performed at the discretion of the operator, typically n-butyl cyanoacrylate (nBCA) glue (2.5-3:1 oil:glue) ± coils.

Results: Ten patients were evaluated with an average follow-up of 68 days (range 1-249 days). The average age was 79.0±9.5 years (70% male). The approach was from the left side in 90% of patients. Technical success was achieved in 100% of cases, and there were no procedure related complications. Operating room time averaged 43.2±12.8 min (range 24-61 min). Fluoroscopy time averaged 5.5±4.9 min (range 1.6-13.2 min), and the average amount of contrast used was 13.1±10.2 mL (range 9-30 mL). All of the patients were treated using glue embolization, and one patient also underwent coil embolization. The amount of glue mixture utilized averaged 4.7±0.7 mL. The aneurysm sacs remained stable in size on follow-up.

Conclusions: This study suggests that the Artis-Zeego iGuide program is a useful adjunct for the treatment of T2Es. It allows for rapid and safe access using the translumbar approach.
Full Program & Abstracts
Pulmonary Emboli and Internal Jugular Vein Aneurysm In A Patient With Neurofibromatosis 1
Brian Santin, Sara McKeever*, Chris Paprzycki*, Matt Recht* - Good Samaritan Hospital, Cincinnati, OH

Introduction and Objectives: Neurofibromatosis Type 1 (NF1), also known as von Recklinghausen disease, is an autosomal dominant condition characterized by proliferation of neural crest cell elements, such as neurofibromas and café au lait spots. Venous malformations, specifically those of the internal jugular vein are extremely rare and have only been reported in three patients. We present a case of a large, 6.5cm fusiform aneurysm of the right internal jugular vein in a NF1.

Methods: The patient who presented with bilateral pulmonary emboli (PE). The patient had a history significant for two previous neck dissections for neurofibromal removal twenty years prior and presented with a two week onset of an enlarging neck mass. Imaging of the mass consisted of both a CT of the neck and MRA as well as duplex ultrasound.

Results: The right internal jugular vein was ligated both proximally and distally to the aneurysm and was subsequently evacuated and over sewn. The estimated blood loss for the procedure was less than 50ml. The vein wall histology demonstrated inflammation of the adventitia. Postoperatively the patient had an uneventful recovery and was therapeutically anticoagulated secondary to the PE.

Conclusions: Internal jugular vein aneurysms are extremely rare and have universally been treated by ligation. Due to an increased incidence of severe bleeding caused by vessel friability, great care must be taken to avoid entering the aneurysm sack prior to ligation.
Heparin Bonding Does Not Improve Patency of PTFE Arteriovenous Grafts
Matthew T Allemang**, Brian Schmotzer**, Virginia L. Wong*, Alex Chang**, Ryan Lakin**, Kenneth Woodside*, John Wang**, Vikram S. Kashyap - **University Hospitals Case Medical Center, Cleveland, OH; *Case Western Reserve University, Cleveland, OH

Introduction & Objectives: To compare the patency of arteriovenous grafts (AVG) for dialysis access with and without heparin bonding in a tertiary care setting.

Methods: Records of patients who had a AVGs placed from January 2008 until June 2011 were retrospectively reviewed. Outcomes were assisted primary patency and secondary patency. Marginal survival models (to account for correlation of accesses within subjects) utilizing Cox proportional hazard regression were used for statistical comparisons.

Results: A total of 223 patients with 265 Grafts. Of these 62 (23%) were heparin bonded. The average age was 65.9 ± 15.3 for heparin and 59.2 ± 16.7 for control (p<0.01). Of the heparin group, 39% were male, 81% were black, 63% were diabetic, and 81% had a tunneled catheter at the time of access placement. Of the control group, 35% were male, 85% were black, 56% were diabetic, and 83% had a tunneled catheter. Heparin bonded grafts were no different in either assisted primary or secondary patency (HR: 1.39 CI: (0.98, 1.96) and HR: 1.20 CI: (0.73, 1.96) respectively). Kaplan-Meier estimates for secondary patency are shown in the Figure. There was no significant difference in the number of interventions (p>0.30). To correct for inequalities, a multivariable model including age, diabetes, PVD, ever used tobacco, previous access placement, and tunneled catheter found HR for heparin bonded grafts was again not significantly different than standard grafts in either assisted primary patency or secondary patency (HR: 1.35 CI: (0.91, 1.99) and HR: 1.15 CI: (0.62, 2.16) respectively).

Conclusions: In this retrospective review, heparin bonded grafts did no better in long-term patency or number of interventions. Prospective studies are needed to confirm these results.
Full Program & Abstracts
Is There Benefit To Universal Carotid Artery Duplex Screening Prior To Cardiac Surgery?
Brian C Adams*, Ross M Clark*, James M Goff, Jr.1,2.
1University of New Mexico School of Medicine, Albuquerque, NM; 2Raymond G. Murphy VA Medical Center and the University of New Mexico School of Medicine, Albuquerque, NM

Introduction & Objectives: Perioperative stroke is a devastating complication following cardiac surgery. To avoid this complication, cardiac surgeons routinely order carotid duplex studies prior to cardiac surgery to assess for significant carotid stenosis. We hypothesize that the routine screening of preoperative cardiac surgery patients with carotid duplex detects few patients who require carotid intervention or reliably predicts stroke risk from the carotid artery bifurcation following cardiac surgery.

Methods: A retrospective review identified 394 patients who underwent cardiac surgical procedures from January 2007 to September 2010. Data collected included patient demographics, comorbidities, history of prior stroke, preoperative carotid duplex results, location of post-operative stroke, and carotid endarterectomy prior to, in conjunction with, or after cardiac surgery. Statistical methods included univariate and Chi square analysis.

Results: Eleven perioperative strokes were identified (2.8%) and 3 patients (0.76%) underwent carotid endarterectomy prior to or in conjunction with cardiac surgery. In the 10 post-operative stroke patients for whom there is complete carotid duplex data, no significant carotid stenosis (>70%) was detected preoperatively. Post-operative strokes occurred in the anterior cerebral circulation (55%), posterior cerebral circulation (27%), or both (18%). Two patients underwent carotid endarterectomy (0.51%) following cardiac surgery. No patient comorbidities, preoperative carotid duplex screening velocities, or type of cardiac surgical procedure was predicative for stroke.

Conclusions: Routine carotid duplex screening detects few patients who benefit from carotid endarterectomy prior to or in conjunction with cardiac surgery. The vast majority of post-operative strokes following cardiac surgery are not related to extracranial carotid artery disease and they are not detected by preoperative carotid duplex screening. Universal carotid duplex screening cannot be recommended and a selective approach should be adopted.
Saturday, February 2, 2013

6:00 am – 7:00 am  Continental Breakfast

6:00 am – 9:30 am  Registration

7:00 am – 9:00 am  SCIENTIFIC SESSION III
Moderators: W. Darrin Clouse, MD & Ravi Rajani, MD

7:00 am – 7:15 am  The Impact of Gender On Angioplasty and Primary Stenting For Femoropopliteal Occlusive Disease: Results of the DURABILITY II Trial
Rami O Tadros1, Peter L. Faries1, Krishna J Rocha-Singh2, Sungyup Kim*1, Victoria Teodorescu1, Sharif H Ellozy1, Michael L Marin1, Ageliki G Vouyouka1 - 1The Mount Sinai Medical Center, New York, NY; 2St. John’s Hospital, Springfield, IL

Introduction & Objectives: This study investigates the impact of gender on angioplasty and primary stenting for the treatment of claudicants with femoropopliteal occlusive disease (FPOD).

Methods: The 287 patients enrolled in the DURABILITY II trial (a prospective, non-randomized, core lab audited, and independently adjudicated investigational device exemption (IDE) trial) were stratified by gender (190 Men and 97 Women) and reviewed.

Results: Women presented with FPOD at an older age than men (71.3±11.2 vs. 65.9±9.9 years, p<0.001, Table). Men were more likely to be hyperlipidemic (89.5% vs. 79.4%, p=0.030). No other statistically significant differences were observed in peri-procedural comorbidities and demographics. Clinically, women presented more often with severe claudication (64.9% vs. 51.1%, p=0.033) as compared with men that exhibited more moderate claudication (44.2% vs. 29.9%, p=0.022). The incidence of rest pain and tissue loss was low and did not vary between genders. Angiographically, women had smaller reference vessels (4.4±0.8 mm vs. 5.0±0.9 mm, p<0.001). Longer lesion lengths (91.6±46.8 mm vs. 87.8±43.9 mm) and higher primary (79.0% vs. 76.5%), primary assisted (90.6% vs. 85.1%), and secondary patency (90.6% vs. 85.7%) rates in women did not achieve statistical significance (Graph, p=NS). Mean percent stenosis and occlusion rates were similar between groups, but men were more likely to have severe calcification (47.9% vs. 34.0%, p=0.020). TASC II classifications were similar between groups. The target lesion revascularization (TLR), major adverse event (MAE), and mortality rates were similar between groups.

Conclusions: Despite presenting with FPOD at a later age, with more severe claudication and smaller vessels than men, women achieved equal patency rates utilizing angioplasty and primary stenting with similar TLR, MAE, and mortality rates.
## Table: Summary of Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Men (N=190)</th>
<th>Women (N=97)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at presentation</td>
<td>65.9±9.9 years</td>
<td>71.3±11.2 years</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>89.5%</td>
<td>79.4%</td>
<td>0.030</td>
</tr>
<tr>
<td>Moderate Claudication, Rutherford class 2</td>
<td>44.2%</td>
<td>29.9%</td>
<td>0.022</td>
</tr>
<tr>
<td>Severe Claudication, Rutherford class 3</td>
<td>51.1%</td>
<td>64.9%</td>
<td>0.033</td>
</tr>
<tr>
<td>Ischemic rest pain, Rutherford class 4</td>
<td>4.2%</td>
<td>5.2%</td>
<td>NS</td>
</tr>
<tr>
<td>Minor tissue loss, Rutherford class 5</td>
<td>0.5%</td>
<td>0.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Reference vessel diameter</td>
<td>5.0±0.9mm</td>
<td>4.4±0.8mm</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Lesion length</td>
<td>87.8±43.9mm</td>
<td>91.6±46.8mm</td>
<td>NS</td>
</tr>
<tr>
<td>Mean percent stenosis</td>
<td>85.5%±16.2%</td>
<td>86.2%±16.2%</td>
<td>NS</td>
</tr>
<tr>
<td>Total Occlusions</td>
<td>46.8%</td>
<td>50.5%</td>
<td>NS</td>
</tr>
<tr>
<td>Severe Calcification</td>
<td>47.9%</td>
<td>34.0%</td>
<td>0.020</td>
</tr>
<tr>
<td>Primary patency (12 month)</td>
<td>76.5%</td>
<td>79.0%</td>
<td>NS</td>
</tr>
<tr>
<td>Primary assisted patency (12 month)</td>
<td>85.1%</td>
<td>90.6%</td>
<td>NS</td>
</tr>
<tr>
<td>Secondary patency (12 month)</td>
<td>85.7%</td>
<td>90.6%</td>
<td>NS</td>
</tr>
<tr>
<td>Target lesion revascularization (12 month)</td>
<td>11.9%</td>
<td>18%</td>
<td>NS</td>
</tr>
<tr>
<td>Major adverse events (30 days)</td>
<td>0%</td>
<td>0%</td>
<td>NS</td>
</tr>
<tr>
<td>All-cause Mortality (30 days)</td>
<td>0%</td>
<td>0%</td>
<td>NS</td>
</tr>
</tbody>
</table>
Graph: Primary Patency at 12 Months

1 Year Primary Patency
Men: 76.5%
Women: 79.0%
P=0.95
Full Program & Abstracts

7:15 am – 7:30 am

21

Patient-Centered Outcomes and Risk-Adjusted Hospital Mortality In Major Vascular Surgery
Micah E Girotti*, Jonathan L Eliaason, Justin B Dimick*, Peter K Henke* - University of Michigan, Ann Arbor, MI

Introduction & Objectives: Patient-centered outcomes have captured the interest of policymakers, health services researchers, and vascular surgeons. However, it is unknown to what degree patient perception correlates with other important measures of technical quality such as risk-adjusted hospital mortality.

Methods: We used national Medicare claims data to study all patients undergoing open abdominal aortic aneurysm repair and lower extremity bypass in 2000-2008. We first assessed hospital-level performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey. These questions included patient perceptions of overall hospital ranking, likelihood of recommendation of the hospital, and quality of physician communication. We defined the best and worst hospitals as the top and bottom quartiles, respectively. Hospital performance on each of the three questions was then compared to risk-adjusted 30-day mortality rates.

Results: Significant variability existed in patient perception of overall hospital quality. In the worst group of hospitals, 60% of patients rated the hospital “9 or 10 out of 10”, compared to 77% of patients in the best hospitals (p<.001). Similarly, 62% of patients said they would “definitely recommend the hospital to family or friends” in the worst hospitals compared to 81% in the best hospitals (p<.001). Ultimately however, disparate performance on these questions provided little discrimination between hospitals with the best and worst mortality rates. Of the hospitals in the best performance group by patient surveys, 24% were in the group of worst hospitals according to rankings by mortality rates. Similarly, 27% of hospitals in the best mortality group were in the worst group by patient rankings.

Conclusions: There is significant variability in patient perceptions of hospital quality, but these variations fail to significantly correlate with measures of technical quality such as hospital mortality rates. As the focus on patient-centered outcomes increases, consideration of multiple domains of hospital quality is important.
Full Program & Abstracts

7:30 am – 7:45 am

22
Use of Anti-Xa Levels To Monitor Heparin Therapy - A Failed Trial In A Hospitalized Population
Joann M Lohr, Thomas Panke, Thomas Imhoff, Janice Miller, Angela N Fellner* - Good Samaritan Hospital, Cincinnati, OH

Introduction and Objectives: Demonstrate that Anti-Xa monitoring of hospitalized patients treated with heparin does not consistently correlate with therapeutic PTT levels.

Methods: Eighteen hospitalized patients being treated with therapeutic heparin were monitored by simultaneous Anti-Xa and PTT levels.

Results: Seventy-eight simultaneous PTT and Anti-Xa levels were analyzed. PTTs ranged from 24.9-190 (mean, 65.7). Anti-Xa levels ranged from 0.10-1.00 (mean, 0.36). Peripheral draw sites were most common (87%). Patients were classified as very sick (17%), recovering (43%) or well (blood clot only issues, 40%). Samples were spun within one hour of being drawn 97.6% of the time. PTT was therapeutic 63.4% of the time, while Anti-Xa was in therapeutic range 68% of the time. For the entire group there was a significant mismatch in therapeutic status. Non-therapeutic Anti-Xa levels were associated with therapeutic PTT levels 16.7% of the time while therapeutic Anti-Xa levels were associated with non-therapeutic PTT levels 52.1% of the time (p=.007). For mismatches by patient status, non-therapeutic Anti-Xa levels were associated with therapeutic PTT levels 14.3, 28.6 and 0% of the time in the very sick, recovering and well, respectively. Therapeutic Anti-Xa levels were associated with non-therapeutic PTT levels 83.3, 45.0 and 50.0% of the time in the very sick, recovering and well, respectively.

Conclusions: Anti-Xa level monitoring in hospitalized patients is not reliable. Patients may be over or under treated and cases of serious bleeding and PE resulted. The hospital policy of using Anti-Xa levels was discontinued after six weeks. Serious complications have been reported locally. Potential etiologies for the variations will be presented.
Outcome Predictors of Limb Salvage In Traumatic Popliteal Artery Injury
Anahita Dua*, Jaecel O Shah, Robert E Lasky, Kristofer Charlton-Ouw, Ali Azizzadeh, Anthony Estrera, Hazim J Safi, Sheila M Coogan - University of Texas-Houston, Houston, TX

Introduction & Objectives: This study aims to identify predictors of limb salvage in a civilian cohort from a level I trauma center who sustained traumatic popliteal artery injury.

Methods: A single institution, retrospective review was performed of 68 patients presenting from January 2002-June 2009 with traumatic popliteal artery injury. Data was compiled utilizing the institutional trauma registry; demographics, mechanism of injury, associated injury fasciotomy, mangled extremity severity score (MESS), and injury severity score (ISS) were documented. Statistical analysis included descriptive statistics, univariate and multivariate analysis.

Results: 70 traumatic popliteal artery injuries were identified in 68 patients. Mean age was 33 years (range, 5-88). The majority of patients were male (57, 81%) and 73% sustained blunt injury. Associated venous injury was present in 16 (23%) cases. Associated orthopedic injuries included 19 (27%) dislocations and 49 (70%) fractures. Median MESS was 5 (range, 2-9) and median ISS was 9 (range, 4-41).

Revascularization was performed in 62 cases (89%). 23% of patients developed compartment syndrome. 56% of patients underwent fasciotomy. 15 (21%) patients required amputation and of those 11% were primary and 10% secondary. Univariate analysis was calculated for each predictor variable. Four variables were significantly associated with amputation: MESS (OR=2.4, P<.0001), ISS>10 compared to ISS<9 (OR=7.4, P<.045), blunt injury (OR=10.7, P=.009), and fractures (OR=0.13, P<.045). Using multiple exact logistic regression, MESS (P<.05) was the only significant predictor of amputation. The increased odds of amputation were similar for both primary (OR=2.6, P=.001) and secondary (OR=2.4, P=.002) amputations.

Conclusions: Patients with traumatic popliteal artery injury are at high risk for amputation. Blunt injury, associated fractures, MESS and ISS >9 were significantly associated with amputation. MESS was a significant predictor of amputation and should be considered along with the clinical picture prior to revascularization attempts in these patients.
8:00 am – 8:10 am  24 (RF)
The Endovascular Management of Arterial Injuries Associated With Posterior Knee Dislocation
Zachary K. Baldwin, Rishi Roy*, Andrea Barker - University of Mississippi Medical Center, Jackson, MS

Introduction: Traumatic knee dislocations are associated with popliteal artery injury in approximately 50% of cases. Timely revascularization of the affected limb is critical, and conventional management typically involves arterial bypass. However, due to the affected patient population, these procedures are often difficult and complex secondary to difficult exposure, traumatic soft tissue injury, venous injury and vasospasm. Endovascular management of these difficult to treat injuries may be an effective and alternative method for revascularization. And yet, there are no reports in the literature of primary endovascular repair for this pathology. This report details our experience managing posterior knee dislocations treated through endovascular means.

Methods: Patients with popliteal artery injury related to traumatic knee dislocation were retrospectively evaluated. Six patients met criteria. Of the five patients who underwent revascularization, all had an initial attempt at endovascular repair. In two patients, the wire was unable to traverse the injury and the artery was subsequently found to be completely severed on open exploration. In three patients, the wire successfully traversed the injury and revascularization was performed utilizing combinations of mechanical thrombectomy, thrombolysis, angioplasty and stenting.

Results: All patients treated endovascularly were successfully revascularized. One patient required prophylactic fasciotomies at the time of revascularization. Follow-up was notable for no re-occlusions, though one patient did require angioplasty of in-stent restenosis two years after injury.

Conclusions: Management of popliteal artery injury secondary to knee dislocation can be challenging given the patient population and associated anatomy. For this reason, endovascular repair may be beneficial for early and effective revascularization. This less invasive option has the potential to minimize wound-related complications and speed recovery. Though the long-term patency of these endovascular repairs is a potential drawback, open repair remains a future option and can be performed in an optimal setting remote from the traumatic injury.
8:10 am – 8:20 am  25 (RF)
Assessment of Initial Wound Healing Following Amputations

Introduction: Amputations are common procedures in vascular surgery for which wound non-healing can lead to prolonged wound care, infections, and need for revision, often to a higher level, an outcome associated with increased mortality risk. In surgical settings, comorbid conditions such as diabetes or chronic steroid use predispose patients to wound non-healing following surgery. In this study, the association of patient characteristics and comorbidities with initial wound non-healing following amputation was investigated.

Methods: Operating room records were reviewed for lower extremity amputations on any service and for all indications between August 2007 and August 2011. Medical records, including operative notes and clinic visits, were reviewed for operative details, pre-operative infections, antibiotic use, medical comorbidities, wound healing, and need for further intervention. Analyses were performed using SPSS 20.

Results: 407 amputations were identified. At first post-operative clinic visit, 25% of amputations demonstrated non-healing. Patients with non-healing wounds were more often diabetic (p=0.06) and on hemodialysis (p=0.02), had increased duration of antibiotics (p=0.04) and more frequent interventions for infection (p<0.001). Multivariate logistic regression analysis identified dialysis dependence (p=0.005, OR 2.5) and Rutherford category 6 or grade III status (p=0.047, OR 2.6 and 0.040, 3.8) as independent predictors of wound non-healing. Factors associated with a change in level of amputation include prior outflow/runoff revascularization, pre-operative infection, increased Rutherford stage, dialysis dependence, and peripheral arterial disease. By multivariate analysis, dialysis dependence, peripheral arterial disease, age, and Rutherford class were predictive of a change in level of amputation (p<0.02 for all).

Conclusions: Our data show that among multiple risk factors examined, dialysis dependence and Rutherford classification were independent predictors of early non-healing. Although significant in this amputation population, this model will have to be validated in a larger sample. Understanding these outcomes may guide preoperative risk modification and inform shared decisionmaking by patient and surgeon.
When To Call It A Day: Incremental Risk of Amputation After Multiple Revascularization

Introduction & Objectives: Patients with Peripheral Vascular Disease often undergo revascularization prior to amputation. The exact relationship between increased procedures and increased risk of amputation is unclear. We sought to determine the increased risk of amputation for each additional revascularization.

Methods: We searched the Statewide Inpatient Databases for California (2007-2009), identifying patients who underwent one or more lower extremity angioplasty ± stent (PTA) or peripheral bypass graft (PBG) within a one-year period. We analyzed crude risk of 1-year amputation or death along with a test of deviation from linearity and multivariable-adjusted outcomes of in-hospital mortality and major amputation.

Results: Out of 5,147,981 patients, we identified 14,793 (0.2%) who underwent one or more PTA and/or PBG within a 1-year period. The mean age was 68.44. In a 1-year period, 555 (3.8%) underwent amputation and 1375 (9.3%) died. The crude risk of amputation (1 PTA: 5.3%, 2 PTA: 8.5%, 3+ PTA 11.4%; P-value: < 0.001) increased with multiple PTA. The risk increases appear to be linear (P=0.842). The risk of amputation (1 PBG : 8%, 2+ PBG: 13.1%; P-value: < 0.001) increases with multiple PBG. In a multivariate analysis, the odds of amputation significantly increased with multiple PTA (1 vs 2 PTA - OR: 1.50 (1.21-1.87) P<0.001; 1 vs 3+ PTA - OR: 1.82 (1.29-2.56) P<0.001) and multiple PBG (1 vs 2 PBG - OR: 1.62 (1.24-2.25); P=0.001).

Conclusions: The crude risk of amputation increases in a linear fashion with increasing PTA procedures. Risk adjusted odds for amputation increase with increasing revascularization procedures.
Full Program & Abstracts

8:30 am – 8:45 am

27
A Cost-Effectiveness Analysis of Revascularization For Limb Salvage Among Patients With Marginal Baseline Functional Status
Neal R. Barshes1, Panos Kougias1, C. Keith Ozaki2, George Pisimisis1, Carlos F. Bechara1, Helene K. Henson*, Michael Belkin2 - 1Baylor College of Medicine, Houston, TX; 2Brigham and Women’s Hospital, Boston, MA

Introduction & Objectives: Revascularization and limb salvage efforts are typically offered to acceptable-risk patients with good functional status. We evaluated the utility of limb salvage efforts for elderly patients with marginal baseline function through a formal cost-effectiveness analysis.

Methods: A probabilistic Markov model with deterministic sensitivity analyses was used to simulate outcomes during a 10-year period under various strategies for managing chronic limb ischemia with non-healing wounds. Clinical and functional outcomes were modeled on PREVENT III and VSGNE data that represented a patient population with limited lifespan, increased perioperative mortality and marginal functional status (see Table 1). Estimates of the total long-term direct and indirect costs (including secondary amputations, wound care, nursing home costs, etc.) were obtained from our previous single-center study. The primary endpoint was cost per year of preserving ambulatory ability (either through limb salvage or with a limb prosthesis).

Results: The total long-term costs of endovascular and surgical revascularization strategies were much lower than the costs of local wound care alone or primary amputation (see Table 2). Revascularization also produced more health benefits as measured in years of ambulation, years of limb salvage, or quality-adjusted life-years. In none of the scenarios modeled in sensitivity analyses did primary amputation prove to be more cost-effective than revascularization strategies.

Conclusions: Revascularization and limb salvage efforts may provide significant cost-savings (i.e. increased health benefits and lower total costs) when compared to local wound care alone or to primary amputation when done for patients with marginal functional status and elevated mortality risk.
# Full Program & Abstracts

Table 1: Selected clinical and functional parameters used in the model.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Surgical Bypass</th>
<th>Endovascular Intervention</th>
<th>Wound Care Only</th>
<th>Primary Amputation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual (baseline) mortality, %</td>
<td>18.0</td>
<td>18.0</td>
<td>18.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Additional perioperative mortality, %</td>
<td>5.2</td>
<td>3.9</td>
<td>0</td>
<td>7.9</td>
</tr>
<tr>
<td>Annual rate of major amputation during year 1, %</td>
<td>10.8</td>
<td>12.2</td>
<td>38.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual rate of major amputation during years 2-10, %</td>
<td>2.0</td>
<td>2.0</td>
<td>30.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual rate of wound healing, %</td>
<td>90.0</td>
<td>60.3</td>
<td>41.0</td>
<td>84.0</td>
</tr>
<tr>
<td>Rate of vascular reintervention, %</td>
<td>22.7</td>
<td>26.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proportion initially remaining ambulatory (with limb salvage or with limb prosthesis), %</td>
<td>72.1</td>
<td>72.3</td>
<td>100</td>
<td>87.9</td>
</tr>
<tr>
<td>Proportion with initial discharge to rehabilitation facility, %</td>
<td>20.6</td>
<td>20.6</td>
<td>0</td>
<td>20.6</td>
</tr>
<tr>
<td>Proportion that remain independently living, %</td>
<td>82.5</td>
<td>82.5</td>
<td>100</td>
<td>62.8</td>
</tr>
<tr>
<td>Health utility with unhealed foot wound or amputation stump</td>
<td>0.52</td>
<td>0.52</td>
<td>0.42</td>
<td>0.48</td>
</tr>
<tr>
<td>Health utility with healed foot wound or amputation stump</td>
<td>0.62</td>
<td>0.62</td>
<td>0.64</td>
<td>0.54</td>
</tr>
</tbody>
</table>

Table 2: Long-term costs and health benefits associated with various management strategies.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Median 5-year patient survival, %</th>
<th>Median 5-year limb salvage, %</th>
<th>Median Total Costs 2011 USD</th>
<th>Median Years of Ambulation</th>
<th>Median Years of Limb Preservation</th>
<th>Median Quality-adjusted Life-years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endovascular intervention; endovascular reintervention as needed</td>
<td>34.5</td>
<td>80.5</td>
<td>104,118</td>
<td>2.458</td>
<td>3.031</td>
<td>1.762</td>
</tr>
<tr>
<td>Initial endovascular revascularization; surgical bypass as needed</td>
<td>34.4</td>
<td>80.3</td>
<td>108,794</td>
<td>2.459</td>
<td>3.015</td>
<td>1.769</td>
</tr>
<tr>
<td>Initial surgical bypass; endovascular revision as needed</td>
<td>33.7</td>
<td>79.8</td>
<td>110,910</td>
<td>2.410</td>
<td>2.941</td>
<td>1.781</td>
</tr>
<tr>
<td>Surgical bypass; surgical revisions as needed</td>
<td>33.7</td>
<td>79.8</td>
<td>113,944</td>
<td>2.410</td>
<td>2.941</td>
<td>1.781</td>
</tr>
<tr>
<td>Wound care only; major amputation as needed</td>
<td>34.9</td>
<td>27.9</td>
<td>129,651</td>
<td>0.834</td>
<td>1.473</td>
<td>1.644</td>
</tr>
<tr>
<td>Primary amputation</td>
<td>33.5</td>
<td>0</td>
<td>185,955</td>
<td>1.585</td>
<td>0</td>
<td>1.520</td>
</tr>
</tbody>
</table>
Full Program & Abstracts

8:45 am – 8:55 am  28 (CR)
Re-Entry Device Aided EVAR In Patients With AAA and
Unilateral Iliac Artery Occlusion
Jason T Lee, George K. Lee, Vinit Varu*, Shu Chang* - Stanford
University Medical Center, Stanford, CA

Introduction & Objectives: We report two cases of patients undergoing EVAR utilizing re-entry devices to re-canalize unilateral iliac artery occlusions and complete a bifurcated endovascular repair.

Methods: Patient 1 was a 74-year old male with an enlarging 5.5 cm AAA and severe left leg claudication (ABI 0.4) with L common iliac occlusion. Patient 2 was a 69-year old man with an asymptomatic 6.7 cm AAA and occluded L common iliac (ABI 0.7) and minimal leg symptoms.

Results: Both patients underwent elective percutaneous EVAR along with left iliac artery revascularization. Initial angiography in both cases showed a blind ending of the left common iliac artery (FIGURE A). Retrograde sub-intimal dissection through the occluded iliac segment was attempted but in both cases the wire was unable to traverse back into the true aortic lumen (B,C). Using either the Outback LTD or Pioneer re-entry catheter, direct visualization of the true aortic lumen was obtained to re-enter the true lumen (D,E). The sub-intimal iliac tract was then pre-dilated to facilitate routine EVAR in both cases (F). Both patients were discharged the following day, and one-year follow-up imaging revealed aneurysm exclusion, no endoleak, and patent bilateral common iliac arteries with resolution of claudication symptoms and normal ABIs.

Conclusions: Management of peripheral arterial occlusions using re-entry catheters to facilitate sub-intimal angioplasty and re-canalization has been well described. To our knowledge, these are the first cases in the literature describing the use of re-entry catheters to facilitate EVAR. The ability to cross the iliac occlusions and place a bifurcated graft in these patients precluded the need for aorto-uni-iliac configuration and avoided the potential morbidity of a crossover fem-fem bypass.
Full Program & Abstracts

8:55 am – 9:05 am  Introduction of the President

9:05 am – 9:35 am  PRESIDENTIAL ADDRESS
I Have But One Candle of Life To Burn…
Ruth L. Bush, MD, MPH

12:00 pm – 1:00 pm  SKI-IN/SKI-OUT LUNCH

3:00 pm  Registration Re-Opens

3:30 pm – 4:00 pm  Coffee/Snacks
Last Chance To Visit Exhibitors
4:00 pm – 4:15 pm  29
Concomitant Intracranial Aneurysm and Carotid Artery Stenosis: An Institutional Review of Patients Undergoing Carotid Revascularization

INTRODUCTION AND OBJECTIVES: The incidence of concomitant carotid artery stenosis and intracranial aneurysm has been reported to be between 3-5%. In these patients treatment strategies must balance the risk of stroke with the risk of aneurysmal rupture. Several studies have examined the natural course of small intracranial aneurysms (<10mm) in the setting of carotid revascularization; however, the final recommendations are not uniform. The purpose of this study was to review our institutional experience with concomitant intracranial aneurysms and carotid artery stenosis.

METHODS: We performed a retrospective review of all patients with carotid artery stenosis who underwent carotid artery endarterectomy (CEA) or carotid artery stenting (CAS) at our institution between 2003-2010. Only patients with preoperative imaging demonstrating intracranial circulation were included. Charts were reviewed for specific patient demographic data, duration of follow up, and aneurysm size and location. Patients were divided into two groups: carotid stenosis with intracranial aneurysm and carotid stenosis without intracranial aneurysm.

RESULTS: 305 patients met the inclusion criteria and had a total of 316 carotid procedures (CAS or CEA) performed. 11 patients (3.61%) were found to have intracranial aneurysms prior to carotid revascularization. The male and female incidence was 2.59% and 5.26% (p=0.22), respectively. Patient demographics did not differ significantly between the two groups. The average aneurysm size was 3.25±2.13 mm, and the most common location was the cavernous segment of the internal carotid artery. No patient in the study suffered from aneurysm rupture, and the mean follow up time was 26.5 months for the carotid stenosis with intracranial aneurysm group.

CONCLUSIONS: Concomitant carotid artery stenosis and intracranial aneurysm is a rare entity. Carotid revascularization does not appear to increase the risk of rupture for small aneurysms in the midterm. Although not statistically significant, there was a higher incidence of aneurysms in females in our patient population.
Endovascular Popliteal Artery Aneurysm Repair: A Decade of Experience
Jeffrey Jim, Enjae Jung, Brian G Rubin, John A Curci, Luis A Sanchez, Patrick J Geraghty - Washington University in St. Louis, St. Louis, MO

Objective: To evaluate a single center experience of endovascular popliteal artery aneurysm repair (EVPAR) over the past decade.

Method: A retrospective review at a single institution was performed for patients treated with EVPAR from 2002 to 2011. Demographics, preoperative imaging, surgical technique, and patient outcomes were analyzed.

Results: During the study period, 38 limbs (37 males, 97%) with a mean age of 71.7 years (range 55-85) were treated electively. The mean aneurysm diameter was 2.68 cm with 6 (16%) symptomatic limbs. All patients underwent EVPAR with the use of Viabahn endoprosthesis. Aneurysm exclusion was achieved in 100% of cases. There were 5 adjunctive procedures (3 patch repairs of access vessel; 1 bare metal stent placement for stent graft infolding, 1 outflow thrombectomy). There were 2 periprocedural complications (percutaneous access site hematoma and device misdeployment both requiring open repair). The mean length of stay was 1.3 (range 0-3) days. On follow-up, there were no instances of limb loss. Secondary interventions were performed on 3 (7.5%) limbs for thrombosis, type I or III endoleaks. Overall, five (12.5%) patients developed stent-graft thrombosis (mean 23.6 months) with four requiring open bypass. Seven (17.5%) patients died (mean 43.0 months) with intact limbs. The remaining 28 patients are doing well with a mean follow-up of 45.3 months.

Conclusions: EVPAR is technically feasible and associated with low rates of periprocedural complications and short hospital stay. EVPAR may be considered a preferred option in select patients with popliteal artery aneurysms.
Disparate Preoperative Surveillance and Rupture of Abdominal Aortic Aneurysm For the Elderly Poor
Matthew W Mell, Laurence C Baker*, Mark A Hlatky* - Stanford University, Stanford, CA

Objective: To determine the factors, with specific emphasis on the role of preoperative surveillance, contributing to increased rate of ruptured abdominal aortic aneurysms (AAA) for the elderly poor.

Methods: Medicare claims were analyzed for patients who underwent AAA repair for previously diagnosed AAA from 2006 to 2009 (n=14,948), with preoperative abdominal imaging collected for up to 5 years. Repair for ruptured versus intact AAA was the primary outcome measure. We used logistic regression to determine the relationship between Medicaid eligibility and the risk of rupture, sequentially adding variables related to patient characteristics, socioeconomic status, receipt of preoperative AAA surveillance, and hospital AAA volume. We then estimated the proportional effect of each factor.

Results: Poor patients were 83% more likely to present with ruptured AAA (OR 1.83, 95% CI 1.36 - 2.47). These differences were more pronounced in men (OR 2.41, 95% CI 1.65 - 3.52), who comprised 75% of the cohort. Poor patients were 50% more likely to have gaps in preoperative surveillance (OR 1.50, 95% CI 1.22 - 1.83). After adjusting for variability in preoperative surveillance, patient factors, socioeconomic status and hospital factors, the disparity in risk of rupture was no longer significant (OR 0.88, 95% CI 0.53 - 1.54). We estimate that 47% of the observed disparity in rupture for the elderly poor is explained by patient factors, 34% by gaps in preoperative image surveillance, 7% by socioeconomic factors and 12% by hospital factors.

Conclusions: Gaps in preoperative surveillance is a key contributor to increased rupture of AAA in the elderly poor. Efforts aimed at improving disparities must include systems to provide reliable preoperative surveillance.

<table>
<thead>
<tr>
<th>Model</th>
<th>Risk of Ruptured AAA for the Poor</th>
<th>Proportion of Disparity Explained (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unadjusted</td>
<td>1.83 (1.36 - 2.47)</td>
<td>--</td>
</tr>
<tr>
<td>Adjusted for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>1.76 (1.23 - 2.34)</td>
<td>7</td>
</tr>
<tr>
<td>Hospital factors</td>
<td>1.70 (1.23 - 2.34)</td>
<td>12</td>
</tr>
<tr>
<td>Surveillance</td>
<td>1.51 (1.08 - 2.11)</td>
<td>34</td>
</tr>
<tr>
<td>Patient factors</td>
<td>0.88 (0.53 - 1.44)</td>
<td>47</td>
</tr>
</tbody>
</table>
Introduction & Objectives: The purpose of this study is to evaluate morbidity, mortality and survival in octogenarians undergoing open repair of ruptured abdominal aortic aneurysm (RAAA) in comparison to the younger population.

Methods: A retrospective analysis of a prospectively maintained database. All consecutive RAAA patients who underwent open repair from 1990 to 2011 were included.

Results: Overall 463 patients were identified of which 138 (30%) were octogenarians with a mean age 84+/-0.47 and 96 (69%) males. Median long term survival for octogenarians (group 2) was 78 days compared to 3017 days in the below 80 years population (group 1), p<0.001. There were more females in group 2 (31%) compared to group 1 (14%), p=0.05. Median preoperative Hb (p<0.001) and creatinine (p=0.031) were significantly different between the groups. 30 day mortality for group 2 was 45.3% compared to 28.1% for group 1, p<0.001. There was no significant difference between the two groups in terms of postoperative complications and length of hospital stay.

Conclusions: Based on the findings of this study, perioperative variables and postoperative complications were comparable between octogenarians and younger patients and do not explain the difference in long term survival between the two groups. Increasing age and female gender might have contributed to this difference in survival.
Introduction: Middle aortic syndrome refers to segmental narrowing of the distal thoracic/abdominal aorta, often with involvement of the visceral vessels. We describe successful endovascular treatment in a newborn who presented with lower extremity ischemia secondary to severe, segmental narrowing of the supraceliac aorta and an associated saccular aneurysm.

Case Report: A 2 week old, 4.3kg male presented with episodes of transient, acute bilateral lower extremity ischemia during feeding. CT angiogram demonstrated severe stenosis of the distal thoracic aorta and an associated saccular aneurysm. Additionally, the celiac and superior mesenteric arteries had severe stenoses at their origins and were perfused via large collateral arteries. The pressure gradient between the thoracic and infrarenal aorta was 52mm. The aorta was accessed via surgical exposure of the left common carotid artery. Two overlapping 5mm x 22mm PTFE covered stent-grafts (iCast, Atrium, inc.) were deployed across the aneurysmal segment with good resultant seal. An additional 5mm x 14mm bare metal stent (Paramount, Bard, inc.) was placed across the residual coarctation. Completion angiography demonstrated excellent flow across the stented segment with retrograde filling of the SMA and celiac artery via the pre-existing collateral. At one month follow-up, angiography demonstrated continued aneurysm exclusion and brisk visceral arterial flow, and the patient was growing appropriately.

Conclusions: Endovascular management of complex aortic pathology in the neonatal period is safe and effective. Reinterventions are anticipated for restenoses and size mismatch as patients grow. Long-term follow-up is needed to determine the effectiveness of this strategy in comparison to open surgical therapy.
Full Program & Abstracts
Coil Embolization of Ascending Aortic Pseudo-Aneurysm Post Open Repair of Type A Aortic Dissection 
Vikalp Jain*, Luis Gruberg*, Thomas V Bilfinger*, Apostolos K Tassiopoulos, Shang A Loh - Stony Brook University Medical Center, Stony Brook, NY

Introduction and Objectives: Anastomotic pseudoaneurysms represent an uncommon and challenging complication of open aortic repair with prosthetic graft. First characterized by Clayton et. al. in 1956, they affect approximately 1.4 - 4% of arterial anastomoses. These pseudoaneurysms are the result of many factors, foremost of which are infection, integrity of the host tissue, surgical technique, and location of the anastomosis.

Pseudoaneurysms were traditionally treated with open resection of the pseudoaneurysm and revision of the anastomosis. This case presents a novel approach to the treatment of pseudoaneurysms in a difficult location.

Methods/Results: The patient is a 77 year-old male status post repair of a Type A aortic dissection with a dacron tube graft. Follow up imaging eighteen months post op showed a 1.6 cm x 1.7 cm pseudoaneurysm off of the posteromedial proximal suture line. Through a right brachial artery approach, a diagnostic angiogram was performed demonstrating a bi-lobed pseudoaneurysm. A Judkins left 3.5 catheter and 0.035" angled Glidewire was used to engage the orifice of the pseudoaneurysm. Two 4 mm x 6 cm Boston Scientific Interlock coils were then deployed into the pseudoaneurysm sac. Completion angiogram demonstrated complete exclusion of the pseudoaneurysm. The patient did well and was discharged the following day. Follow up CT scan at 3 months showed regression and complete thrombosis of the pseudoaneurysm.

Conclusion: Traditional operative repair of anastomotic pseudoaneurysms can lead to long operations, high blood loss, and increased morbidity and mortality as a result of their reoperative nature. Coil embolization is a safe and effective approach for the treatment of anastomotic pseudoaneurysms in difficult locations.
Full Program & Abstracts
A Novel Approach To EVAR Simulation Using Patient Specific Modeling
Gavin R Davis, Murray L Shames, Karl A Illig, George Yang*, Thu-Hoai Nguyen* - USF, Tampa, FL

Introduction and Objectives: The Simbionix Angiomentor Procedure Rehearsal Studio (PRS) offers accurate virtual anatomy for measurement, stent graft selection and deployment of endovascular AAA (EVAR) devices.

Methods: Selected Gore Excluder EVAR cases from our EVAR database were reviewed and DICOM data loaded into the Symbionix Angiomentor simulator using PRS software. Using centerline measurements created on PRS neck diameter (D1), length from lowest renal artery to each iliac bifurcation (Ll and Lr) and common iliac artery diameter (Dl and Dr) were recorded. All measurements for device selection were made based on data recorded on the simulator. Simulated EVAR was then performed using PRS on a dual limb endovascular simulator. Changes in device selection based on intraoperative measurements and use of 3D anatomic overlay were recorded. The devices actually used for successful repair were considered gold standard for comparison. Simulations were rated by an experienced vascular surgeon for realism, imaging quality, final product on a 5 point scale.

Results: 10 cases were identified with complete operative data and available CT scans. 50% of cases (5/10) had changes in device length when using the "in-vivo" 3D volume filled model and angiographic measurements. When changes were made the devices inserted it resulted in correction of limb length to that of inserted devices in 100% (5/5) of cases. Review of simulation scoring showed ratings of diminished realism (average 2.3/5) due to unrealistic ease of wire passage and gate cannulation, however, simulation imaging and final product were scored favorably (3.7 and 3.4 respectively).

Conclusion: PRS offers an approach to simulation for EVAR that allows for case variability not seen in other simulation modalities. The use of centerlines, angiographic measurements and 3D modeling within the PRS software predicts real life device selection and represents an opportunity for high fidelity patient specific preoperative EVAR practice.
Full Program & Abstracts

5:30 pm – 5:45 pm  36
Validated Assessment Tool Paves the Way For
Standardized Evaluation of Trainees On Anastomotic
Models
Cassidy Duran¹, Murray L Shames², Jean Bismuth¹, Jason T
Lee³, APDVS Committee for Education and Simulation - ¹The
Methodist DeBakey Heart & Vascular Center, Houston, TX;
²University of South Florida Health, Tampa, FL; ³Stanford
University School of Medicine, Stanford, CA

Objective: Duty hour restrictions that limit operative exposure and declining numbers of open
operations have raised concern about open technical skills acquisition. Simulation modules
allow for the safe practice of techniques and are becoming important in the shift towards
education for integrated vascular residents. There is an unquestionable need to standardize the
evaluation of trainees on these simulation models. We sought to validate such an assessment
tool for performance of basic open anastomosis.

Methods: Vascular fellows, residents, and students attending SCVS, IAVS, and Boot Camp in
2012 were asked to participate in simulations using multiple anastomotic models (Limbs &
Things, Vascular International, Lifelike Biotissue) and given 20 minutes to complete an end-side
anastomosis. Trained observers assessed subjects using the tool and graded performance on a
5-point global assessment scale with 8 parameters. Self-assessment was also performed by
each trainee.

Results: 96 trainees participated. Scores on the global assessments correlated with experience
and were higher for the senior trainees, with median global summary scores increasing by PGY
(PGY1-3=2, PGY4-6=3, PGY7-8=5). For those that performed self-assessment, there was poor
correlation between grades given by the expert observers and the trainee, but good correlation
between scores assigned by trained observers (Table 1). Assessment of appropriate hemostasis
was poor, likely reflecting the difficulty of evaluating this parameter in an inanimate model.

Conclusions: Performance on an open simulation model correlates to trainee experience level.
This initial work confirms the ease, validity, and applicability of the grading tool. The portability,
reproducibility, and validity of our grading tool will continue to be developed towards the final
goal of a technical skills curriculum available for vascular trainees in the US.
Full Program & Abstracts

Table 1: Median score on Global Rating Scale (5-point Likert) for performance of open anastomosis.

<table>
<thead>
<tr>
<th>Score on Global Rating Scale</th>
<th>Respect for Tissue</th>
<th>Time and Motion</th>
<th>Instrument Handling</th>
<th>Hemostasis</th>
<th>Knot Tying/ Suturing</th>
<th>Use of Assistant</th>
<th>Procedural Flow</th>
<th>Quality of Final Product</th>
<th>Global Summary Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained Observer (Median)</td>
<td>4</td>
<td>3</td>
<td>3.5</td>
<td>3.5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Correlation between Trained Observers (R-value)</td>
<td>0.66</td>
<td>0.80</td>
<td>0.77</td>
<td>0.49</td>
<td>0.73</td>
<td>0.77</td>
<td>0.64</td>
<td>0.67</td>
<td>0.70</td>
</tr>
<tr>
<td>Self Assessment (Median)</td>
<td>3</td>
<td>3.5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Correlation Self/trained Observer (R-value)</td>
<td>0.50</td>
<td>0.67</td>
<td>0.53</td>
<td>0.46</td>
<td>0.20</td>
<td>0.58</td>
<td>0.55</td>
<td>0.62</td>
<td>0.61</td>
</tr>
</tbody>
</table>

5:45 pm – 6:00 pm  Q & A, Discussion

7:00 pm – 10:00 pm  PRESIDENT’S DINNER
All attendees are welcome to purchase tickets to attend this separate subscription event.
Full Program & Abstracts

Sunday, February 3, 2013

6:30 am – 7:00 am  Continental Breakfast
6:30 am – 9:00 am  Registration

7:00 – 9:00 am  SCIENTIFIC SESSION V
Moderators: Ravi Veeraswamy, MD & Christopher Smolock, MD

7:00 am – 7:15 am  37
Risk Factors Associated With the Abdominal Aortic Aneurysm Diagnosis In Patients Screened At A Regional Veterans Affairs Health Care System
Kevin C Chun1, Kai Y. Teng1, LeAnn A. Chavez1,2, Elyse N. Van Spyk1, John G. Carson1,2, Eugene S. Lee1,2 - 1VA Northern California Health Care System, Mather, CA; 2University of California, Davis, Sacramento, CA

Introduction & Objectives: An active abdominal aortic aneurysm (AAA) screening program at a regional Veterans Affairs (VA) health system identifies patients at risk for AAA. The purpose of this study is to evaluate unique risk factors associated with AAA diagnosis upon AAA screening examination to identify the most at risk patients for AAA.

Methods: Data were extracted from a regional VA health care system to identify patients who underwent AAA screening within a 3-year period. An aortic diameter ≥ 3.0 cm was defined as AAA. Patient risk factors: age, body mass index, total cholesterol, serum creatinine, hypertension, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), statin use, and active smoking were evaluated. Risk factors were compared between AAA and non-AAA groups.

Results: A total of 6,329 patients (72.8 ± 5.3 years old) were screened for AAA from January 2007 to December 2009. A total of 478 patients (7.6%) with AAA were identified. The following risk factors were significantly associated (P< .001) with the AAA diagnosis after adjusting for Bonferonni correction: age (73.9±6.6 years old vs. 72.7±5.2 years old), creatinine (1.3±0.7 mg/dl vs. 1.1±0.7 mg/dl), CAD (42.7% vs. 28.5%), COPD (25.9% vs. 16.5%), PVD (16.2% vs. 7.6%), and active smoking (23.2% vs. 15.3%). Diabetes (P< .001) and elevated cholesterol levels (P= .002) were found to be significantly associated against the AAA diagnosis.

Conclusions: These results confirm previous findings that AAA is typically identified in higher risk patients. Novel findings such as renal insufficiency increasing risk, as well as diabetes and cholesterol decreasing risk, may provide further insight into AAA development and expansion, leading to refined AAA surveillance guidelines.
Full Program & Abstracts

7:15 am – 7:30 am  38

Mini-Incision Thoracobifemoral Bypass In the Endovascular Era
Amy E Reppert*, Omid Jazaeri*, Ashok Babu*, Mark Nehler*, Brett T Reece* - University of Colorado, Aurora, CO

Introduction & Objectives: Endoluminal revascularization has generally supplanted open techniques for aortoiliac occlusive disease. Today, patients undergo open surgery following a history of multiple endovascular failures or complete aortoiliac occlusions. In addition, hostile abdomens, calcified aortic anatomy, and tenuous pelvic circulation with significant inferior mesenteric artery contribution make the abdominal reconstruction suboptimal. Given the constraints in these patients, we prefer a minimally invasive thoracobifemoral (mini-TBF) approach to aortic bypass.

Methods: Mini-TBF bypasses were performed in high risk patients with aortoiliac occlusive disease and critical limb ischemia. Outflow was constructed from the distal descending aorta via a ≤8 cm thoracotomy. The left limb was tunneled retroperitoneally over the psoas and the right limb anterior to the abdominal fascia below the umbilicus to the groin. Eleven patients (mean age 64, 82% male) underwent mini-TBF bypass between 2009 and 2012. Three had previous endovascular failures, 1 had failed prior aortic and extra-anatomic bypass, three required IMA preservation and the remaining had an unclampable aorta or hostile abdomen.

Results: Median length of stay was 8 days. Mean preoperative ABI was 0.23 and 0.38 for the right and left respectively. Post operatively, mean ABI was 0.81 on the right and 0.78 on the left. There was no perioperative mortality. Postoperative complications occurred in 5 patients: 1 stroke, 2 pulmonary (both contralateral lung issues), and 2 limb occlusion secondary to outflow disease. At median follow up of 18 months, 2 patients required amputations, both from preexisting tissue loss.

Conclusions: The mini-TBF bypass has become an innovative approach for patients requiring revascularization after failed intervention, infrarenal occlusive disease, or hostile abdomen. This approach provides a hemodynamically sound inflow with preservation of tenuous pelvic circulation with complex femoral reconstructions.
Full Program & Abstracts

7:30 am – 7:45 am

39

CEAP Classification Relationship To VLU Closure: A Retrospective Analysis of A Prospective Randomized Controlled Trial of VLU Treatment With A Novel Spray-Applied Cell Therapy
Jamie A Schwartz*, Cynthia Gendics*, Robert S Kirsner**, Herbert B Slade**, John C Lanits, III* - 1St Luke’s- Roosevelt Hospital Center, New York, NY; 2University of Miami, Miami, FL; 3University of North Texas Health Science Center, Fort Worth, TX

Introduction & Objectives: The Clinical Etiology Anatomy Pathophysiology (CEAP) classification was revised in 2004. The exact outcomes of the 6 lesions as defined by the CEAP categories are not well delineated. Therefore, in order to determine the relationship of CEAP classification on Venous Leg Ulcers (VLU) with regard to healing progress and potential need for vascular intervention, we assigned CEAP classifications to a placebo-controlled trial of VLU undergoing treatment therapy.

Methods: HP802-247 is a novel investigational spray-applied cell therapy that was employed in a phase 2, double-blind, randomized, placebo-controlled trial to treat 205/228 adult patients with a chronic VLU over a 12 week study period at 28 outpatient centers in USA and Canada. All groups received four-layer compression therapy in conjunction with cell treatment or vehicle alone. A retrospective review of 76% (173/228) of subjects enrolled was undertaken to evaluate the association of VLU healing to the CEAP classification of the ulcers.

Results: In the vehicle only cohort the healing rate was 52% over the 12 week study period. In this cohort, unlike the treatment group, not finding a perforator or deep vein involvement was associated (RR >1.0) with non-healing. Additionally, combination venous disease was associated with better than average closure rates (A_d,p 83%; A_s,p,d 75%). Completely obstructive etiology was associated with 0% closure versus 57% for the reflux group (P<0.05).

Conclusions: Not surprisingly the prospective study of healing rates showed the postphlebitic obstruction was associated with very poor healing rates. Interestingly, deep vein and perforator reflux was noted to have the best healing rates. This may have implications for a more aggressive attempt at vascular reconstructive procedures in the patient with deep venous occlusion, or possible superficial interventions in the combination group, while the average closure rate for patients with superficial reflux supports the ESCHAR trial data.
Introduction & Objectives: Non-invasive vascular laboratory determinations for peripheral arterial disease (PAD) often combine pulse volume recordings (PVR), segmental pressure readings (SP) and Doppler waveform traces (DW). Our objective was to assess the corresponding diagnostic values for each test.

Methods: Over 2000 non-invasive diagnostic reports were reviewed through our institutional database. Data from non-invasive records with corresponding angiograms performed within 3 months led to a cohort of 76 patients (89 limbs) for analysis. Four vascular specialists, blinded to the angiographic results, stratified the noninvasive studies as representative of normal, <50% “sub-critical” or >50% “critical” stenosis at the upper thigh, lower thigh, popliteal and calf segments using four randomized non-invasive modalities: (1) PVR alone; (2) SP alone; (3) SP+DW; and (4) SP+DW+PVR. The angiographic records were independently graded by another three evaluators and used as a standard to determine the non-invasive diagnostic values and interobserver agreements.

Results: Interobserver variance for all modalities except SP was high (Figure 1). Sensitivity (range 25-75%) was lower than specificity (range 50-84%) for all modalities. Accuracy for detecting a critical or sub-critical stenosis with SP+DW was significantly higher than PVR alone (Figure 2). However, when only assessing critical stenoses, no statistically significant relationships were found between any modalities for sensitivity, specificity or diagnostic accuracy.

Figure 1: Fleiss Kappa agreement values for 4 interpreters (Mean between segments with SD).
Conclusions: SP has the greatest interobserver agreement in evaluation of PAD. Given the lower accuracy of PVR for detecting either sub-critical and critical disease, PVR tests could be omitted from the non-invasive vascular exam without significant reductions in overall diagnostic value.
Endovascular Management of Chronic SVC Syndrome With SVC Occlusion
Robert W Fincher*, Magdiel Trinidad* - University of Arizona, Tucson, AZ

Introduction & Objectives: SVC syndrome occurs from benign and malignant causes. The presentation can be acute or chronic. For patients with chronic, symptomatic SVC syndrome from benign causes, few trials regarding treatment have been published. Controlled trials of endovascular therapy versus surgery for symptomatic SVC occlusion remain unpublished. We present a case of chronic, type III SVC syndrome treated with thrombolytic therapy, angioplasty, and stenting, followed by a review of the literature. Endovascular therapy should be considered first line management in symptomatic patients with chronic SVC occlusion.

Methods: A 56-year-old female with a history of AML, chronic graft versus host disease, with a right indwelling internal jugular access port, presented with a 6-week history of face and arm swelling, headaches, visual impairment, and increasing prominence of her chest veins. CT thorax revealed occlusive thrombus of the SVC, left brachiocephalic vein, and left subclavian vein. Venography revealed complete SVC occlusion, right innominate venous occlusion, and reversal of flow in the azygous vein (Type III SVC Syndrome). An infusion catheter was placed across the occluded SVC and the patient was started on thrombolytic therapy. Forty-eight hours post-lysis, completion venography revealed persistent clot at the atrio caval junction. Angioplasty and stenting of the SVC was performed. Completion venography revealed patent flow from the innominate veins through the SVC into the right atrium.

Results: The patient was subsequently discharged on oral anticoagulation with complete resolution of her symptoms on postoperative day three. At two weeks, duplex venous ultrasound of the neck was negative for residual internal jugular thrombus, and the patient remained asymptomatic.

Conclusions: Angioplasty and stenting of the SVC for symptomatic benign SVC syndrome has excellent primary and secondary patency in several published series. It should be considered first line therapy in patients with chronic SVC syndrome with SVC occlusion secondary to benign causes.
Percutaneous Retrieval of An Inferior Vena Cava Filter Causing Right Ureter Obstruction
Kristina Thornburg*, Amber Batool*, Melissa Obmann, Shivprasad Nikam*, David Mariner* - Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA

Introduction & Objectives: Retrievable inferior vena cava filters (IVCF) have been available in the United States since 2003. Although retrieval rates have improved over the last several years, they are still low. A number of severe late complications have been reported, including aortic and duodenal perforations. We present a case of percutaneous retrieval of a Bard Recovery filter causing right ureteral obstruction 6 years after placement.

Methods: A 44 year old female presented to the emergency department with abdominal pain, nausea, and vomiting. A CT scan abdomen/pelvis showed right ureter obstruction by an IVCF strut and resultant hydronephrosis. She underwent cystoscopy with placement of a JJ stent. She then underwent percutaneous retrieval of the IVCF several days later.

Results: The patient tolerated both procedures well and had relief of her symptoms. There was no evidence of contrast extravasation noted on completion venogram. She had a follow-up cystoscopy with removal of her stent 1 month later and there were no inflammatory changes within the ureter.

Conclusions: We believe this is the first reported case of percutaneous retrieval of an IVCF causing right ureter obstruction. Although percutaneous retrieval becomes more difficult over time due to endothelial overgrowth of the filter struts, it may be reasonable to attempt retrieval before committing a patient to major surgery. More vigilant retrieval registries in institutions with a high volume of retrievable filter placement may help decrease late complications.
Full Program & Abstracts
Full Program & Abstracts

8:20 am – 8:30 am  43 (RF) - Unable To Attend Meeting
Isolated Axillary Artery Aneurysm In A Patient With A Patent Ipsilateral Arteriovenous Fistula
Yan T. Ortiz-Pomales*, Jennifer B Smith*, Jeffrey S Weiss, Kevin Casey - Naval Medical Center San Diego, San Diego, CA

Introduction & Objectives: Axillary artery aneurysms (AxAA) are rare entities commonly associated with trauma or repetition injuries. Less recognized associations include connective tissue, mycotic, or atherosclerotic processes. Treatment is warranted to avoid limb threatening complications such as distal embolization and aneurysm thrombosis. We herein report a case of a rare tortuous AxAA causing neurologic symptoms in a woman without any identifiable risk factors.

Methods: A 58 year-old non-smoker, normotensive female who is 10 years status post brachio-cephalic fistula presented complaining of a 5-month history of progressively worsening ipsilateral upper arm pain and hand paresthesia. She denied any significant personal or family history. Physical examination revealed a tender pulsatile mass proximal in the left axilla and normal distal pulses. Computed tomographic angiogram confirmed a highly tortuous and ectatic dilation of her left axillary artery causing compression of her median nerve (Fig 1).

Results: The patient underwent surgical exploration which identified an extremely tortuous and aneurysmal vessel that was carefully dissected free from surrounding nerves, excised in its entirety, and replaced with an 8-mm Dacron interposition graft. The fistula was not ligated due to the potential need for future hemodialysis access. The patient did well and had complete resolution of her symptoms.

Conclusions: AxAA are rare findings often associated with trauma from repetitive motions in competitive athletes, crutch-related iatrogenesis, or penetrating trauma. This is a rare tortuous AxAA in a renal transplant patient with a patent but unused brachio-cephalic arteriovenous fistula. We successfully repaired our patient’s aneurysm with an interposition graft allowing for complete resolution of her symptoms. Future studies are warranted to identify a possible relationship between upper extremity fistulas and proximal vessel aneurysms.
Full Program & Abstracts
Full Program & Abstracts

8:30 am – 8:45 am  44
**Short- and Mid-Term Results of Iliac Artery Flush Occlusion Stenting With the Assistance of An Occlusive Contralateral Iliac Artery Balloon**
Carlos F Bechara, Neal R Barshes, George Pisimisis, Peter H Lin, Panagiotis Kougias - Baylor College of Medicine, Houston, TX

**Introduction & Objectives:** Endovascular treatment of flush iliac artery occlusion remains a challenge and most are treated by open surgery. We report the outcomes of 10 cases successfully recanalized endovascularly with the assistance of a contralateral occlusive balloon.

**Methods:** Retrospective review of patients undergoing iliac artery stenting was performed at a single institution. Technical success, short and midterm patency as well as 30-day complications were reported.

**Results:** A total of 10 patients were identified. Technical success was 100% when a brachial approach was used. Retrograde recanalization was attempted in 3 cases. Re-entry into the aorta could not be achieved in one case. The aorta was entered above the IMA in the other 2 cases and the decision was made to attempt from a brachial approach to avoid stenting to above the IMA. There were no dissections or perforations. 2 patients developed brachial access complications, but only one required operative repair for a pseudoaneurysm. Nine patients (90%) remain patent at a mean f/u of 10.4 months (3-16). One patient presented 8 months later with iliac stent and lower extremity bypass thrombosis requiring an amputation. There was no immediate or long-term death in this series.

**Conclusion:** Iliac stenting for flush iliac artery occlusion can be achieved with this technique with encouraging short- and mid-term results and with minimal morbidity.

8:45 am – 9:00 am  Q & A/Discussion
9:00 am  Winter Annual Meeting Adjourns
Notes
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Newly Elected Active Members (‘12)

Faisal Aziz, MD  Penn State University/Hershey Medical Center
Omar C. Morcos, MD  Northshore University Health Systems
Donald Edward Patterson, MD  Vascular Surgical Associates @ Evansville Surgical
Jonathan A. Schor, MD  Staten Island University Hospital
Theodore R. Sullivan, MD  Abington Health
Timothy Wu, MD  University of Pittsburgh
Newly Elected Candidate Members (‘12)

Francesco Aiello, MD
Shipra Arya, MD
Andrew Bakken, MD
Shannon Beal, MD
Emelia Bittenbinder, MD
Matthew Borkon, MD
Megan Carroll, MD
Alexander Chang, MD
Kristopher Charlton-Ouw, MD
Jason Christie, MD
Contantinos Constantinou, MD
Phong Dargon, MD
Michael Dudkiewicz, MD
Cassidy Duran, MD
Bryan Fisher, MD
Racheed Ghanami, MD
Aaron Hurd, MD
Mun Jye, MD
Angela Kokkosis, MD
Marcus Kret, MD
Rishi Kundi, MD
Maria Litzendorf, MD
Joanelle Lugo, MD
Junaid Malek, MD
Neil Moudgil, MD
Patrick Neville, MD
Richard Ofstein, MD

Vicente Orozco, MD
John Park, MD
Siddharth Patel, MD
Alexis Powell, MD
Daniel Ramirez, MD
Muhammad Rana, MD
Irina Shakhnovich, MD
Sherene Shalhub, MD
Jessica Simons, MD
Varinder Singh, MD
Pushpinder Sivia, MD
David Sprenger, MD
Zac Steiner, MD
Rami Tadros, MD
Axel Thors, MD
Joshua Unger, MD
Marvin Weaver, MD
Scott Ziporin, MD
Active Membership Roster 2012

ABOU-ZAMZAM, AHMED M.
Loma Linda University Medical Center
11175 Campus Street, #21123
Loma Linda, CA 92354
909-558-8665
aabouzamzam@ahs.llumc.edu

ACOSTA, IGNACIO
I. Acosta, M.D., Inc.
1808 Verdugo Blvd., Suite 409
Glendale, CA 91208-1481
818-790-8020

ADAMS, ERIC D.
777 Rural Drive
Williamsport, PA 17701
570-321-2805
eadams@susquehannahealth.org

*ADCOCK, G. KENDRIX
400 S. Maitland Avenue
Maitland, FL 32751
407-539-2100

*ADEDUNTAN, AZEEZ P.
Victory Vascular & General Surg. of GA
2167 Northlake Pkwy., Building 2
Suite 106
Tucker, GA 30084
770-492-8636
vvgs@aol.com

*ADELMAN, MARK A.
NYU Medical Center
530 First Avenue, #6F
New York, NY 10016
212-263-7311
mark.adelman@nyumc.org

*ADINOLFI, MICHAEL F.
810 Crystal Street
New Orleans, LA 70124
504-486-7415

AIELLO, FRANCESCO A.
UMass Medical Center
55 Lake Avenue North
Worcester, MA 01655
508-856-5599
faaiello@hotmail.com

*AKERS, DONALD L.
1840 Regents Park Road
Knoxville, TN 37922
504-587-7520
dakersjr@bellsouth.net

AL-KHATIB, WESAM KASSIM
Stanford University
300 Pasteur Drive, Suite H3600
Stanford, CA 94305-5642
650-725-5227
walkhatib@yahoo.com

*ALEXANDER, JAMES B.
Robert W. Johnson Medical School
3 Cooper Plaza, #411
Camden, NJ 08103
856-342-2151
jim.alexander@umdnj.edu

ALI, AHSAN T.
University of Arkansas Medical Center
4301 W. Markham #520-2
Little Rock, AR 72205
501-686-6176

ALMOND, BRETT A.
Bay Surgical Specialists
960 7th Avenue N
St. Petersburg, FL 33705
352-273-5484
balmond@ufl.edu

ALVAREZ-TOSTADO, JAVIER A.
Marymount Vascular Surgery
12000 McCracken Road, Suite 351
Garfield Heights, OH 44125
216-587-4280
alvarej3@ccf.org

AMANKWAH, KWAME S.
University of New York @ Syracuse
Vascular & Endovascular Surgery
750 E. Adams Street
Syracuse, NY 13210
315-464-6241
amankwak@upstate.edu

*Senior Member
Active Membership Roster 2012

*ANDERSEN, CHARLES A.*
1302 28th Avenue Court
Milton, WA 98354
253-952-2135
cande98752@aol.com

ANGLE, NIREN
Naval Medical Center San Diego
34800 Bob Wilson Drive
San Diego, CA 92134
858-603-1720
nangleka@gmail.com

*ANNENBERG, ALAN J.*
Cardiovascular & Thoracic Surgeons, Inc.
4030 Smith Road, Suite 300
Cincinnati, OH 45209
513-421-3494

*ANNEST, STEPHEN J.*
Vascular Institute of the Rockies
1601 E. 19th Avenue, Suite 3950
Denver, CO 80218-3950
303-830-8822

APPLE, JEFFREY M.
CTVS
1010 W. 40th Street
Austin, TX  78756
512-459-8753
jtapple1@yahoo.com

ARKO, FRANK R.
Sanger Heart and Vascular Institute
Vascular & Endovascular Surgery
1001 Blythe Blvd, Suite 300
Charlotte, NC 28203
704-446-4907
farkomd@gmail.com

ARTHURS, ZACHARY M.
San Antonio Military Medical Center
3511 Rogerbrook Drive
 Ft. Sam Houston, TX 78234
210-916-1174
zachary.arthurs@us.army.mil

ATKINSON, CLINTON K.
Pinehurst Surgical Clinic
35 Memorial Drive
Pinehurst, NC 28374
910-295-0884
ckatkinson@hotmail.com

AULIVOLA, BERNADETTE
Loyola University Hospital
2160 South First Avenue
EMS Building 110, Room 3216
Maywood, IL 60153
708-327-2686
baulivola@lumc.edu

AUSTIN, JOSEPH PATRICK
Valley Vascular Surgery, Inc.
18350 Roscoe Blvd., Suite 205
Northridge, CA 91325-4150
818-709-7900
patrick.austin@orlandohealth.com

AZIZ, FAISAL
Penn State University/Hershey Med Ctr
Mail Code H053, Room C4632
Hershey, PA 17033
717-531-8898
faziz@hmc.psu.edu

BACK, MARTIN
University of South Florida
2 Tampa General Circle, Suite 7001
Tampa, FL 33606
813-259-0956
mback@health.usf.edu

BAKKEN, ANDREW
Sanford Health
737 Broadway N
Fargo, ND 58122
701-234-2251
abakken@medicine.nodak.edu

BALDWIN, ZACHARY K.
University of Mississippi
Division of Vascular Surgery
2500 N. State Street
Jackson, MS 39216
601-984-2680
zbaldwin@umc.edu

*Senior Member
Active Membership Roster 2012

*BALLARD, JEFFREY L.
St. Joseph Hospital
1140 W. La Veta Avenue, Suite 850
Orange, CA 92868
714-560-4450
jeffreyballard@visoc.org

BALLINGER, BETH ANN
Mayo Clinic
200 First Street, SW
Rochester, MN 55905
502-255-4789
ballinger.beth@mayo.edu

BARIL, DONALD T.
University of Massachusetts
55 Lake Avenue North
Worcester, MA 01655
508-856-5599
donald.baril@umassmemorial.org

BARSCHES, NEAL R
1709 Dryden Street, Suite #1500
Houston, TX 77030
781-690-4312
neal.barsches@gmail.com

*BASSIOUNY, HISHAM
Dar Al Souad Hospital
Egypt

*BATSON, ROBERT
LSU School of Medicine
1111 Medical Center Blvd., #713
Marrero, LA 70072
504-349-6713

*BAXTER, B. TIMOTHY
Omaha Vascular Surgery LLC
515 N. 162nd Avenue, Suite 300
Omaha, NE 68118-2540
402-393-6624

BAZAN, HERNAN A.
Ochsner Clinic Foundation
1514 Jefferson Hwy, 8th Floor
New Orleans, LA 70121
504-842-4053
hbazan@ochsner.org

BEAVERS, FREDERICK P.
Washington Hospital Center
106 Irving St., NW POB North, Rm 3150
Washington, DC 20010
202-877-8050
suavejazz@hotmail.com

BECARCA, CARLOS F.
Baylor College of Medicine
2002 Holcombe Blvd (112)
Houston, TX 77030
bechara@bcm.edu

*BELL, WILLIAM H.
Coastal Surgical Specialists
2203 Neuse Blvd.
New Bern, NC 28560-4311
252-639-8118
drbell@coastalsurgicalspecialists.com

*BENVENISTY, ALAN I.
Columbia University
St. Luke’s Roosevelt Hospital Center
1090 Amsterdam Avenue, 12th Floor
New York, NY 10025
212-523-4706
aib3@columbia.edu

*BEGAMINI, THOMAS M.
4003 Kresge Way, #100
Louisville, KY 40207
502-897-5139
t.bergamini@insightbb.com

*BERGER, ALAN
1259 S. Cedar Crest Boulevard
Allentown, PA 18103
610-439-0372
tyb4cut@hotmail.com

BERLAND, TODD
NYU
530 First Avenue, HCC-6F
New York, NY 10016
917-209-2212
todderland@gmail.com

*Senior Member
### Active Membership Roster 2012

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Address</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berman, Scott S.</td>
<td>Tucson Vascular Institute</td>
<td>1815 W. St. Mary’s Road, Tucson, AZ 85745-5727</td>
<td>520-628-1400</td>
<td><a href="mailto:sberman@azvasc.com">sberman@azvasc.com</a></td>
</tr>
<tr>
<td>Bernik, Thomas R.</td>
<td>Beth Israel Medical Center</td>
<td>1st Avenue &amp; 16th Street, Fierman Hall, 12th Floor, New York, NY 10003</td>
<td>212-838-3055</td>
<td><a href="mailto:bernik@optonline.net">bernik@optonline.net</a></td>
</tr>
<tr>
<td>Best, Irwin M.</td>
<td>Emory University Hospital School of Medicine</td>
<td>1364 Clifton Road NE, Atlanta, GA 30322</td>
<td>404-712-7033</td>
<td><a href="mailto:imb@hotmail.com">imb@hotmail.com</a></td>
</tr>
<tr>
<td>Bhatia, Devinder S.</td>
<td>Southeast Texas Cardiovascular, PA</td>
<td>8901 FM 1960 Bypass, Suite 303, Humble, TX 77338</td>
<td>281-397-7000</td>
<td>dbhatam@<a href="mailto:z@aol.com">z@aol.com</a></td>
</tr>
<tr>
<td>Bigatel, David A.</td>
<td>100 Lancaster Avenue, Suite 275 MSB</td>
<td>Wynnewood, PA 19096</td>
<td>619-642-1908</td>
<td><a href="mailto:dbigatel@ptd.net">dbigatel@ptd.net</a></td>
</tr>
<tr>
<td>Bismuth, Jean</td>
<td>The Methodist Hospital</td>
<td>6560 Fannin Street, Suite 1401, Houston, TX 77030</td>
<td>713-441-9319</td>
<td><a href="mailto:Jbismuth@tmhs.org">Jbismuth@tmhs.org</a></td>
</tr>
<tr>
<td>Black, James H.</td>
<td>Johns Hopkins Hospital</td>
<td>Harvey 611, 600 North Wolfe Street, Baltimore, MD 21287</td>
<td>410-955-1708</td>
<td><a href="mailto:jhblack@jhmi.edu">jhblack@jhmi.edu</a></td>
</tr>
<tr>
<td>Bloemandal, Lee C.</td>
<td>1325 Pennsylvania Avenue, #720</td>
<td>Fort Worth, TX 76104-2144</td>
<td>817-336-7305</td>
<td></td>
</tr>
<tr>
<td>Bogey, William M.</td>
<td>Brody School of Medicine @ ECU Vascular Surgery</td>
<td>115 Heart Drive, Greenville, NC 27834</td>
<td>252-744-4668</td>
<td><a href="mailto:bogeyw@ecu.edu">bogeyw@ecu.edu</a></td>
</tr>
<tr>
<td>Bohannon, W. Todd</td>
<td>Scott &amp; White Hospital &amp; Clinic</td>
<td>2401 South 31st Street, Temple, TX 76508</td>
<td>254-724-0657</td>
<td><a href="mailto:wbohannon@swmail.sw.org">wbohannon@swmail.sw.org</a></td>
</tr>
<tr>
<td>Borromeo, Jose R.M.</td>
<td>5880 University Avenue</td>
<td>West Des Moines, IA 50266</td>
<td>515-633-3600</td>
<td><a href="mailto:jborromeo@iowahs.com">jborromeo@iowahs.com</a></td>
</tr>
<tr>
<td>Boshier, L. Paul</td>
<td>Virginia Surgical Associates</td>
<td>417 Libbie Avenue, Richmond, VA 23226-2678</td>
<td>804-288-1953</td>
<td></td>
</tr>
<tr>
<td>Bowser, Thomas C.</td>
<td>Mayo Clinic</td>
<td>200 First Street SW, Rochester, MN 55905</td>
<td>507-284-1443</td>
<td><a href="mailto:bower.thomas@mayo.edu">bower.thomas@mayo.edu</a></td>
</tr>
<tr>
<td>Bowser, Andrew</td>
<td>Texas Hills Vascular Specialists</td>
<td>205 West Windcrest, Suite 350, Fredericksburg, TX 78624</td>
<td>830-997-7138</td>
<td><a href="mailto:ab5329@yahoo.com">ab5329@yahoo.com</a></td>
</tr>
<tr>
<td>Breckwoldt, William L.</td>
<td>955 Main Street, #G2A</td>
<td>Winchester, MA 01890</td>
<td>617-720-2020</td>
<td></td>
</tr>
</tbody>
</table>

*Senior Member*
Active Membership Roster 2012

BREWSTER, LUKE P.
Emory University
1500 Clifton Road
Atlanta, GA 30322
404-727-8413
lukebrewst@aol.com

*BRIIGHAM, ROBERT A.
Reading Vascular Surgical Associates
301 S. 7th Avenue, #1070
West Reading, PA 19611-1493
610-378-9667
brighamr@readinghospital.org

BROWN, JEFF A.
Virginia Surgical Associates
8237 Meadowbridge Road
Mechanicsville, VA 23116-2336
804-559-7634
ayersv@vasurgical.com

BROWN, KELLIE R.
Medical College of Wisconsin
Division of Vascular Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
krbrown@mcw.edu

*BROWN, LYLE L.
1023 N. Mound Street, Suite B
Nacogdoches, TX 75961
936-559-0800
dubllb@suddenlink.net

*BROWN, O. WILLIAM
31700 Telegraph Road, Suite 140
Bingham Farms, MI 48025
248-433-0881
owbmd@aol.com

BRUMBERG, ROBERT S.
Vascular Surgery Associates
2631 Centennial Blvd, Suite 100
Tallahassee, FL 32308
850-877-8539
rbrumberg@pol.net

*BUCHEINDER, DALE
Good Samaritan Hospital
5601 Loch Raven Blvd., Suite 412B
Baltimore, MD 21239
443-849-2393

BULGER, CHRISTOPHER M.
Vein Clinics of America
95 Glastonbury Blvd., Suite 202
Glastonbury, CT 06033
860-652-8400
cbulger@echn.org

BUNCH, CHRISTOPHER T.
Duluth Clinic
400 East Third Street
Duluth, MN 55805
218-786-3231
ctbunch_2000@yahoo.com

*BURKE, PAUL M.
10 Research Pl., Suite 207
North Chelmsford, MA 01863-2439
978-250-9500
pmbjrmd@aol.com

BUSH, RUTH L.
Texas A & M Health Science Center
Round Rock Campus, Suite N404H
3950 No. A. W. Grimes Blvd.
Round Rock, TX 78665
512-341-4929
rbush@medicine.tamhsc.edu

BUSUTTIL, STEVEN J.
CVTSA
2921 Telestar, Suite 140
Falls Church, VA 22042
703-280-5858
SJB@Busuttil.me

CALIK, MUSTAFA K.
Kadikoyysifa Hospital Atasehir
Isiklar Caddesi, No: 35/A, Atasehir
Istanbul, Turkey, 34805
Turkey
mkcalik@gmail.com

*Senior Member
Active Membership Roster 2012

CALTON, WILLIAM CUYLER
Foothills Cardiothoracic & Vascular
Ste 500 225 E Wood St
Spartanburg, SC 29303-3050
864-560-4420
calton@srhs.com

*CAMBRIA, ROBERT A.
Vascular Care of Maine
489 State Street
Bangor, ME 04401
207-973-6670
rcambria@emh.org

*CAMPBELL, JESSICA B.
1246 Ashland Avenue, Suite #101
Zanesville, OH 43701
740-453-0730
jboc@columbus.rr.com

CAPARRELLI, DAVID J.
The Arizona Heart Institute
2632 N. 20th Street
Phoenix, AZ 85006
602-266-2200
dcaparrelli@azheart.com

CARLON, DOUGLAS J.
3033 N. Central, Suite 610
Phoenix, AZ 85012
602-277-7430
dougcarlon@gmail.com

*CARNEY, WILFRED I.
2 Dudley Street, #470
Providence, RI 02905
401-553-8225

CARSON, JOHN G.
UC Davis Health System
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-0448
jgcarson@hotmail.com

CARSTEN, CHRISTOPHER G.
Greenville Hospital System
701 Grove Road, Support Tower
Greenville, SC 29605
864-455-7886
ccarsten@ghs.org

CASEY, KEVIN M.
Naval Medical Center San Diego
34800 Bob Wilson Drive
San Diego, CA 92134
619-532-6400
irishnola@yahoo.com

CAYNE, NEAL S.
530 1st Avenue, Suite 6F
New York, NY 10016
212-263-7311
neal.cayne@nyumc.org

CERVEIRA, JOAQUIM J.
Kaiser Permanente
13562 Cantara Street, CMOB 201
Panorama City, CA 91402
818-375-3195
joaquim.j.cerveira@kp.org

CHAER, RABIH A.
UPMC Presbyterian
200 Lothrop Street, Suite A1011
Pittsburgh, PA 15213-2536
412-802-3025
chaerra@upmc.edu

*CHAIKOF, ELLIOT L.
Beth Israel Deaconess Medical Center
110 Francis Street, Suite 58
Boston, MA 02215

CHAMBERS, CHRISTOPHER M.
Spectrum Health Medical Group
4069 Lake Drive, Suite 312
Grand Rapids, MI 49546
616-459-8700
christopher.chambers@spectrum-health.org

CHANDRA, ANKUR
University of Rochester Medical Center
601 Elmwood Avenue, Box 652
Rochester, NY 14642
585-273-2596
ankur_chandra@urmc.rochester.edu

*Senior Member
Active Membership Roster 2012

*CHANG, BENJAMIN B.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-5640
changb@albanyvascular.com

*CHARNEY, KIM J.
1140 W. LaVeta Street, #620
Orange, CA 92868
714-550-0600

CHAUVAPUN, JOE
Harbor-UCLA Medical Center
1000 W. Carson Street, Box 11
Torrance, CA 90502
310-953-5502
joechauvapun@yahoo.com

CHERR, GREGORY S.
Buffalo General Hospital
100 High Street
Buffalo, NY 14203
716-859-2810
gcherr@buffalo.edu

CHETTER, IAN C.
Academic Vascular Surgical Unit
Anlaby Road
Hull, HU3 2JZ
United Kingdom
441482674212
ian.Chetter@hey.nhs.uk

CHIRIANO, JASON T.
Pettis VA Hospital Loma Linda
11201 Benton Street (112)
Loma Linda, CA 92357
909-825-7084
jason.chiriano@va.gov

CHOI, LORRAINE
UTMB
301 University Boulevard
Galveston, TX 77555-0735
409-772-6366
lori.choi@utmb.edu

*CHURCH, PHILLIP J.
Cardiothoracic & Vascular Surgeons
1010 W. 40th Street
Austin, TX 78756
512-459-8753
pchurch@ctvsottexans.com

*CIKRIT, DOLORES F.
Indiana University
1801 N. Senate Blvd., MPC 2, Suite D
Indianapolis, IN 46202
317-630-7169
dcikrit@iupui.edu

*CIOCCA, ROCCO G.
184 Wellesley Avenue
Wellesley, MA 02481

CIRES, GIANCARLO
West Palm Beach VA Medical Center
7305 North Military Trail
West Palm Beach, FL 33410
561-422-8262
giancarlo.cires@va.gov

*CLAIR, DANIEL G.
Cleveland Clinic Foundation
9500 Euclid Avenue, F30
Cleveland, OH 44195-0001
216-444-3857

*CLARK, ELIZABETH T.
2150 East Lake Cook Road, Suite 40-C
Buffalo Grove, IL 60089
847-465-6064
elizabeth.clark@comcast.net

CLOUSE, W. DARRIN
UC Davis
4860 Y Street, ACC Bldg., Suite 3400
Sacramento, CA 95817-2307
916-734-2022
wdclouse@ucdavis.edu

*COFFEY, JAMES A.
301 S. Seventh Avenue, Suite 1070
West Reading, PA 19611
215-378-9667
jacoffey76@gmail.com

*Senior Member
Active Membership Roster 2012

COHN, EDWARD J.
Savannah Vascular Institute
4750 Waters Avenue, Suite 500
Savannah, GA 31404
912-629-7800
jcohn@savannahvascular.com

*COLE, C. WILLIAM
Kaiser Permanente Southern California
4760 Sunset Boulevard
Los Angeles, CA 90027
323-783-5774
cwmcole@hotmail.com

COLL, DAVID
Greater Baltimore Vascular Surgery
6569 N. Charles Street, Suite 701
Baltimore, MD 21204
410-512-8686
david.p.coll@medstar.net

COLLINS, DAVID E.
University of Tennessee at Chattanooga
979 East 3rd Street, Suite 401
Chattanooga, TN 37403
dec@blackirishman.net

*COLLINS, JOHN T.
315 East Lindsey Street, Apt. #3
Chattanooga, TN 37403

*COLLINS, P. STEVEN
960 7th Avenue N
St. Petersburg, FL 33705
727-821-8101
sclpac@aol.com

*COMEROTA, ANTHONY J.
Jobst Vascular Institute
Conrad Jobst Tower
2109 Hughes Drive, Suite 400
Toledo, OH 43606
419-291-2088
marilyn.gravett@promedica.org

CONNERS, MICHAEL S.
CVT Surgical Center
7777 Hennessy, Suite 1008
Baton Rouge, LA 70808
225-766-0416
msconners@cox.net

CONNOLLY, PETER
New York Presbyterian
525 East 68th Street, Payson-720
New York, NY 10065
646-660-2240
pc2227@gmail.com

CONRAD, MARK F.
Massachusetts General Hospital
15 Parkman Street, WAC 440
Boston, MA 02114
617-724-7660
mconrad@partners.org

*CONTE, MICHAEL S.
400 Parnassus Avenue
OOM A-581, Box 0222
San Francisco, CA 94143-0222
415-353-4366
michael.conte@ucsfmedctr.org

COOGAN, SHEILA M.
Memorial Hermann Northeast
9813 Memorial Blvd., Suite A
Humble, TX 77338
713-486-1150
Sheila.M.Coogan@uth.tmc.edu

COOK, PATRICK
William Beaumont Army Medical Ctr.
5005 N. Piedras Street
El Paso, TX 79920
706-442-1693
Patrick.Cook@amedd.army.mil

COOPER, SHELBY
Bassett Healthcare
1 Atwell Road
Cooperstown, NY 13326
607-547-3474
shelby.cooper@bassett.org

CORRIERE, MATTHEW A.
Wake Forest Univ. Baptist Medical Ctr.
Medical Center Boulevard
Winston-Salem, NC 27157
336-716-9502
macorrie@wakehealth.edu

*Senior Member
Active Membership Roster 2012

Corry, David C.
Associates in General & Vascular Surgery
1400 E. Boulder Street, Suite 600
Colorado Springs, CO 80909
dcorry@agvscs.com

CORSO, J. Eduardo
Peachtree Vascular Associates, PC
550 Peachtree Street, NE Suite 1085
Atlanta, GA 30308-2232
404-681-3190
corso18@yahoo.com

*Coselli, Joseph S.
One Baylor Plaza, Suite BCM 390
Houston, TX 77030
832-355-9910
jcoselli@bcm.tmc.edu

Costanza, Michael J.
750 East Adams Street
Syracuse, NY 13210
315-464-6241
costanzm@upstate.edu

Cox, Mitchell Wayne
Duke University Medical Center
DUMC 2833
Durham, NC 27710
919-613-5239
mitchell.cox2@duke.edu

*Crepps, J. Thomas
Penrose Cardiac, Thoracic & Vascular Surgery
222 N. Nevada Avenue, Suite 5011
Colorado Springs, CO 80907
719-776-7600
josephcrepps@centura.org

*Criado, Enrique
University of Michigan
CVC - 5463, SPC 5867, 1500 E. Medical Center Drive
Ann Arbor, MI 48109-5867
734-763-0250
ecriado@umich.edu

Crutchley, Teresa A.
Wilford Hall F Medical Center
2200 Bergquist Drive, Suite 1
Lackland AFB, TX 78236
210-292-5050
renogrrrl@yahoo.com

Cuff, Robert F.
MMPC Vascular Surgery
4069 Lake Drive, SE
Grand Rapids, MI 49546-8816
616-459-8700
robert.cuff@spectrum-health.org

*Cull, David L.
701 Grove Road
Greenville, SC 29605-4281
864-455-5599
dcull@ghs.org

Curci, John A.
Washington University School of Med.
660 S. Euclid Avenue
Suite 5105, Campus Box 8109
St. Louis, MO 63110
3143627406
curcij@wudosis.wustl.edu

Curi, Michael A.
150 Bergen Street, F-102
Division of Vascular Surgery
Newark, NJ 07103
973-972-6295
curi@umdnj.edu

*Dalsing, Michael C.
Indiana University Medical Center
1801 North Senate Blvd., MPC II, #3500
Indianapolis, IN 46202
317-630-7360

Dardik, Alan
Yale University School of Medicine
10 Amistad Street, Room 437D, PO Box 208089
New Haven, CT 06520-8089
203-737-2213
alan.dardik@yale.edu

*Senior Member
Active Membership Roster 2012

*DARLING, R. CLEMENT
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-8720
darlingc@albanyvascular.com

DATTILO, JEFFERY B.
Vanderbilt University Medical Center
D-5237 MCN, 1161 22nd Avenue St.
Nashville, TN 37232-2735
615-322-2343
jeffery.dattilo@vanderbilt.edu

*DAUTERIVE, EDWARD
1100 Andre Street, #101
New Iberia, LA 70563
318-369-9309
ndauter@bellsouth.net

*DAVENPORT, PHYLLIS
Peripheral Vascular Association
111 Dallas Street, Suite 200-A
San Antonio, TX 78205
210-225-6508

DAVIES, MARK G.
The Methodist Hospital
6550 Fannin, Suite 1401
Houston, TX 77030
713-441-6201
mark.daviesmdphd@gmail.com

*DAWSON, DAVID L.
UC Davis Medical Center
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-8122
david.dawson@ucdmc.ucdavis.edu

DAYAL, RAJEEV
161 Ft. Washington Avenue, HIP 641
New York, NY 10032
212-305-8665

D'AYALA, MARCUS
New York Methodist Hospital
Dept. of Surgery, 506 Sixth Street
Brooklyn, NY 11215
718-780-3288
mdd9004@nyp.org

DE JESUS, GUSTAVO ALBERTO
PO BOX 19554
San Juan, 00910
Puerto Rico
787-726-0440
gusdejesus@hotmail.com

*DE ROSE, GUY
London Health Sciences Centre
800 Commissioners Road
East Room E2-123
London, ON N6A 5W9
Canada
519-667-6644
guy.deroselhsc.on.ca

*DEATON, DAVID H.
Georgetown University
4th Floor PHC, 3800 Reservoir Road NW
Washington, DC 20007-2113
202-444-2255
david@deaton.md

*DEIPARINE, MICHAEL K.
Liberty Medical Office Building
2521 Glenn Hendren Drive, #112
Liberty, MO 64068
816-781-5006
MDeiparine@planetkc.com

DEITCH, JONATHAN S.
Staten Island University Hospital
256 Mason Avenue, Bldg. B, 2nd Floor
Staten Island, NY 10305
718-226-1278
jdeitch@siuh.edu

DELATORE, JASON R.
540 Parmalee Avenue
Youngstown, OH 44510
330-747-1106
jdelatore@pol.net

*DENNIS, JAMES W.
University of Florida Health Sciences
653-2 West Eight Street
Jacksonville, FL 32209
904-244-3925
james.dennis@jax.ufl.edu

*Senior Member
Active Membership Roster 2012

DERUBERTIS, BRIAN G.
UCLA Gonda Vascular Center
200 Medical Plaza, Suite 510-6
Los Angeles, CA 90095-6908
619-543-6980
bderubertis@mednet.ucla.edu

DESAI, TINA R.
North Shore University Health System
9977 Woods Drive, Suite 355
Skokie, IL 60077
847-663-8042
tdesai2@northshore.org

DESHMUKH, DEEPAK
Vascular & Transplant Specialists
4000 Coliseum Drive, Suite 310
Hampton, VA 23666
757-470-5570
deepakdeshmukh@hotmail.com

DICKSON, CHRISTOPHER S.
2704 Henry Street
Greensboro, NC 27405
336-621-3777
cddolphin@aol.com

*DIETZEK, ALAN M.
111 Osborne Street, Suite 204
Danbury, CT 06810
203-797-1881
alan.dietzek@danhosp.org

DIMUZIO, PAUL J.
Thomas Jefferson University
111 S. Eleventh Street, Gibbon 6270
Philadelphia, PA 19107
215-955-8304
paul.dimuzio@jefferson.edu

*DONAYRE, CARLOS E.
Harbor-UCLA Medical Center
1000 W. Carson Street (Box 304)
Torrance, CA 90509-9823
310-222-2704
cdonayre@cox.net

*DOSCHER, WILLIAM
2001 Marcus Avenue, Suite South 50
Lake Success, NY 11042
516-328-9800
DoscherMD@aol.com

DOSLUOGLU, HASAN H.
VA Western NY Healthcare Systems
3495 Bailey Avenue
Buffalo, NY 14215
716-862-9937
dosluoglu@yahoo.com

DOUGLAS, MICHAEL G.
4 Greenwood Place
Asheville, NC 28803
828-684-7470

DOVGAN, PETER S.
Space Coast Vascular Med
3021 West Eau Gallie Blvd., Suite 103
Melbourne, FL 32934
321-751-2707

DOWNING, LAMIERE J.
2900 Lamb Circle, Suite 300
Christiansburg, VA 24073-6341

*DRASCHER, GARY A.
Surgical Associates of Central NJ
30 Rehill Avenue, Suite 3300
Somerville, NJ 08876
732-356-0770
gdrascher@aol.com

DUENSING, ROBERT A.
24411 Health Center Drive, Suite 350
Laguna Hills, CA 92653
949-457-7900
rduensing@thevasculargroup.com

DUNCAN, AUDRA A.
Mayo Clinic
200 First Street SW, Gonda 4S
Rochester, MN 55905
507-284-4751
duncan.audra@mayo.edu

*Senior Member
Active Membership Roster 2012

*DURHAM, JOSEPH R.*
10347 S. Longwood Drive
Chicago, IL 60643-2610
708-633-2805
drhoser@aol.com

DUWAYRI, YAZAN
Assistant Professor of Surgery
1365 Clifton Road NE
Building A, Suite A3205
Atlanta, GA 30322
404-694-8069
yduwayri@hotmail.com

EAGLETON, MATTHEW J.
The Cleveland Clinic Foundation
Dept. of Vascular Surgery
H52 9500 Euclid Avenue
Cleveland, OH 44195
216-445-1167
eagletm@ccf.org

*EARLY, TODD F.*
Vascular & Vein Specialists of Greensboro
2704 Henry Street
Greensboro, NC 27405
336-621-3777

EDWARDS, MATTHEW S.
Wake Forest Univ. Baptist Medical Ctr.
Medical Center Boulevard
Winston-Salem, NC 27157-1095
336-716-3318
medwards@wfubmc.edu

*EDWARDS, WILLIAM*
The Surgical Clinic PLLC
4230 Harding Road, Suite 525
Nashville, TN 37205-2075
615-383-2674
edwardsjr@comcast.net

EGINTON, MARK T.
Pavillion Surgical Associates
920 E. First Street, Suite 302
Duluth, MN 55805-2225
218-249-6050
megint0n@slhdeluth.com

EISENBERG, JOSHUA A.
Thomas Jefferson University
111 South 11th Street, Suite 6270 Gibbon
Philadelphia, PA 19107
215-955-8304
drjoshmd@gmail.com

ELIASON, JONATHAN L.
University of Michigan
1500 E. Medical Center Drive
SPC 5867 CVC 5463
Ann Arbor, MI 48109-5867
734-936-5786
jonaelia@med.umich.edu

ELLIS, JENNIFER
University of Rochester
601 Elmwood Avenue, Box 652
Rochester, NY 14642
585-273-2048
ellis27@gmail.com

*ELLISON, ROBERT G.*
Robert Ellison, MD, PA
836 Prudential Drive, Pavilion Suite 1405
Jacksonville, FL 32007
904-388-7521
dre@ellisonvein.com

*ELMORE, JAMES R.*
Geisinger Medical Center
Vascular Surgery, 100 N. Academy Ave-
Danville, PA 17822-2150
570-271-6369
jelmore@geisinger.edu

EL-SAYED, HOSAM F.
Methodist Hospital
6550 Fannin Street, Suite 1401
Houston, TX 77030

*ENDEAN, ERIC D.*
Univ. of Kentucky Chandler Medical Ctr.
800 Rose Street, Room C-215
Lexington, KY 40536-0001
859-323-5273
edende0@uky.edu

*Senior Member
Active Membership Roster 2012

ENGLE, JENNIFER S.
3290 W. Big Beaver Road, Suite 410
Troy, MI 48084
248-816-6300
jsuengle@yahoo.com

*ERDOES, LUKE S.
Mountain Medical Vascular Specialists
1486 East Skyline Drive
South Ogden, UT 84405
801-479-6687
erdoesls@gmail.com

ERICKSON, CURTIS A.
Cardiovascular Consultants, LTD.
3805 E. Bell Road, Suite 3100
Phoenix, AZ 85032
602-867-8644
camri@cox.net

ESCOBAR, GUILLERMO A.
University of Michigan
1500 E. Medical Center Drive
CVC 5463 - SPC 5867
Ann Arbor, MI 48109
734-936-5820
guisescob@med.umich.edu

ESMUEDE, NOWOKERE
8055 Spyglass Hill Road, Suite 102
Melbourne, FL 32940
321-255-8080
nesemude@yahoo.com

ESKANDARI, MARK K.
NMFF
676 N. Saint Clair Street, Suite 650
Chicago, IL 60611
312-695-2714
meskanda@nmh.org

*ESSES, GLENN E.
171 Mobile Infirmary Blvd.
Mobile, AL 36607
251-432-0558

EZE, AUGUSTINE R.
PO Box 550490
Gastonia, NC 28055
704-864-6500

*FANTINI, GARY A.
635 Madison Avenue, 7th Floor
New York, NY 10022
212-317-4550
gaf@newyorkphysicians.com

FARBER, MARK A.
University of North Carolina
130 Mason Farm Road
145 Biomedical Informatics Bldg., Box 7212
Chapel Hill, NC 27599
919-966-3391

FARIES, PETER L.
Mount Sinai School of Medicine
5 E. 98th Street, PO Box 1273
New York, NY 10029-6501
212-241-5386
peter.faries@mountsinai.org

FAULK, JIMBOB
The Surgical Clinic, PLLC
4230 Harding Road, Suite 525
Nashville, TN 37205
615-385-1547
jfaulk@tsclinic.com

FEEZOR, ROBERT J.
University of Florida
P.O. Box 100128
1600 SW Archer Road, Rm NG-54
Gainesville, FL 32610
352-273-7020
feezor@surgery.ufl.edu

*FEINBERG, RICHARD L.
Johns Hopkins @ Cedar Lane Richard
11065 Little Patuxent Pkwy, STE 150
Columbia, MD 21044-2895
410-964-2306
rfeinber4@jhmi.edu

FERRIS, BRIAN L.
Lake Washington Vascular Surgery
1135 116th Avenue NE, Suite 305
Bellevue, WA 98004
425-453-1772

*Senior Member
Active Membership Roster 2012

*FERRIS, EUGENE B.
River Region Medical Center
2100 Hwy 61 N
Vicksburg, MS 39183
601-883-6098

*FISHER, JAY B.
3735 Nazareth Road, #206
Easton, PA 18045
610-252-8281

FISHMAN, ERIC
West Med Group
40 E 94th Street, 23F
New York, NY 10128
917-825-3250
efishman@westmedgroup.com

FLEMING, MARK D.
Mayo Clinic
5191 Middlebrook Drive NW
Rochester, MN 55901-2182
507-284-1575
fleming.mark@mayo.edu

FORBES, THOMAS L.
London Health Sciences Center
800 Commissioners Road, E. E2-119
London, ON N6A 5W9
Canada
519-667-6794
Tom.Forbes@lhsc.on.ca

FOTEH, KOUSTA I.
2802 NW 171st Street
Edmund, OK 73012-7932
kousta@yahoo.com

*FOWL, RICHARD
Mayo Clinic- Scottsdale
13400 E. Shea Boulevard
Scottsdale, AZ 85259-7157
480-301-7157
fowl.richard@mayo.edu

FOX, CHARLES J.
Walter Reed Nat’l Military Medical Center
1220 East West Hwy, Apt. 1222
Silver Spring, MD 20910
202-782-6537
charles.fox@us.army.mil

*FRANCO, CHARLES D.
2 Research Way, Suite 206
Monroe Township, NJ 08831-6820
732-246-8266
doccutup@aol.com

FRANKINI, LARRY A.
Vascular Associates of Long Island
2001 Marcus Avenue, Suite 550
Lake Success, NY 11042-1039
516-328-9800

*FRANKLIN, DAVID P.
Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822-2150
717-271-6369

FRANZ, RANDALL W.
Central Ohio Vascular Services
285 E. State Street, Suite 260
Columbus, OH 43215
614-566-9035
RFRANZ2@ohiohealth.com

*FREISCHLAG, JULIE A.
Johns Hopkins Hospital
720 Rutland Avenue, Room 759
Baltimore, MD 21205-3500
443-287-3497
jfreisc1@jhmi.edu

*FUJITANI, ROY M.
UCI Medical Center
333 City Blvd., West Suite 700
Orange, CA 92868
714-456-5453
rmfujita@uci.edu

GABLE, DENNIS R.
Texas Vascular Associates
621 North Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
Den1Beth@aol.com

*Senior Member
Active Membership Roster 2012

*GAGNE, PAUL J.
Southern Connecticut Vascular Center
85 Old Kings Hwy N
Darien, CT 06820
203-425-2790
paul.gagne@optonline.net

*GAHTAN, VIVIAN
Upstate Medical University
College of Medicine, 750 E. Adams St.
Syracuse, NY 13210
315-464-6241

*GALLAGHER, JAMES J.
Hartford Clinical Associates
85 Seymour Street, Suite 409
Hartford, CT 06106
860-522-4158
jgallagher@hartfordspecialists.org

GALLAGHER, KATHERINE
University of Michigan
1500 E. Medical Center Drive, Cvc 5th Floor
Ann Arbor, MI
443-742-7872
kgallag@med.umich.edu

GARCIA-TOCA, MANUEL
Brown University/Rhode Island Hospital
Two Dudley Street, Suite 470
Providence, RI 02905
401-228-0600
mgarciatoca@surg.org

GARG, NITIN
25 Courtenay Drive, MSC 295, Rm 7018
Charleston, SC 29425
843-876-4855
garg@musc.edu

GARGIULO, NICHOLAS J.
University of Rochester
601 Elmwood Avenue, Box 65
Rochester, NY 14642
585-273-5580
ngargiul@gmail.com

*GEARY, KEVIN J.
Vascular Surgery Associates
1445 Portland Avenue #108
Rochester, NY 14621
585-922-5550
kevin.geary@viahealth.org

*GELABERT, HUGH A.
UCLA Division of Vascular Surgery
200 Medical Plaza, #526
Los Angeles, CA 90095-6958
310-825-3684
hgelabert@mednet.ucla.edu

*GENNARO, MARK
270 Pulaski Road
Greenlawn, NY 11743
631-385-7258
mgvasdoc@aol.com

*GEORGE, SALEM M.
Surgical Care Associates, PSC
4003 Kresge Way, Suite 100
Louisville, KY 40207
502-897-5139

GERAGHTY, PATRICK J.
Washington University Medical School
660 S. Euclid, Box 8109
St. Louis, MO 63110
314-362-6490
geraghtyp@wustl.edu

*GEUER, JAMES W.
680 Kinderkamack Road
Gradell, NJ 07649
201-262-8346

*GIANGOLA, GARY
NSUH
270-05 76th Avenue, Dept. of Surgery
New Hyde Park, NY 11040
718-470-4503
ggiangola@mshs.edu

GIGLIA, JOSEPH S.
University of Cincinnati
231 Albert Sabin Way, ML #0558
Cincinnati, OH 45267-0058
513-558-5367
Joseph.Giglia@uc.edu

*Senior Member
Active Membership Roster 2012

GILANI, RAMYAR
Baylor College of Medicine
One Baylor Plaza, MS: 390
Houston, TX 77030
713-873-2801
rgilani@bcm.edu

*GILLESPIE, DAVID L.
Division of Vascular Surgery
601 Elmwood Avenue, Box 652
Rochester, NY 14642
585-275-6772
david_gillespie@urmc.rochester.edu

*GINGERY, ROBERT O.
13851 E. 14th Street, #202
San Leandro, CA 94578
510-247-4700

GO, MICHAEL R.
456 W. 10th Avenue, 3018 Cramglett Hall
Columbus, OH 43210-1228
614-293-8536
michael.go@osumc.edu

GOFF, JAMES M.
Albuquerque VA Medical Center
1501 San Pedro Drive SE (112)
Albuquerque, NM 87108
james.goff2@va.gov

*GOLAN, JOHN F.
495 Central Avenue, Suite 200
Northfield, IL 60093

*GOLMAN, KENNETH A.
Princetown Surgical Associates
281 Witherspoon Street #120
Princetown, NJ 08540-3210
609-921-7223

*GOLDSTEIN, LAWRENCE J.
Surgery Group of Napa Valley
3443 Villa Lane, #3
Napa, CA 94558
707-226-2031

GOLDSTEIN, LEE J.
Univ. of Miami Miller School of Med.
1611 NW 12th Avenue
Miami, FL 33101
305-585-5600
leegoldstein@gmail.com

GONZALES, ALBERTO JOSE
Alberto Jose Gonzalez MD
2809 W Waters Avenue
Tampa, FL 33614
205-821-8734
ajgonzalezmd@gmail.com

GONZE, MARK D.
Vascular Surgery Associates, LLC
520 Upper Chesapeake Drive, Suite 306
Bel Air, MD 21014
410-879-2006

*GOODMAN, GREG R.
5323 Woodrow Street, Suite 102
Salt Lake City, UT 84107-5853
801-408-1000

GOODNEY, PHILIP P.
Dartmouth Hitchcock Medical Center
1 Medical Center Drive
Lebanon, NH 03756-1000
603-650-4682
philip.goodney@gmail.com

*GOODREAU, JAMES J.
1259 S. Cedar Crest
Allentown, PA 18103
215-437-0200

GOSIN, JEFFREY S.
442 Bethel Road
Somers Point, NJ 08244
609-927-3030
jsgosin@comcast.net

*GRAHAM, ALAN M.
UMDNJ-R. W. Johnson Medical School
1 Robert Woods Johnson, CN-19
New Brunswick, NJ 08903-0019
732-235-7816
grahamal@umdnj.edu

*Senior Member
Active Membership Roster 2012

*GRANKE, KENNETH
Michigan State Univ Medical School
1200 E Michigan Avenue, Suite 655
Lansing, MI 48912
734-740-0461
kgranke@yahoo.com

GRAZZIOTIN, MARCELO U.
720 S Van Buren Street, #202
Green Bay, WI 54301
920-438-7155
marcellos33@yahoo.com

GREENBERG, ROY K.
Cleveland Clinic Foundation
9500 Euclid Avenue, Desk H32
Cleveland, OH 44195
216-445-5306

*GREENSTEIN, STUART
Albert Einstein College of Medicine
111 East 210th Street
Bronx, NY 10467-2401
718-920-6157
sgreenst@montefiore.org

*GREENWALD, LORI L.
1 Barnard Lane
Bloomfield, CT 06002-2413
860-761-6666

GRIMSLEY, BRADLEY R.
Texas Vascular Associates
621 N. Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
bradgrimsley@gmail.com

*GROEGER, EUGENE C.
2645 Ocean Avenue, #307
San Francisco, CA 94132
415-239-2300

*GROVE, MARK K.
Cleveland Clinic - Florida
2950 Cleveland Clinic Blvd.
Weston, FL 33331
959-659-5232

*GUPTA, DEEPAK
16700 Bayview Ave.
Newmarket, ON L3X 1W1
Canada
905-953-0637

GUPTA, NAREN
VA Boston Healthcare System
1400 VFW Parkway, Surgery 112
West Roxbury, MA 02132-4927
857-203-6732
naren.gupta2@va.gov

GUPTA, NAVYASH
North Shore Univ. Health System
9977 Woods Drive, Suite 355
Skokie, IL 60077
847-663-8050

GUZZO, JAMES L.
Mercy Medical Center
01 St. Paul Place 5th Floor
Baltimore, MD 21292
410-332-9404
jguzzo@mdmercy.com

*HADCOCK, WILLIAM
Valley Vascular Surgical
1247 E. Allivial, Suite 101
Fresno, CA 93720
559-431-6226

HALANDRAS, PEGGE
Loyola University
2160 South First Avenue
Maywood, IL 60153
708-327-2686
phalandras@lumc.edu

HAMDAN, ALLEN D.
Beth Israel Deaconess M.C.
110 Francis Street, Suite 5B
Boston, MA 02215
617-632-9953
ahamdana@bidmc.harvard.edu

*Senior Member
Active Membership Roster 2012

*HAMILTON, IAN N.
Comprehensive Vascular Care, LLC
1109 Burleyson Road, Suite 202
Dalton, GA 30720-3094
706-259-3336
INHamilton@aol.com

HAN, DAVID C.
Penn State Hershey Medical Center
Division of Vascular Surgery
00 University Drive
Hershey, PA 17033
717-531-8866
DHAN@hmc.psu.edu

*HANSEN, KIMBERLEY J.
Wake Forest School of Medicine
Department of General Surgery
Medical Center Boulevard
Winston-Salem, NC 27157-1095
336-713-5256
kjhansen@wfubmc.edu

*HAQUE, SHAHID N.
218 Common Way, Building B
Toms River, NJ 08755-6427
732-244-4448

HARLIN, STUART A.
Coastal Vascular & Interventional PLLC
5147 N. 9th Avenue, Suite 318
Pensacola, FL 32504
850-479-1805
harlin42k@cox.net

*HARRINGTON, ELIZABETH
Vascular Surgical Associates, PLLC
2 E. 93rd Street
New York, NY 10128
212-876-7400

*HARRIS, E. JOHN
Stanford University
300 Pasteur Drive, H-3641
Stanford, CA 94305-5642
650-725-6492
edjohn@stanford.edu

*HARRIS, KENNETH A.
The Royal College of Physicians
774 Echo Drive
Ottawa, ON K1S 5N8
Canada

HART, JOSEPH P.
Medical University of South Carolina
Dept. of Surgery, Div. of Vascular Surgery
25 Courtenay Drive, Suite 7018 MSC 295
Charleston, SC 29425
843-876-4855
josephphart@aol.com

HARTHUN, NANCY L.
Johns Hopkins Hospital
600 N. Wolfe Street, Harvey 611
Baltimore, MD 21287
410-614-8522

HASER, PAUL B.
UMDNJ-RWJ Medical School
1 Robert Wood Johnson Pl., MEB-541
New Brunswick, NJ 08901-1928
732-235-7816
haserp@umdnj.edu

HAURANI, MOUNIR J.
The Ohio State University Medical Center
456 W. 10th Avenue, Cramblett 3018
Columbus, OH 43210
614-293-8536
jhaurani@hotmail.com

*HAYES, P. GREGORY
Cardiov. & Thoracic Surg. of Greensboro
2704 Henry Street
Greensboro, NC 27405
336-621-3777
canuc57@aol.com

*H’DOUBLER, PETER B.
Vascular Institute of Georgia
5673 Peachtree Dunwoody, NE Suite 675
Atlanta, GA 30342
404-256-0404

*Senior Member
Active Membership Roster 2012

**HEALY, DEAN A.**
West Penn Allegheny Health System
320 East North Avenue
Pittsburgh, PA 15212
412-359-3714
healydean@yahoo.com

**HEDAYATI, NASIM**
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-2022
nhedayati@ucdavis.edu

**HEIDENREICH, MICHAEL J.**
5325 Elliott Drive, Suite 104
Ypsilanti, MI 48197
734-712-8150
heiderm@trinity-health.org

**HERNANDEZ, DIEGO A.**
St Joseph Mercy Oakland
44555 Woodward Avenue, Suite 501
Pontiac, MI 48341
248-338-7117
hernanda@trinity-health.org

**HERRINGTON, JAMES W.**
GFH Surgical Associates
718 Shore Road
Somers Point, NJ 08244
609-927-8550
JamHerr@comcast.net

**HILL, ANDREW B.**
Ottowa Hospital - Civic Campus
1053 Carling Avenue, A280
Ottawa, ON K1Y 4E9
Canada
ahill@ottawahospital.on.ca

**HINGORANI, ANIL**
Maimonides Medical Center
960 50th Street
Brooklyn, NY 11219
718-438-3800
ahingoranilmcmc.com

**HIRKO, MARK K.**
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199
413-794-0900

**HNATH, JEFFREY C.**
Vascular Group
43 New Scotland Avenue, MC 157
Albany, NY 12208
518-262-8720
hnathj@albanyvascular.com

**HOBSON, JOHN R.**
Greenwood Surgery/ Carolina Vasc. Lab
160 Academy Avenue
Greenwood, SC 29646
864-223-8090

**HOCHE, JOHN R.**
University of Wisconsin
600 Highland Avenue, GS/321 Clinical Science Center
Madison, WI 53792-7375
608-263-1388
hoch@surgery.wisc.edu

**HODGKISS-HARLOW, KELLEY D.**
Raiser Permanent
4647 Zion Avenue
San Diego, CA 92120
423-778-7695
khodgkis@gmail.com

**HOGAN, MICHAEL B.**
University of TN
979 East 3rd Street, #401
Chattanooga, TN 37403
michael.hogan@universitysurgical.com

**HOROWITZ, JOHN D.**
Surgical Specialists of Central FL
10000 West Colonial Drive, #495
Ocoee, FL 34761
407-293-5944

*Senior Member*
Active Membership Roster 2012

*HOYNE, ROBERT F.
Vascular Surgery Associates
2631 Centennial Blvd., Suite 100
Tallahassee, FL 32308
850-877-8539
rhtoyne@VSAFL.com

HUGHES, JOHN D.
Arizona Health Sciences Center
1501 N. Campbell Avenue, 4404
Tucson, AZ 85724
520-626-6670
jhughes@email.arizona.edu

HUGHES, KAKRA
Howard University College of Medicine
2041 Georgia Avenue, 4B-34
Washington, DC 20060
202-865-1281
k_hughes@howard.edu

HURIE, JUSTIN
Wake Forest University
Medical Center Boulevard
Winston-Salem, NC 27157
336-713-5256
justin.hurie@gmail.com

HURLBERT, SCOTT N.
Colorado Springs Vascular, P.C.
175 S. Union, Suite 320
Colorado Springs, CO 80910
719-477-1033

HUSEYNOVA, KHUMAR
Toronto General Hospital
200 Elizabeth Street
Toronto, ON MSG 2C4
Canada
khumarhuse@yahoo.ca

*HUTTO, JOHN D.
Prevea Health
1821 South Webster
Green Bay, WI 54301
920-436-1358
jd_hutto@yahoo.com

HUYNH, TAM THI THANH
Thoracic & Cardiovascular Surgery
1400 Pressler Street, FCT19.6000
Houston, TX 77030
713-794-1477
thuynh1@mdanderson.org

IAFRATI, MARK D.
20 Hampshire Road
Wellesley, MA 02481
617-636-5019

IERARDI, RALPH P.
Christian Care Vascular Specialists
4765 Ogletown-Stanton Road, Suite 1E20
Newark, DE 19713
302-733-5700
Rlerardi@christianacare.org

IHNNAT, DANIEL M.
University of Utah Medical Center
30 N 1900 East - Room 3C344
Salt Lake City, UT 84132
801-585-7519
DIhnat@gmail.com

*ILIYA, CHARLES A.
1151 N. Buckner Blvd, #202
Dallas, TX 75218
214-321-2481

ILLIG, KARL A.
USF College of Medicine
2 Tampa General Circle, STC 7016
Tampa, FL 33606
813-259-0921
killig@health.usf.edu

INDES, JEFFREY
Yale University
333 Cedar Street, BB 204
New Haven, CT 06510
203-785-6216
jeffrey.indes@yale.edu

*Senior Member
Active Membership Roster 2012

*INGRAM, JAMES C.*
155 Hospital Drive, #201
Lafayette, LA 70503
318-234-7777
ingramjc@aol.com

IRWIN, CHANCE L.
Amarillo Surgical Group
6 Medical Drive
Amarillo, TX 79106
806-212-6604
chance.irwin@suddenlink.net

*IVARSSON, BENGT*
Doctors Pavilion
701 Ostrum Street, #601
Bethlehem, PA 18015
610-822-4111
bengtitargarsson@prodigy.net

*JACOB, DENNIS M.*
Community Heart & Vascular
1400 N Ritter Avenue, Suite 100
Indianapolis, IN 46219-3045
317-535-9338
jacobden1@gmail.com

JACOBOWITZ, GLENN R.
N.Y.U. Medical Center
530 First Avenue, #6-F
New York, NY 10016
212-263-7311
glenn.jacobowitz@nyumc.org

*JAIN, KRISHNA M.*
Advanced Vascular Surgery
A Division of Paragon Health P.C.
1815 Henson Street
Kalamazoo, MI 49048-1510
616-226-5200
dockrishna@aol.com

*JAXHEIMER, ERIC C.*
Reading Vascular Surgery Specialists
301 South 7th Avenue, Suite 1070
West Reading, PA 19611-1493
610-378-9667
mejx123@aol.com

*JEPSSEN, STEPHEN J.*
Adena Cardio Thor Vasc Surg
4439 State Route 159, Suite 130
Chillicothe, OH 45601
740-779-4360
stephenjep@aol.com

JEYABALAN, GEETHA
UPMC Department of Vascular Surgery
200 Lothrop Street, Suite A1011
Pittsburgh, PA 15213
412-802-3333
jeyabalang@upmc.edu

JIM, JEFFREY
Washington University
660 S. Euclid Avenue, Campus Box 8109
St. Louis, MO 63110
314-362-745
jimj@wudosis.wustl.edu

JIMENEZ, JUAN CARLOS
UCLA
200 Medical Plaza, Suite 526
Los Angeles, CA 90095
310-206-1786
jcjimenez@mednet.ucla.edu

JOELS, CHARLES S.
University Surgical Associates
2108 East 3rd Street
Chattanooga, TN 37404
423-267-0466
csjoels@gmail.com

JOGLAR, FERNANDO L.
UPR Medical Sciences
Campus Suite A-923
San Juan 00936-5067
Puerto Rico
787-403-4349
Fernando.joglar@UPR.edu

JOHANNING, JASON MICHAEL
UNMC
Dept. of Surgery 983280
Omaha, NE 68198-3280
402-559-4395
johanning@unmc.edu

*Senior Member
Active Membership Roster 2012

JOHNNIDES, CHRISTOPHER G.
Colorado Permanente Medical Group
2045 Franklin Street
Denver, CO 80205-5437
303-861-3688
christopher.g.johnnides@kp.org

JOHNSON, BRAD L.
USF Building
2 Tampa General Circle, Suite 7002
Tampa, FL 33606
813-259-0921
bjohnson@hsc.usf.edu

*JOHR, BERNArado
21110 Biscayne Boulevard, #301
Aventura, FL 33180

JONES, WILMER T.
Mike O’Callaghan Federal Hospital
4700 N. Las Vegas Boulevard
Nellis AFB, NV 89191
702-653-3050
joneswt@hotmail.com

*JORDAN, WILLIAM D.
University of Alabama at Birmingham
1808 7th Avenue, S. BDB 503
Birmingham, AL 35294-0012
205-934-2003
wdjordan@uab.edu

JUNG, MATTHEW T.
4003 Kresge Way, Suite 100
Louisville, KY 40207
502-897-5139

KANSAL, NIKHIL
UCSD Medical Center
200 West Arbor Drive, #8403
San Diego, CA 92103-8403
858-552-8585
nkansal@ucsd.edu

*KARANFILLIAN, RICHARD
150 Lockwood Avenue
New Rochelle, NY 10801
914-636-1700

KASHYAP, VIKRAM S.
University Hospitals - Case Medical Ctr
11100 Euclid Avenue, MS LKS 7060
Cleveland, OH 44106-7060
216-844-1631
Vikram.Kashyap@UHhospitals.org

KASIRAJAN, KARTHIK
NMT Corp.
223 SW 41st Street
Renton, WA 98057
kasi@naturalmolecular.com

*KATZ, SHERMAN A.
PO Box 277
Duncan Falls, OH 43734

*KAUFRMAN, JEFFREY L.
Baystate Vascular Services
3500 Main Street, Suite 201
Springfield, MA 01107-1117
413-794-0900
kaufman@massmed.org

KAUVAR, DAVID
San Antonio Military Medical Center
3851 Roger Brooke Drive
Ft. Sam Houston, TX 84132
210-916-0687
david.kauvar@us.army.mil

*KAZMERS, ANDRIS
Petoskey Surgeons PC
560 W. Mitchell, #140
Petoskey, MI 49770
231-487-1900

KEEFER, ADAM JAMES
Coastal Surgical Vasc & Vein Specialists
1327 Ashley River Road, Bldg B
Charleston, SC 29407
843-553-5616
adamkeefer@gmail.com

KELDAHL, MARK L.
Northwestern Memorial Hospital
3000 N Halsted Street, Suite #703
Chicago, IL 60657
312-926-2000
Mark.Keldahl@advocatehealth.com

*Senior Member
Active Membership Roster 2012

KELSO, REBECCA L.
Cleveland Clinic
Desk F30, 9500 Euclid Avenue
Cleveland, OH 44195
216-445-3527
kelsor@ccf.org

*KERR, THOMAS M.
2809 W. Waters Avenue
Tampa, FL 33614-1852
813-348-9088

KETTELER, ERIKA
NMVAHCS
124 15th Street SW
Albuquerque, NM 87104
erika.ketteler@va.gov

*KEUSHKERIAN, SIMON
1701 Cesar Chavez Avenue, #300
Los Angeles, CA 90033
213-264-2633

KIM, JASON K.
University of Rochester
601 Elmwood Avenue, Box 652
Rochester, NY 14642
585-275-6772
kim.jasonk@gmail.com

KIM, SUNG K.
Kaiser Foundation Hospital
10800 Magnolia Avenue
Riverside, CA 92505
909-353-3606
sung.k.kim@kp.org

*KING, TERRY A.
Cleveland Clinic Florida
2950 Cleveland Clinic Blvd.
Weston, FL 33331
954-659-5232
KingT7@ccf.org

*KLAZURA, PAUL J.
Affiliated Surgeons of Rockford
2300 N. Rockton Avenue, Suite 304
Rockford, IL 61103-3692
815-964-3030

*KOHL, ROY D.
625 South Fairoaks Avenue, Suite 400
Pasadena, CA 91105
626-792-1211

KOHN, JAMES S.
9330 Poppy Drive, Suite 406
Dallas, TX 75218
214-321-1662
james-kohn@sbcglobal.net

*KOLLIPARA, VENKATA S.K.
540 Parmalee Avenue, #410
Youngstown, OH 44510
216-747-6759

*KOSKAS, FABIEN F.
Service de Chirurgie Vasculaire
CHU Pitié-Salpêtrière 47 Bd De L’Hôpital
Paris, 75651
France
33142175708
fabien.koskas@psl.aphp.fr

KOUGIAS, PANOS
1709 Dryden, Suite 1500
Houston, TX 77030
713-798-8412
pkougias@bcm.tmc.edu

*KRAISS, LARRY W.
University of Utah
Division of Vascular Surgery
30 North 1900 East
Salt Lake City, UT 84132
801-581-8301
larry.kraiss@hsc.utah.edu

KREIENBERG, PAUL B.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
kreiembergpi@albanyvascular.com

*Senior Member
**Active Membership Roster 2012**

*KRESOWIK, TIMOTHY F.*  
University of Iowa  
200 Hawkins Drive  
Iowa City, IA 52242-1086  
319-356-7976  
timothy-kresowik@uiowa.edu

**KRONSON, JEFFREY W.**  
12291 E. Washington Blvd., #102  
Whittier, CA 90606  
562-698-2291  
vascudoc@gmail.com

**KULWICKI, AARON D.**  
Mount Carmel  
750 Mount Carmel Mall, Suite 240  
Columbus, OH 43222  
614-234-0444  
aaronkulwicki@hotmail.com

*KVILEKVAL, KARA H.V.*  
Vascular Associates of Long Island PC  
4 Technology Drive  
Setayjet, NY 11733  
631-246-8289

**KWASNIK, EDWARD M.**  
Brigham & Women’s Surgical Associates  
South Shore Hospital  
55 Fogg Road  
South Wayne, CT 02190

*KWOLEK, CHRISTOPHER J.*  
Massachusetts General Hospital  
15 Parkman Street, WAC-458, Vascular  
Boston, MA 02114  
617-724-6101

**LAMBERG, ANDREW D.**  
1525 S. Lowell Avenue  
Springfield, IL 62794-9638  
217-545-3925

**LAMBERT, GLENN E.**  
Norton Vascular  
3 Audubon Plaza Drive, Suite 220  
Louisville, KY 40217  
502-636-7242  
teresa.watt@nortonhealthcare.org

**LANDIS, GREGG S.**  
New York Hospital Queens  
56-45 Main Street  
Flushing, NY 11355  
718-445-0220  
grl9006@nyp.org

**LANE, JOHN S.**  
UC Irvine  
333 City Blvd., West Suite 700  
Orange, CA 92868  
714-456-5453  
jslane@uci.edu

*KLANFORD, JEFFREY E.*  
Greenwood Surgical Assoc.  
160 Academy Avenue  
Greenwood, SC 29646-3808  
864-223-8090  
thehamd@pol.net

**LANGAN, EUGENE M.**  
Greenville Hospital System  
701 Grove Road  
Greenville, SC 29605-5601  
864-455-7886  
elangan@ghs.org

**LANSFELD, MARK**  
University of New Mexico Hospital  
1 University of New Mexico, MSC 10 5610  
Albuquerque, NM 87131-0001  
505-272-5850

**LANTIS, JOHN C.**  
St. Lukes-Roosevelt Hospital Center  
1090 Amsterdam, Suite 7A  
New York, NY 10025  
212-523-4797  
jcl161@columbia.edu

**LAREDO, JAMES**  
GW University Medical Faculty Assoc  
Dept. of Surgery  
22nd & I Streets, NW 6th Floor  
Washington, DC 20037  
571-313-0349  
jlaredo@mfa gwu.edu

*Senior Member*
Active Membership Roster 2012

LARSON, ROBERT A.
Guthrie Clinic
1 Guthrie Square
Sayre, PA 18840
570-882-3087
rlarson@mac.com

LASALLE, ANDRE
Rockwood Clinic
East 400 Fifth Avenue, TAF c-13
Spokane, WA 99220-4013
509-838-2531

LASKOWSKI, IGOR A.
Vascular Associates of Westchester
19 Bradhurst Avenue, Suite 700
Hawthorne, NY 10532-2171
914-593-1200
laskowski@ccwpc.com

LAUTERBACH, STEPHEN R.
1676 Sunset Avenue, Faxton 4th Floor
Utica, NY 13502
315-624-8110
SRLMD@hotmail.com

LAWRENCE, DAVID M.
Surgical Specialists Dept.
830 4th Avenue
Cedar Rapids, IA 52403
319-362-5118

LEE, EUGENE S.
University of California, Davis
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-6061
eugenesc@ucdmc.ucdavis.edu

LEE, JASON T.
Stanford University Medical Center
300 Pasteur Drive, Suite H3600
Stanford, CA 94305
650-724-8292
jtlees@stanford.edu

LEON, LUIS R.
Agave Surgical Associates
4240 East Knight Drive, #118
Tucson, AZ 85712
520-320-5665

LEPORE, MICHAEL R.
Sarasota Vascular Specialists
600 North Cattlemen Road, Suite 220
Sarasota, FL 34232
941-371-6565
mlepore@veinsandarteries.com

LEVISON, JONATHAN A.
The Cardiovascular Care Group
433 Central Avenue
Westfield, NJ 07090
973-759-9000
jlevison@comcast.net

LEVY, MARK M.
The Medical College of Virginia
12000 E. Broad Street, PO Box 980108
Richmond, VA 23298
804-828-3211
mmlevy@vcu.edu

*LILLY, MICHAEL P.
University of Maryland Hospital
Div. of Vasc. Surg., Rm S10B00
22 S. Greene Street
Baltimore, MD 21201-1595
410-328-5840
mlilly@mail.umaryland.edu

LIN, JUDITH C.
Henry Ford Hospital
2799 W. Grand Boulevard
Detroit, MI 48202
313-916-3156
jlin1@hfhs.org

LIN, PETER H.
Faculty Center
1709 Dryden Street, Suite 1500
Houston, TX 77030
713-794-7895
plin@bcm.tmc.edu

LIN, STEPHANIE C.
1501 Trousdale Drive, 5th Floor
Burlingame, CA 94010
650-652-8787
lins3@pamf.org

*Senior Member
LIPSCOMB, AMY L.
The Vascular Center
3735 Nazareth Road, Suite 206
Easton, PA 18045
610-252-8281

LIPSITZ, EVAN C.
Montefiore Medical Center
111 E. 210th Street
Bronx, NY 10467
718-920-2016
ELipsitz@aol.com

LITZENDORF, MARIA E.
The Ohio State University Medical Center
376 W. 10th Avenue, 701 Prior Hall
Columbus, OH 43210
614-293-8536
Dawn.Sagle@osumc.edu

*LOFTUS, JOHN P.
Surgical Group of Napa Valley
3443 Villa Lane, 3
Napa, CA 94558
707-226-2031

*LOHR, JOANN M.
Lohr Surgical Specialists
6350 Glenway Avenue, Suite 208
Cincinnati, OH 45211
513-451-7400
geri_meister@trihealth.com

*LONG, DAVID D.
988 Oak Ridge Turnpike, #350
Oak Ridge, TN 37830-6930
865-483-7030
LAkens@CovHlth.com

LONGO, GERNON MATTHEW
University of Nebraska Medical Center
985182 Nebraska Medical Center
Omaha, NE 68198-5182
402-559-9549
glongo@ummc.edu

*LLOSSING, ALAN G.
16700 Bayview Avenue
New Market, ON L3X 1W1
Canada
905-953-8787
kellystein.drlossingoffice@gmail.com

LUCAS, LAYLA C.
Saguaro Surgical
6422 E. Speedway Blvd., Suite 150
Tucson, AZ 85710
520-318-3004
lucassurgical@gmail.com

LUCAS, PAUL R.
The Vascular Center at Mercy
301 St. Paul Place, 5th Floor
Baltimore, MD 21202
410-332-9404
prlucasmd@gmail.com

LUH, EDDY H.
8930 West Sunset Road, Suite 300
Las Vegas, NV 89148
702-258-7788

LUM, YING WEI
Johns Hopkins Hospital
600 N Wolfe Street, Harvey 611
Baltimore, MD 21287
410-955-5020
ylum@jhmi.edu

*LUMSDEN, ALAN B.
Methodist DeBakey Heart Center
6550 Fannin Street, Suite 1006
Houston, TX 77030-2700
713-441-6201
ablumsden@tmhs.org

LYDEN, SEAN P.
Cleveland Clinic Foundation
9500 Euclid Avenue, S40
Cleveland, OH 44195
216-444-3581
lydens@ccf.org

*Senior Member
Active Membership Roster 2012

*MACKEY, WILLIAM C.*
Tufts Medical Center
750 Washington Street, Box 1035
Boston, MA 02111
617-636-5927
wmackey@tuftsmedicalcenter.org

MACKRELL, PETER J.
2411 W. Belvedere Avenue
Baltimore, MD 21215
410-601-0500
p.mackrell@aol.com

*MACRIS, DEMETRIOS N.*
Peripheral Vascular Associates
111 Dallas Street, Suite 200
San Antonio, TX 78205
210-225-6508
dmacris@pvasatx.com

MAHARAJ, DALE A.
Medical Associates
Abercrombie Street
St. Joseph Trinidad
Trinidad and Tobago
868630528
dalemaharaj@hotmail.com

*MAKHOUL, RAYMOND G.*
Surgical Associates of Richmond
1051 Johnson-Willis Drive, #200
Richmond, VA 23235
804-560-7895

MALAS, MAHMOUD
Johns Hopkins Medical Center
4940 Eastern Avenue, 531A
Baltimore, MD 21224
410-550-5332
mmalas1@smail.jhu.edu

MALDONADO, THOMAS
NYU
530 First Avenue, Suite 6F
New York, NY 10016
212-263-7311
thomas.maldonado@nyumc.org

MANNAVA, KRISHNA
618 Pleasantville Road, Suite #302
Lancaster, OH 43130
krishnamannava@yahoo.com

MANORD, JEFFREY D.
255 Medical Drive, Suite 4
Winfield, AL 35594
205-477-800
jeffrey.manord@lpnt.net

*MANSOUR, M. ASHRAF*
4069 Lake Drive, SE Suite 312
Grand Rapids, MI 49546-8816
616-459-8700
Ashmans2@aol.com

*MARACCIO, EDWARD J.*
Rhode Island Hospital
2 Dudley Street, #470
Providence, RI 02905
401-553-8318

MAREK, JOHN M.
1 University of New Mexico, MSC 10 5610
Albuquerque, NM 87131-0001
505-272-5850
jmarek@salud.unm.edu

MARICA, SILVIU C.
Guthrie Clinic
1 Guthrie Square
Sayre, PA 18840
570-882-2320
marsc92@hotmail.com

*MARIN, MICHAEL L.*
Mt. Sinai Medical Center
5 East 98th Street, Box 1259
New York, NY 10029-6501
212-241-5392
michael.marin@mountsinai.org

MARROCCO, CHRISTOPHER J.
Harbor-UCLA Medical Center
1000 W. Carson Street
Torrance, CA 90509
chris.marrocco@gmail.com

*Senior Member*
Active Membership Roster 2012

MARTINEZ, JORGE L.
Mansion Real 604 Calle Felipe II
Coto Laurel, PR 00780

MARU, SANDIP T.
Eastern CT Medical Professionals
29 Haynes Street, Suite D
Manchester, CT 06040
860-333-6551

MASTRACCI, TARA M.
The Cleveland Clinic Foundation
9500 Euclid Avenue, Desk H32
Cleveland, OH 44195
216-445-1338
mastrat@ccf.org

MATSUURA, JOHN H.
The Iowa Clinic
5950 University Avenue, Suite 231
West Des Moines, IA 50266
515-875-9090
jmatsuura@iowaclinic.com

MATTHEWS, THOMAS C.
1808 7th Avenue S, BDB 503U
Birmingham, AL 35294-0012
205-934-2006
matthewstc@gmail.com

*MCCREADY, ROBERT A.
CorVasc MD's, P.C.
1801 N. Senate Blvd., Suite 755
Indianapolis, IN 46202
317-923-1787
RMCCGoIrish@aol.com

*MCCULLOUGH, JAMES L.
1259 S. Cedar Crest Blvd., #301
Allentown, PA 18103
215-439-0372

*MCDONALD, SANDY I.
50 Alliance Boulevard
Barrie, ON L4M 5K3
Canada
705-728-8778

*MCKINSEY, JAMES F.
Columbia Presbyterian Medical Ctr.
161 Ft. Washington Avenue, Suite 648
New York, NY 10032
212-342-3255
jfm2111@columbia.edu

*MCLAUGHLIN, DANIEL J.
18099 Lorain Avenue, #545
Cleveland, OH 44111
216-476-9669

*MCNEIL, JAMES W.
7777 Hennessy Blvd., Suite 1008
Baton Rouge, LA 70808
225-766-0416
jmcneill@cvts.com

*MCNEILL, PAUL M.
Maryland Surgical Care
77 Thomas Johnson Drive, Suite E
Fredrick, MD 21702
301-695-8346

*MCPHILLIPS, FRANK
Cardio-Thor. & Vasc. Surgical Assoc.
1855 Spring Hill Avenue
Mobile, AL 36607
251-471-3544

MEHTA, MANISH
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-5640
mehtam@albanyvascular.com

*MEISSNER, MARK H.
University of Washington
Dept. of Surgery, Box 356410
1959 NE Pacific Street
Seattle, WA 98195-6410
206-221-7047
meissner@u.washington.edu

MELL, MATTHEW
Stanford University
300 Pasteur Drive, Room H3637
Stanford, CA 94305-5642
650-723-4322
mwmell@stanford.edu

*Senior Member
Active Membership Roster 2012

*MENA, JOSE
221 Delta Drive
Mandeville, LA 70448-7570
504-837-4130
jmena@ochsner.org

*MENDES, DONNA M.
Mendes Vein Care
10 West 66th Street
New York, NY 10023
212-636-4990
dmendes@chpnet.org

METHODIUS-RAYFORD, WALAYA CHIYEM
Georgia Vascular Specialist
1718 Peachtree Street, STE 360
Atlanta, GA 30309
404-350-9505
wmethodi@comcast.net

*MILLER, JAY S.
550 Peachtree Street, NE Suite 1085
Atlanta, GA 30308-2232
404-892-0137

*MILLS, JOSEPH L.
Arizona Health Sciences Center
1501 North Campbell, #4404
Tucson, AZ 85724-5072
520-626-6670
jmills@email.arizona.edu

MILNER, ROSS
Loyola University Medical Center/
Stritch School of Medicine
2160 South First Avenue
EMS Building 110; Rm #3215
Maywood, IL 60153
708-327-3431
rmilner@lumc.edu

MINION, DAVID J.
University of Kentucky Medical Ctr.
800 Rose Street, C-217
Lexington, KY 40536-0298
859-332-6346
djmini@email.uky.edu

*Mitchell, Eric A.
OHSU
3181 SW Sam Jackson Park Road, OP11
Portland, OR 97239
503-494-7593
mitcheer@ohsu.edu

MOHABBAT, WALID
Specialist Vascular Clinic
69 Christie Street, Suite 104
St Leonards, 02065
Australia
61294391110
wald@specialistvascularclinic.com.au

MOINE,P, MIREILLE A.
Metrohealth Hospital
2500 Metrohealth Drive, 9th Floor
Cleveland, OH 44109
216-778-5904
astridmoise@gmail.com

MOLINA, ALEJANDRO
Hospital Cardio Vascular del Nino
cra 16 82 74 cons 704
Bogota
Colombia
5716047489
amolinah@yahoo.com

*MOLL, FRANS L.
University Medical Center Utrecht
Heidelberglaan 100 GOU 12g
Utrecht, 3584 CX
Netherlands
312-506-965
f.l.moll@umcutrecht.nl

MONAHAN, THOMAS S.
University of Maryland
22 South Greene Street, S10800
Baltimore, MD 21201
410-328-5840
t.monahan@hotmail.com

*Senior Member
Active Membership Roster 2012

*MONEY, SAMUEL R.
Mayo Clinic
5779 E. Mayo Boulevard
Scottsdale, AZ 85054
480-301-7157
money.samuel@mayo.edu

MOONEY, CHARLES B.
Gwinnett Surgical
631 Professional Drive, Suite 300
Lawrenceville, GA 30046
770-962-9977

MOORE, ERIN M.
Cardiothoracic & Vasc Surgical Assoc. PA
836 Prudential Drive, Suite 1804
Jacksonville, FL 32207
904-398-3888
vascularmd@gmail.com

MOORE, PHILLIP S.
WFUBMC
Medical Center Boulevard
Winston-Salem, NC 27157
336-716-9502
moorephillip4@gmail.com

MORASCH, MARK D.
NMFF
675 N. Saint Clair Street, Galter 19-100
Chicago, IL 60654
312-695-2714
mdmorasch@gmail.com

MORCAS, OMAR C.
Northshore University Health Systems
9977 Woods Drive, Suite 355
Skokie, IL 60077
847-663-8050
omorcos@northshore.org

MORGAN, JOE H.
2300 Dawson Road, Suite 101
Albany, GA 31707

*MORRISON, EDWARD C.
1327 Ashley River Road, Bldg. B
Charleston, SC 29407
803-577-4551

MORRISSEY, NICHOLAS J.
Columbia/Weill Cornell
161 Ft. Washington Avenue, Suite 639
New York, NY 10032
212-342-2929
njm2106@columbia.edu

MOTAGANAHALLI, RAGHUNANDAN L.
1821 N. Senate Blvd., MPC-2
Suite D-3500
Indianapolis, IN 46202
317-962-0282
raghunandanml@yahoo.com

MUCK, PATRICK E.
7502 State Road, Suite 1180
Cincinnati, OH 45255
513-232-8181
patrick_muck@trihealth.com

MUELLER, MARK P.
2526 California Avenue
Santa Monica, CA 90403-4610

*MULUK, SATISH C.
Allegheny General Hospital
320 E. North Avenue, 14th Floor
Pittsburgh, PA 15212
412-359-3714
muluk@.net

*MUNN, JOHN S.
1815 Henson
Kalamazoo, MI 49048-1510
616-226-5200

MUREESE, LEILA
Duke University Medical Center
Box 3467
Durham, NC 27710
919-681-2800
leila.mureebe@duke.edu

MUSSA, FIRAS F.
New York University School of Medicine
530 First Avenue, Suite 6F
New York, NY 10016
212-263-7311
firas.mussa@nyumc.org

*Senior Member
Active Membership Roster 2012

MUTO, PAULA M.
100 Amesbury Street
Lawrence, MA 01840
978-685-5474

NALBANDIAN, MATTHEW M.
247 Third Avenue, Suite L1
New York, NY 10010
212-254-6882
matthew.nalbandian@med.nyu.edu

NAOUM, JOSEPH J.
The Methodist Hospital
6550 Fannin Street, Suite 1401
Houston, TX 77030
713-441-5200
jjnaoum@tmhs.org

NASLUND, THOMAS C.
Vanderbilt University Medical Center
1161 22nd Avenue S., D-5237 MCN
Nashville, TN 37232-2735
615-322-2343
thomas.naslund@vanderbilt.edu

NAZZAL, MUNIER
Medical College of Ohio
3065 Arlington Avenue, Dowling Hall
Toledo, OH 43614
419-383-3576

NELSON, PETER R.
Univ. of Florida College of Medicine
PO Box 100128
Gainesville, FL 32610-0128
352-273-5484
peter.nelson@surgery.ufl.edu

NESCHIS, DAVID G.
Baltimore Washington Medical Center
301 Hospital Drive
Glen Burnie, MD 21061
410-553-8300
dneschis@bwmc.umms.org

*NEWTON, WM. DENNIS
United Surgical Associates PSC
1401 Harrodsburg Road, #C-100
Lexington, KY 40504-3766
859-278-2334
Dnewton553@aol.com

NICHOLSON, RACHEL
University of Iowa Hospitals & Clinics
200 Hawkins Drive
Iowa City, IA 52242
319-356-8242
rachael-nicholson@uiowa.edu

NOLAN, BRIAN W.
Dartmouth Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-1000
603-650-8670
Brian.Nolan@hitchcock.org

*NOLAN, KEVIN D.
22250 Providence Drive, #555
Southfield, MI 48075-6512
248-424-5748

NOLL, ROBERT E.
Sacramento VA Medical Center
10535 Hospital Way
Mather, CA 95655
916-843-9388
robert.noll@va.gov

OBMANN, MELISSA A.
Geisinger Wyoming Valley Medical Ctr.
1000 E. Mountain Drive
Wilkes-Barre, PA 18711
570-808-6125
maobmann@geisinger.edu

O’BRIEN, PATRICK JOSHUA
Duke University Health System
The Duke Health Center
3116 North Duke Street
Durham, NC 27704
919-681-2550
josh.obrien@duke.edu

OCHOA, CHRISTIAN J.
USC
1520 San Pablo, Suite 4300
Los Angeles, CA 90033
323-442-5899
dr8amd@gmail.com

*Senior Member
Active Membership Roster 2012

OCHOA CHAAR, CASSIUS IYAD
Yale School of Medicine
330 Cedar Street, Boardman 204
New Haven, CT 06477
203-785-4582
cassuis.chaar@yale.edu

O’CONNELL, JESSICA B.
Gonda Vascular Center
200 Medical Plaza, Suite 510-6
Los Angeles, CA 90095-6908
310-825-5275
jbocjboc@hotmail.com

ODERICH, GUSTAVO S.
Mayo Clinic
200 First Street SW
Rochester, MN 55905
507-284-1575
oderich.gustavo@mayo.edu

*O’DONNELL, SEAN D.
4310 Bayview Drive
Ft. Lauderdale, FL 33308-5327
202-782-9184

*O’HARA, PATRICK J.
Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44195
216-444-8226
oharap@ccf.org

*OLINDE, ANDREW J.
Vascular Surgery Associates
8595 Picardy Avenue, #320
Baton Rouge, LA 70809-3675
225-769-4493

*O’MARA, CHARLES S.
501 Marshall Street, #100
Jackson, MS 39202
601-948-1416

OMBRELLINO, MICHAEL
Vein Institute of New Jersey
95 Madison Avenue, Suite 109
Morristown, NJ 07960
973-539-6900
omby@aol.com

O’NEILL, ALISSA BROTMAN
Vein & Vascular Institute
1000 Whitehorse Road, Suite 703
Voorhees, NJ 08043
asbrotman@yahoo.com

*ORECCHIA, PAUL M.
The Heart Doctors Cardiology Associates
4150 Fifth Street
Rapid City, SD 57701
605-399-4300

ORTEGA, RAUL E.
North Texas Vascular Specialists
2900 N. I-35, Suite 105
Denton, TX 76201
940-591-0500
reomd@yahoo.com

*OSBORNE, ROBERT
3201 17th Street, PL SE
Puyallup, WA 98374
253-279-0254

OWENS, ERIK L.
VA Medical Center - San Diego
Surgical Service (112)
3350 La Jolla Village Drive
San Diego, CA 92161
858-642-3621
eowens@ucsd.edu

OZSVATH, KATHLEEN J.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
ozsvathk@albanyvascular.com

*PADBERG, FRANK T.
UMD
Doctors Office Center
90 Bergen Street, Suite 7200
Newark, NJ 07103
973-972-9371
padbergjr@aol.com

*Senior Member
Active Membership Roster 2012

*PAINTER, THOMAS A.
15 S. Dryden Place
Arlington Heights, IL 60004
847-577-5814
tapain41@aol.com

PALADUGU, RAMESH
Vascular & Vein Center
1325 Pennsylvania Avenue, Suite 440
Fort Worth, TX 76104
817-332-8346
rameshpal@pol.net

*PANETTA, THOMAS
600 Northern Blvd., Suite 115
Great Neck, NY 11021
516-482-8220

*PANNETON, JEAN M.
Sentara Heart Hospital
600 Greshan Drive, Suite 8620
Norfolk, VA 23507
757-622-2649

PAOLINI, DAVID J.
ABQ Surgical Associates
715 Dr. Martin Luther King Jr. Avenue
Albuquerque, NM 87102
505-262-7281
punch25@aol.com

*PARENT, F. NOEL
Sentara Vascular Specialists
3300 South Building
397 Little Neck Road, Suite 100
Virginia Beach, VA 23452
757-470-5570
fnp3md@aol.com

PARK, W. MICHAEL
Iowa Heart Center
5880 University Avenue
West Des Moines, IA 50266
515-633-3600
mpark@iowaheart.com

PARMER, SHANE S.
Marietta Memorial Hospital
400 Matthew Street, Suite 304
Marietta, OH 45750
740-568-5466
SParmer@mhsystem.org

PARRA, JOSE R.
9 Long Bow Court
Cockeysville, MD 21030
443-287-2312
mjstrooper@gmail.com

PASSMAN, MARC A.
University of Alabama @ Birmingham
1808 7th Avenue S BDB 503
Birmingham, AL 35294-0012
205-934-2003
Marc.Passman@ccc.uab.edu

PATETSIOS, PETER
LI Surgical Specialists
639 Port Washington Boulevard
Port Washington, NY 11050
516-883-2212

PATTERSON, DONALD EDWARD
Vasc Surg Assoc @ Evansville Surgical
520 Mary Street, Suite 520
Evansville, IN 47710-1682
812-424-8231
Donald.Patterson@EvansvilleSurgical.com

PATTERSON, MARK A.
Univ. of Alabama @ Birmingham
1808 7th Avenue S BDB 503
Birmingham, AL 35294-0012
205-934-279
mark.patterson@ccc.uab.edu

*PATTERSON, ROBERT B.
Providence Surgical Care Group, Inc.
486 Silver Spring Street
Providence, RI 02904-1566
401-454-0690
robert_patterson@brown.edu

*Senior Member
Active Membership Roster 2012

*PATY, PHILIP S.K.
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208-3479
518-262-5640
patyp@albanyvascular.com

*PAXTON, LAMONT D.
Gen. Vascular Surgery Medical Group
13851 E. 14th Street, #202
San Leandro, CA 94578
510-347-4700

PEARCE, BENJAMIN J.
University of Texas - HSCSA
7703 Floyd Curl Drive, MC 7741
San Antonio, TX 78229-3900
210-567-5715
pearceb3@uthscsa.edu

PEARCE, JEFFREY D.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606-6736
706-549-8306
jpearece@athensvascular.com

PECK, MICHAEL A.
Peripheral Vascular Associates
San Antonio, TX
210-614-7414
mpeck@pvvasatx.com

PEDEN, ERIC K.
Methodist CardioVascular Surgical Assoc.
6550 Fannin Sreet, Suite 1401
Houston, TX 77030
713-441-5200

*PENNELL, RICHARD C.
St. Louis Vascular Center
625 S. New Ballas Road, Suite 7063
St. Louis, MO 63141
314-251-4200
Richard.Pennell@Mercy.net

PEREDA, JUAN CARLOS
Miami Vascular Surgery
6200 Sunset Drive, Suite 505
South Miami, FL 33143
305-598-0888
juanCarlosPereda@yahoo.com

PERKOWSKI, PAUL E.
Vascular Clinic
5425 Brittany Drive, Suite B
Baton Rouge, LA 70808
225-767-5479
pperkowski@cox.net

PETERSON, BRIAN G.
St. Louis University
3635 Vista Avenue
St. Louis, MO 63110-0250
314-577-8310
bpeters1@slu.edu

PETRIK, PAVEL
1331 West Avenue, J 203
Lancaster, CA 93534
661-945-4433
p.petrikmd@gmail.com

*PEVEC, WILLIAM C.
4860 Y Street, Suite 3400
Sacramento, CA 95817
916-734-4738
william.pevec@ucdmc.ucdavis.edu

PEYTON, BRIAN
Univ of Colorado Health Sciences Center
13631 E 17th Avenue, Mail stop C312
Aurora, CO 80016
303-724-2690
vascmd.peyton@gmail.com

PFEIFFER, RALPH B.
Wiregrass Surgical Associates
1118 Ross Clark Cr., Suite 310
Dothan, AL 36301
344-793-1534

*Senior Member
Active Membership Roster 2012

PHADE, SACHIN V.
Univ of Tennessee @ Chattanooga
979 East Third Street, Suite C 300
Chattanooga, TN 37403
423-267-0466
saphade@aol.com

PICKETT, TAYLOR K.
8901 FM 1960 Bypass Road, W Suite 303
Humble, TX 77338
281-397-7000
taylpicke@aol.com

PIERCY, K. TODD
Mid-South Surgeons, PLLC
1222 Trotwood Avenue, Suite 211
Columbia, TN 38401
931-380-3003
ktpiercy@bellsouth.net

PIETROPOLO, JOHN A.
Chesapeake Vein Clinic, LLC
3904 Chaneyville Road
Owings, MD 20736
410-535-3625

*PIGOTT, JOHN P.
2109 Hughes Drive, #450
Toledo, OH 43606-3845
419-471-2003

PIN, RICHARD
Grant Medical Center
285 East State Street, Suite 260
Columbus, OH 43215
614-566-9035
rhpin@hotmail.com

*POINDEXTER, JAMES M.
Georgia Vascular Surgery PC
1718 Peachtree Street, NW Suite 360
Atlanta, GA 30309-2453
404-350-9505
trenton.shy@pmratl.com

*POLIQUIN, JAMES R.
Pikeville Medical Center
911 Bypass Road
Pikeville, KY 41501
804-839-9254
comgenvasc@aol.com

POLITZ, JOHN K.
1010 W. 40th Street
Austin, TX 78756
512-459-8753
doc@ctvstexas.com

*POMPOSELLI, FRANK B.
St. Elizabeth’s Medical Center
736 Cambridge Street, Suite CMP 1
Boston, MA 02135
617-779-6487
frank.pomposelli@steward.org

*PROCTER, CHARLES D.
Vascular Disease Institute
1250 Jesse Jewel Pkwy, Suite 300
Gainesville, GA 30501
770-534-0110
cdprocter@gmail.com

PUCKRIDGE, PHILLIP J.
Flinders Medical Centre
Flinders Drive
Bedford Park, 05042
Australia
61882045445
phillip.puckridge@health.sa.gov.au

*PULLIAM, CARY W.
Middle Tennessee Vascular
4601 Carothers Pkwy., Suite 375
Franklin, TN 37067
615-791-4790

PURCELL, PETER N.
401 Mulberry Street
Lenoir, NC 28645
828-758-5501

PURTILL, WILLIAM A.
900 Northern Blvd., Suite 140
Great Neck, NY 11021
516-466-0485

*QUERAL, LUIS
301 St. Paul Place, 5th Floor
Baltimore, MD 21202
410-332-9404
lqueral@vassurg.com

*Senior Member
Active Membership Roster 2012

QUICK, RHONDA C.
Tucson Vascular Surgery
1815 W. St. Mary's Road
Tucson, AZ 85745
520-628-1400
rquick@azvasc.com

*QUIGLEY, TERENCE M.
Northwest Surgical Specialists
1560 N. 115th Street, Suite 102
Seattle, WA 98133
206-363-2882

QUINNEY, BRENT E.
Professional Office Building
2018 Brookwood Medical Center Drive
Suite 214
Birmingham, AL 35209
205-401-6915
bequinney@gmail.com

*QUINONES-BALDRICH, WILLIAM J.
UCLA Medical Center
200 UCLA Medical Plz, 526
Los Angeles, CA 90095-6904
310-825-7032
wquinones@mednet.ucla.edu

QUIROGA, ELINA
University of Washington
325 9th Avenue, Box 359796
Seattle, WA 98104
206-540-4148
elinaq@uw.edu

RACHEL, ELIZABETH S.
Surgical Care Associates, PSC
4003 Kresge Way, Suite 100
Louisville, KY 40207
502-897-5139

RAJANI, RAVI
Emory University
69 Jesse Hill Jr. Drive, Office 304
Atlanta, GA 30303
404-251-8916
r.rajani@emory.edu

*RAMADAN, FUAD M.
Melbourne Vascular Center, P.A.
1250 S. Harbor City Blvd., Suite A
Melbourne, FL 32901
321-725-8919
flyerdoc@melbournevascular.com

RAMAN, KATHLEEN G.
Washington Univ. School of Medicine
660 S. Euclid Campus Box 8109
St. Louis, MO 63110
314-362-6460
kathleen.raman@gmail.com

RAMOHOAN, SURIANARAYANAN
106-4256 Portage Road
Niagra Falls, ON L2E 6A4
Canada
905-357-3336
driramo@yahoo.ca

*RAMOS, TAMMY K.
Midwest Vascular and Endovascular Surg.
9202 West Dodge Road, Suite 305
Omaha, NE 68114
402-390-6601

RANDEL, MARK A.
3618 N. University Drive
Nacogdoches, TX 75965
936-568-9993
marmd@markrandelmd.com

*RAO, NIRANJAN V.
78 Easton Avenue
New Brunswick, NJ 08901-1838
908-249-0360

RASMUSSEN, TODD E.
Institute of Surgical Research
3400 Rawley E. Chambers Ave., Suite B
Fort Sam Houston, TX 78234-6315
210-916-5185
todd.rasmussen@amedd.army.mil

RAYAN, SUNIL S.
9850 Genesse Ave., Suite 560
La Jolla, CA 92037
858-452-0306

*Senior Member
Active Membership Roster 2012

*RAZZINO, RICHARD A.
Vascular Associates, PC
800 Poplar Church Road
Camp Hill, PA 17011
717-763-0510
poncho2433@verizon.net

RECTENWALD, JOHN E.
1500 E. Medical Center Drive
CVC 5463, SPC 5867
Ann Arbor, MI 48109-5867
734-763-0250
jrectenw@umich.edu

REED, AMY B.
Penn State Heart & Vascular Inst.
500 University Drive, H053
Hershey, PA 17033
717-673-3616
areed3@hmc.psu.edu

REEVES, JAMES G.
Emory University
1364 Clifton Road NE
Atlanta, GA 30322
404-727-0093
iron140.6@gmail.com

REHRING, THOMAS F.
Colorado Permanente Medical Group
2045 Franklin Street, Third Floor
20th Avenue Medical Center
Denver, CO 80205
303-861-3688
thomas.f.rehring@kp.org

*REICHMAN, WAYNE
Vascular Surgery Associates, LLC
520 Upper Chesapeake Dr., Suite 306
Bel Air, MD 21014-4324
410-879-2006

*REISSER, JOHN
266 Joule Street
Alcoa, TN 37701

*RHEE, ROBERT Y.
UPMC
5200 Centre Avenue, Suite 313
Pittsburgh, PA 15232
412-623-3333
rrhee@maimonidesmed.org

*RHEE, SAN WON
Vascular Services of West, New England
3500 Main Street, Suite 201
Springfield, MA 01107-0126
413-784-0900

*RHEUDASIL, J. MARK
Vascular Institute of Georgia
5673 Peachtree Dunwoody Road
Suite 675
Atlanta, GA 30342
404-256-0404
jmr56@comcast.net

RHODES, JEFFREY M.
20 Hagen Drive, Suite 210
Rochester, NY 14625
585-922-5550
jeffrey.rhodes@rochestergeneral.org

*RICHARDSON, JAMES W.
1222 Trotwood Avenue, #211
Columbia, TN 38401
931-380-3033

RICOTTA, JOSEPH J.
230 Trimble Quest Drive, NE
Atlanta, GA 30342
404-727-8407
joseph.ricotta@northside.com

*RIFKIN, KERRY V.
Vasc. Surgery Assoc. of N. FL, P.A.
2140 Kingsley Avenue, Suite 14
Orange Park, FL 32073-5129
904-276-7997
terrifkin@aol.com

RIGBERG, DAVID A.
UCLA Medical Center
200 Medical Plaza, Suite 510-6
Los Angeles, CA 90095
310-206-5594
drigberg@mednet.ucla.edu

*Senior Member
Active Membership Roster 2012

*RIGGS, PATRICK N.
Vascular Surgery Associates
1445 Portland Avenue, #108
Rochester, NY 14621
585-922-5550

RITS, EVGENIY
Wayne State University
3990 John R
Detroit, MI 48201
313-745-8637
yrits@dmc.org

RIZVI, ADNAN Z.
Minneapolis Heart Institute
920 East 28th Street, Suite 300
Minneapolis, MN 55407
612-863-6800
adnan.rizvi@allina.com

RIZZO, ANTHONY
Cleveland Clinic Foundation
6801 Mayfield Road, Bldg. 2, Suite 146
Mayfield Heights, OH 44124
440-461-1150
rizzoa@ccf.org

*ROBERTS, RICK M.
Vascular Surgery Associates, PC
201 Sivley Road, Suite 305
Huntsville, AL 35801
256-536-9000
rmroberts@yahoo.com

ROBINSON, WILLIAM P.
UMass Medical School
UMass Memorial Medical Center
55 Lake Ave North Drive, Room 53819
Worcester, MA 01655
508-856-5599
william.robinson@umassmemorial.org

ROCKMAN, CARON B.
NYU University Medical School
530 First Avenue, #6F
New York, NY 10016-6402
212-263-7311
caron.rockman@nyumc.org

RODDY, SEAN P.
The Vascular Group, PLLC
43 New Scotland Avenue, MC-157
Albany, NY 12208-3412
518-262-8720
roddys@albanyvascular.com

RODRIGUEZ, CHRISTIAN C.
Foundation Vascular Surgery
8 Prospect St., North II Specialty
PO Box 1184
Nashua, NH 03061
603-577-3070
crodrigueznh@gmail.com

RODRIGUEZ, HERON E.
Northwestern Med Faculty Foundation
676 N. Saint Clair Street, Suite 650
Chicago, IL 60611
312-695-4857
herodrig@nmh.org

*ROLAND, CHRISTOPHER F.
Minnesota Heart & Vascular Center
6405 France Ave. South, Suite 440
Edina, MN 55435
952-927-7004
croland1@comcast.net

*ROLLINS, DAVID L.
36060 Euclid Avenue, #107
Willoughby, OH 44094-4661
440-269-8346
dlrmd@safier.com

ROSA, PATRICIO
Tenet Florida Physician Services
Del Ray Beach, FL
561-499-7707
patriciorosa@aol.com

ROSCA, MIHAI
NSLIJ Health System
1999 Marcus Ave., Suite 106B
Lake Success, NY 11042
516-233-3701
mihairosca@optonline.net

*Senior Member
Active Membership Roster 2012

*ROSENFIELD, JOEL C.
St. Luke's Hospital
801 Ostrum Street
Bethlehem, PA 18015
rosenfj@slhn.org

*ROSS, CHARLES B.
Piedmont Heart Institute
404-605-5699
charles.ross@piedmont.org

ROSSI, PETER J.
Medical College of Wisconsin
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
prossi@mcw.edu

*ROULHAC, MAURICE R.
Carolina Vascular
1251 Oliver Street
Fayetteville, NC 28304
910-822-6587
vasmd@aol.com

ROUSH, TIMOTHY S.
Carolinas Heart Institute
1001 Blythe Blvd., Suite 300
Charlotte, NC 28203
704-355-9430
timothy.roush@carolinas.org

ROWE, VINCENT L.
Keck USC School of Medicine
LAC + USC Medical Center
200 North State St., Room 9442
Los Angeles, CA 90033
323-226-5818
vrowe@surgery.usc.edu

*RUBIN, JEFFREY R.
Detroit Medical Cnt./Harper Univ. Hosp
3990 John R
Detroit, MI 48201
313-745-8637
jrubin@med.wayne.edu

RUBINSTEIN, CHEN
Hadassah Hebrew University Medical Ctr
PO Box 12000
Jerlem, 91120
Israel
97226779698
chenr@hadassah.org.il

*RUBY, STEVEN T.
1000 Asylum Avenue, #2120
Hartford, CT 06105
860-246-4000

*RUDO, NEIL D.
236 San Jose Street
Salinas, CA 93901-3901

*RUSHTON, FRED W.
University of Mississippi Medical Center
2500 N. State Street, Suite L228-4
Jackson, MS 39216
601-984-2680
frushton@umc.edu

RUSSELL, TODD E.
2109 Hughes, #450
Toledo, OH 43606
419-471-2003

SAILORS, DAVID M.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606
706-549-8306
dsailors@bellsouth.net

*SALANDER, JAMES M.
11119 Rockville Pike, #204
Rockville, MD 20852
301-881-5503
marysalander@hotmail.com

*SALANDER, JAMES M.
The Cardiovascular Care Group
45 Farbrook Drive
Short Hills, NJ 07078-3008
973-759-9000
csales@tcvcg.com

*Senior Member
Active Membership Roster 2012

SALTZBERG, STEPHANIE
The Vascular Group, PLLC
43 New Scotland Avenue (MC 157)
Albany, NY 12208
845-338-1992
saltzbergs@albanyvascular.com

SAMPSON, JAMES BUCHANAN
University of Alabama - Birmingham
1530 3rd Avenue, South BDB 503
Birmingham, AL 35294
205-934-2006
jambbsam@gmail.com

*SAMPSON, LAWRENCE N.
Guthrie Clinic
One Guthrie Square
Sayre, PA 18840
570-882-2428
sampson_lawrence@guthrie.org

*SANCHEZ, LUIS A.
1 Barnes-Jewish Plaza, #5103
St. Louis, MO 63110

*SANTILLI, STEVEN M.
University of MN
420 Delaware Street, SE MMC195
Minneapolis, MN 55455
612-625-1485
santl002@umn.edu

*SAWCHUK, ALAN P.
Indiana University Vascular Surgery
1801 N. Senate Blvd., MRC 2 #D3500
Indianapolis, IN 46202
317-630-8854

*SCHELLACK, JON V.
Vascular Clinic
5425 Britanny Drive, Suite B
Baton Rouge, LA 70808
225-767-5479

SCHERMERHORN, MARC L.
110 Francis Street, Suite 5B
Boston, MA 02215
617-632-9971
mscherm@bidmc.harvard.edu

*SCHMITT, DAVID D.
1111 Delafield Street, #209
Wauhesa, WI 53188-3403
262-542-0444
dds509@aol.com

SCHMITTLING, ZACHARY C.
3800 South National, Suite 400
Springfield, MO 65809
417-875-3755
katzefs@hotmail.com

SCHNEIDER, DARREN B.
Weill Cornell Medical College
525 E. 68th Street, P-707
New York, NY 10065
212-746-5192
dschneider@med.cornell.edu

SCHOR, JONATHAN A.
Staten Island University Hospital
256 Mason Ave., Bldg B, 2nd Floor
Staten Island, NY 10305
718-226-6800
jschor@siuh.edu

*SCHRODER, WILLIAM B.
Cardio & Vascular Surgical Assoc.
688 Walnut Street, Suite 200
Macon, GA 31201
478-742-7566
wschroder@vascularsurgery.com

*SCHWARTZ, LEWIS B.
Abbott Laboratories
200 Abbott Park Road, AP52-2, AV2R
Abbott Park, IL 60064-6229
847-936-3104
lewis.schwartz@abbott.com

SCHWARTZ, MARK A.
The North Shore Vein Center
1 Hollow Lane, Suite 210
Lake Success, NY 11042
516-869-8346
mschwartz@veincenters.com

*Senior Member
Active Membership Roster 2012

*SCRIBNER, ROBERT G.
1800 Sullivan Avenue, #308
Daly City, CA 94015
650-755-1132
rscrib@sbcglobal.net

*SEABROOK, GARY
Medical College of Wisconsin
Division of Vascular Surgery
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
414-805-9160
gseabroo@mcw.edu

*SEDWITZ, MARC M.
Pacific Coast Vascular & General Surg.
9850 Genesse Ave., #560
La Jolla, CA 92037
619-452-0306

SEIDEL, SCOTT A.
Cardiothoracic & Vascular Surgeons
1010 West 40th
Austin, TX 78756
512-459-8753
saseidel@ctvstexas.com

*SEIWERT, ANDREW J.
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*SEIWERT, ANDREW J.
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*SEIWERT, ANDREW J.
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*SEIWERT, ANDREW J.
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*SEIWERT, ANDREW J.
Jobst Vascular Physicians
Conrad Jobst Tower
2109 Hughes Drive, Suite 450
Toledo, OH 43606
419-471-2003
aseiwert@jvc.org

*SHARAFUDDIN, MEL J.
University of Iowa College of Medicine
200 Hawkins Drive
Iowa City, IA 52242
319-356-1907
Mel-sharafuddin@uiowa.edu

*SHARP, WILLIAM J.
University of Iowa Hospital & Clinics
Iowa City, IA 52242
319-356-1907

SHEEHAN, MAUREEN K.
Univ. of Texas Health Science Ctr.
7703 Floyd Curl Drive, MSC 7741
San Antonio, TX 78229
210-567-5715
sheehanm@uthscsa.edu

SHERWOOD, ANDREW J.
Eastern Maine Medical Center
489 State Street
Bangor, ME 04402-0404
207-973-6670
ajsherwood@emh.org

*Senior Member
Active Membership Roster 2012

*SHORTELL, CYNTHIA K.
Duke University Medical Center
DUMC, Box 3538
Durham, NC 27710
919-681-2223
cynthia.shortell@duke.edu

SHUSTER, THOMAS A.
3485 Ambleside Drive
Flushing, MI 48433
810-487-1638
ttshuster@comcast.net

*SHUTZE, WILLIAM P.
Texas Vascular Associates
621 North Hall Street, Suite 100
Dallas, TX 75226
214-821-9600
willshut@sbcglobal.net

*SIMONI, EUGENE J.
116 Meadow Flower Circle
Bellefonte, PA 16823
ejca@aol.com

SIMONIAN, GREGORY T.
211 Essex Street, Suite 102
Hackensack, NJ 07601
201-487-8862
GSimonian@aol.com

SIMOSA, HECTOR F.
MetroWest Medical Center
85 Lincoln Street, 6th Floor
Framingham, MA 01702
508-383-1078

SINGH, MICHAEL J.
Univ. of Rochester Medical Ctr.
601 Elmwood Ave., Box 652
Rochester, NY 14642
585-273-1745
michael_singh@urmc.rochester.edu

SINGH, NITEN
Madigan Army Medical Ctr.
Attn: MCHJ-SV Fitzsimmons Drive Bldg. 9040
Tacoma, WA 98431
253-968-2290
nhsingh@aol.com

SINGH, MICHAEL J.
2 Dudley Street, Suite 470
Providence, RI 02905
401-553-8333
jslaiby@surg.org

SMEDS, MATTHEW R.
St. Louis University
3635 Vista Avenue @ Grand Blvd
St. Louis, MO 63110-0250
314-577-8562
msmeds@slu.edu

SMILANICH, ROBERT
Utah Vascular Center
1055 N. 300 W., Suite 205
Provo, UT 84604-3374
801-374-9100
UVC@comcast.net

SMITH, TAYLOR A.
Ochsner Medical Center
1514 Jefferson Highway
New Orleans, LA 70121
504-842-4053
taysmith@ochsner.org

*SMITH, VANCE H.
Vance H. Smith, MD Vascular Surgery
296 Seminole Road
Norton Shores, MI 49444-3733
231-737-8814
vsmithmd@comcast.net

SOHN, MICHELLE E.
St. Joseph Hospital
2950 Squalicum Pkwy, Suite B
Bellingham, WA 98225
360-788-6063
msohnmd@gmail.com

SORIAL, EHAB E.
3800 Nicholasville Road, #12338
Lexington, KY 40503
859-327-1391
eesori2@email.uky.edu

*Senior Member
Active Membership Roster 2012

SOUNDARARAJAN, KRISH
Temple University Hospital
Div. of Vascular Surgery, 3401 N. Broad St.
Philadelphia, PA 19140-5103
215-707-3796
endovas@hotmail.com

SPROUSE, LARRY R.
UT College of Medicine
979 E. Third Street, Suite 401
Chattanooga, TN 37403
423-778-7695
LRSii@msn.com

SRIVASTAVA, SUNITA D.
The Cleveland Clinic
9500 Euclid Avenue
Cleveland, OH 44195
216-445-6939
srivass@ccf.org

STANZIALE, STEPHEN F.
Vasc. & Endovasc. Surg. Cardiology Assoc.
2002 Medical Parkway, Suite 500
Annapolis, MD 21401
stephen_stanziale@hotmail.com

STARNES, BENJAMIN W.
Harborview Medical Center
325 Ninth Avenue, Box 359796
Seattle, WA 98104
206-744-3033
starnes@u.washington.edu

*SТЕPHANIAN, EDIC
700 Walter Reed Blvd., Suite 311
Garland, TX 75042
972-487-6400
drstephanian@ndallassurg.com

STERMBACH, YARON
The Vascular Group, PLLC
43 New Scotland Avenue (MC-157)
Albany, NY 12208
518-262-5640
sternbachy@albanyvascular.com

STERNBERGH, W. CHARLES
Ochsner Clinic
1514 Jefferson Highway
New Orleans, LA 70121
504-842-4053
csternbergh@ochsner.org

*STEWART, JOHN D.
Fayette Surgical Associates
1401 Harrodsburg Road, Suite C100
Lexington, KY 40504-3766
859-278-4960

*STEWART, MARK T.
Cardiothoracic & Vascular Surgeons
1010 W. 40th Street
Austin, TX 78756
512-459-8753

STONE, PATRICK A.
3200 Maccorkle Avenue SE
Charleston, WV 25304
304-347-1371
pstone0627@yahoo.com

STONER, MICHAEL C.
East Carolina University Heart Institute
115 Heart Drive, ECHI Office 3237
Greenville, NC 27834
252-744-4668
stonerm@ecu.edu

STONEROCK, CHARLES E.
SC Cardiovascular Surgery
805 Pamplico Hwy. Medical Mall
Suite 300
Florence, SC 29505
843-676-2760

*SUGGS, WILLIAM D.
Montefiore Medical Center
111 E. 210th Street
Bronx, NY 10467
718-920-4108

SULLIVAN, THEODORE R.
Abington Health
1245 Highland Avenue, Suite 600
Abington, PA 19001
215-887-3990
tsullivan@amh.org

*Senior Member
Active Membership Roster 2012

*SULLIVAN, TIMOTHY M.
Minneapolis Heart Institute
920 E. 28th Street, #300
Minneapolis, MN 55407
612-863-6800
timothy.sullivan@allina.com

SULTAN, SHERIF
Western Vascular Institute
Univ. College Hospital Galway
Vasc. & Endovasc Surgery
Galway
Ireland
35391720120
sherif.sultan@hse.ie

SUN, LUCY
Mount Kisco Medical Group
110 South Bedford Road
Mount Kisco, NY 10549
914-241-1050
lsun@mkmg.com

SUNDARAM, SHANKAR M.
Harrison Health Partners Thoracic and Vascular Surgery
1225 Campbell Way, Suite 101
Bremerton, WA 98310
360-479-4203
sms5217@yahoo.com

SUROWIEC, SCOTT M.
4507A Medical Center Drive
Fayetteville, NY 13066
315-663-0508
ssurowi@vascare.com

*SYKES, MELLICK T.
4330 Medical Drive, Suite 120
San Antonio, TX 78229-3920
210-692-9700
mellicksykes@aol.com

TAGGERT, JOHN B.
The Vascular Group, PLLC
43 New Scotland Avenue, MC157
Albany, NY 12208
518-262-8720
taggettj@albanyvascular.com

*TAMEZ, DANIEL D.
Peripheral Vascular Associates
111 Dallas Street, Suite 200-A
San Antonio, TX 78215
210-225-6508

TAORMINA, MARTIN V.
Carolina Vascular Surgery
1721 Ebenezer Road, Suite 115
Rock Hill, SC 29732
803-985-4000

TASSIOPOULOS, APOSTOLOS K.
SUNY
HSC T19-090
Stony Brook, NY 11794-8191
631-444-2037
apostolos.tassiopoulos@stonybrook.edu

*TAYLOR, SPENCE M.
Department of Surgical Education
701 Grove Road
Greenville, SC 59605
864-455-7886
staylor2@ghs.org

TAYLOR, STEVEN M.
UAB Vascular Surgery
1808 7th Avenue, S BDB 503
Birmingham, AL 35294
205-934-2003
steve.taylor@ccc.uab.edu

TEFERA, GIRMA
University of Wisconsin Med. School
600 Highland Avenue, Suite G5/319
Madison, WI 53792-3236
608-265-4420
tefera@surgery.wisc.edu

TERUYA, THEODORE H.
11201 Benton Street, #112
Loma Linda, CA 92357
tteruya@hawaii-vascular.com

THOMAS, BRADLEY G.
Surgical Care Associates
4003 Kresge Way, Suite 300
Louisville, KY 40207
502-897-5139
BThomas76@gmail.com

*Senior Member
Active Membership Roster 2012

*THOMASON, ROBERT BRADLEY
Salem Vascular Specialists
2827 Lyndhurst Avenue, Suite 203
Winston-Salem, NC 27103
336-794-8624
rbt@salesmsurgical.com

THOMPSON, CHARLES S.
Vascular Specialists of Central Florida
80 West Michigan Street
Orlando, FL 32806-4453
407-648-4323
cmtmd83@yahoo.com

THOMPSON, J. KEITH
Hattiesburg Clinic
415 S. 28th Avenue
Hattiesburg, MS 39401
601-264-6000
keiththompson23@hotmail.com

TILLMAN, BRYAN W.
University of Pittsburgh Medical Ctr.
200 Lothrop Street, A1011, PUH
Pittsburgh, PA 27023
412-623-1280
tillmanbw@upmc.edu

TONNESSEN, BRITT H.
Roper Heart and Vascular Center
316 Calhoun Street
Charleston, SC 29401
843-720-5665
britt.tonnessen@rsfh.com

TORRES, GUSTAVO A.
6826 Fair Cove Drive
Rancho Palos Verdes, CA 90275
gatgus@hotmail.com

TOURSKISSIAN, BOULOS
University of Texas Health Science Ctr.
7703 Floyd Curl Drive
San Antonio, TX 78229
210-567-5715
tourskissian@uthscsa.edu

TRACHTENBERG, JEFFREY D.
Surgical Specialists of Central Illinois
1750 E. Lake Shore Drive, Suite 200
Decatur, IL 62521-3805
217-876-2740
jefftrach@aol.com

TRINIDAD, MAGDIEL
University of AZ Health Sciences Center
1501 North Campbell Avenue, PO Box
245072
Tucson, AZ 85724
520-626-6670
mtrinidad@surgery.arizona.edu

*TROTTER, MICHAEL C.
Delta Regional Medical Center
1693 S. Colorado Street
Greenville, MS 38703
662-335-6703

TULLIS, MICHAEL J.
Cardiovasc. & Chest Surgical Assoc. PA
333 N. 1st Street #280
Boise, ID 83702
208-345-6545

TWENA, MORDECHAI F.
6508 E. Carondelet Drive
Tucson, AZ 85710-2117
520-885-6717

VADDINENI, SARAT K.
Health Care Midwest
601 John Street, Suite 283
Kalamazoo, MI 49007
269-349-7696
vaddineni@msn.com

VALENTIN, MARLENE D.
2509 W. Waters Avenue
Tampa, FL 33614
813-348-9088

VARNAGY, DAVID
2105 North Orange Avenue, Suite 402
Orlando, FL 32804
407-303-7250
davidvarnagy@hotmail.com

*Senior Member
Active Membership Roster 2012

VEERASWAMY, RAVI K.
101 Woodruff Circle, W5015 WMB
Atlanta, GA 30322
404-727-8413
ravi.veeraswamy@emoryhealthcare.org

*VERTA, MICHAEL J.
1501 McPherson
Mt. Vernon, IL 60864
vascudoc@earthlink.net

VOGEL, TODD R.
One Robert Wood Johnson Pl., MEB 541
New Brunswick, NJ 08903-0019
732-235-7816

*VOGT, PHILIP A.
1818 N. Meade Street, 240-W
Appleton, WI 54911-3496
920-731-8131
philip.vogt@thedacare.org

*WAGMEISTER, ROBERT
2001 Santa Monica Blvd., Suite 690W
Santa Monica, CA 90404-2124
310-828-5626
rwagmd@aol.com

*WAGNER, WILLIS H.
Willis Wagner
8631 West Third Street, #615 East #615-E
Los Angeles, CA 90048
310-652-8132
willis.wagner@cshs.org

WAHLGREN, CARL-MAGNUS
Karolinska University Hospital
Dept. of Vascular Surgery
Stockholm, 171 76
Sweden
46-071-48535
carl.wahlgren@karolinska.se

WAIN, REESE A.
Thoracic and Cardiovascular Surgery
120 Mineola Blvd., Suite 300
Mineola, NY 11501
516-633-4400
rawain@optonline.net

WARREN, THOMAS R.
Scott & White Memorial Hospital
2401 South 31st Street
Temple, TX 76508
254-724-2232
tcw Warren97@aol.com

*WALTKE, EUGENE A.
Omaha Vascular Surgery LLC
515 N. 162nd Avenue, Suite 300
Omaha, NE 68118-2540
402-393-6624
ewaltke@radiks.net

*WATERS, HARRIS J.
Silverton Surgical LLC
450 Welch Street
Silverton, OR 97381
503-873-5310

*WATTENHOFER, SCOTT P.
Omaha Vascular Specialists
515 N. 162nd Avenue, Suite 300
Omaha, NE 68118-2540
402-393-6624

*WEINGARTEN, MICHAEL S.
Drexel Univ. College of Medicine
245 N 15th Street, M/S 413
Philadelphia, PA 19102
215-762-4005
michael.weingarten@drexelmed.edu

WEISWASSER, JONATHAN M.
Vascular Associates of New Jersey
68 Melrose Place
Montclair, NJ 07042
973-322-7233

*WELCH, HAROLD J.
Lahey Clinic
41 Mall Road
Burlington, MA 01805
781-744-8193
harold.j.welch@lahey.org

*WELKIE, JOHN F.
1259 S. Cedar Crest Blvd., #301
Allentown, PA 18103
610-439-0372

*Senior Member
WELLONS, ERIC
Atlanta Vascular Specialists
775 Poplar Road, Suite 260
Newnan, GA 30265
404-524-0095
ewellons@gmail.com

WESTERBAND, ALEX
Tucson Vascular Surgery
1815 W. St. Mary’s Road
Oro Valley, AZ 85745
520-901-6230
awesterband@comcast.net

*WHALEN, RALPH C.
3919 Ravine Hollow Ct.
Maumee, OH 43537-9288
419-867-3421
rwhalen@jvc.org

WHITLEY, W. DAVID
2660 10th Avenue South, Suite 608
Birmingham, AL 35205
205-939-3495
dw6931@yahoo.com

WHITTEN, MATTHEW G.
Mountain Medical Vascular Specialists
5323 S. Woodrow Street, Suite 102
Murray, UT 84107
801-713-1010
matthew.whitten@gmail.com

WIDMEYER, JEFFREY H.
Vein and Cosmetic Solutions
7626 Timberlake Road
Lynchburg, VA 24502
434-847-5347
jhwid@aol.com

WILDERMAN, MICHAEL J.
Hackensack University Medical Center
20 Prospect Avenue, Suite 707
Hackensack, NJ 07601
201-343-0040
michael.wilderman@gmail.com

WILKENS, TODD H.
131 Hospital Road
Jellico, TN 37762
423-784-7269
wilkensth@yahoo.com

*WILLIAMS, LARRY R.
1201 Seventh Avenue North
St. Petersburg, FL 33705
727-894-4738
drwilliams_630@hotmail.com

WILSON, DAVID B.
Michigan Vascular Center
G-5020 W. Bristol Road
Flint, MI 48507-2929
810-732-1620
dbwilson@mac.com

WILSON, JEFFREY S.
Bay Pines VAMC
1000 Bay Pines Boulevard
Bay Pines, FL 33744
727-398-6661
jwcwilson@msn.com

WINKLER, GABOR A.
Deborah Heart & Lung Center
Dept. of Surgery 200 Trenton Road
Browns Mills, NJ 08015
gawinkler@mac.com

*WINTER, ROBERT P.
Florida Vascular Consultants, PA
400 S. Maitland Avenue
Maitland, FL 32751
407-539-2100
Runningdog57@aol.com

WIRTHLIN, DOUGLAS J.
Mountain Medical
5323 S. Woodrow Street, Suite 102
Murray, UT 84107
801-713-1010
douglas_wirthlin@yahoo.com

*Senior Member
Active Membership Roster 2012

WITTGEN, CATHERINE M.
St. Louis University Hospital
3635 Vista Avenue, PO Box 15250
St. Louis, MO 63110-0259
314-577-8310
wittgenc@slu.edu

WOOLFORD, HEATHER Y.
1884 Silverado Trail
Napa, CA 94558
hyw@alum.dartmouth.org

WOO, KAREN
1520 San Pablo Street, Suite 4380
Los Angeles, CA 90033
Karen.Woo@med.usc.edu

WOODY, JONATHAN D.
Athens Vascular Surgery
195 King Avenue
Athens, GA 30606-5902
706-549-8306
woody@athensvascular.com

*WRIGHT, J. GORDON
Midwest Vein Center
2001 Butterfield Road, Suite 100
Downers Grove, IL 60515-1590
630-322-9126

WU, TIMOTHY
University of Pittsburgh
200 Lothrop Street, Suite A1011
Pittsburgh, PA 15213
412-802-3333
wut@upmc.edu

WYBLE, CHARLES W.
Vascular Surgical Associates, PC
61 Whitcoker Street, Suite 2100
Marietta, GA 30060
770-423-0595
cwyble@vascularsurgical.com

XENOS, ELEFTHERIOS
University of Kentucky
800 Rose Street, Room C-225
Lexington, KY 40536-0293
859-323-6346
lxenos@yahoo.com

YANCEY, ANDREA E.
University Surgical Associates
401 East Chestnut Street, Suite 710
Louisville, KY 40202
502-583-8303
yanceybates@yahoo.com

*YANG, PAUL M.
Beth Israel Medical Center
1st Ave. & 16th St., 16 Baird Hall
New York, NY 10003
212-420-2295
pyang@chpnet.org

YAVORSKI, CHESTER C.
Surgical Specialists of Wyoming Valley
200 S. River Street
Plains, PA 18705-1143
570-821-1100

*YEARY, II, EDWIN C.
1725 E. 19th Street, #800
Tulsa, OK 74104
918-744-3638

YOLYAPAN, AYKUT
Mugla Devlet Hastanesi
Muslihittin Mah
Mugla, 48000
Turkey
op.draykut@hotmail.com

YORK, JOHN W.
SC Assoc. for Cardiac & Vasc. Disease
890 W. Faris Road, Suite 320
Greenville, SC 29605-4281
864-455-6800
jyork@ghs.org

ZAKHARY, EMAD M.A.
St Louis University
3635 Vista Avenue
St. Louis, MO 63110
314-577-8310
zakhare@gmail.com

*Senior Member
Active Membership Roster 2012

*ZATINA, MICHAEL A.  
Maryland Vascular Associates, LLC  
3350 Wilkins Street, #100 BMD 21229  
Baltimore, MD 21229  
410-646-4888  
mzatina@marylandvascular.com

*ZENNI, GREGORY C.  
Cardic, Vasc. & Thoracic Surgeons, Inc.  
4030 Smith Road, Suite 300  
Cincinnati, OH 45209  
513-241-3494

ZHOU, WEI  
Stanford University  
300 Pasteur Drive, H3640  
Stanford, CA 94305  
650-849-0507  
weizhou@stanford.edu

ZIPORIN, SCOTT J.  
Centura Health/St. Anthony Hospital  
11700 W 2nd Place, Medical Plaza 2, Suite 210  
Lakewood, CO 80228  
720-321-8090  
sziporin@bidmc.harvard.edu

ZUNIGA, CARLOS  
EsSalud-HNGAI  
Av. Grau 800 La Victoria  
Lima, L-13  
Peru  
5113242983  
czl28@hotmail.com

*Senior Member
Geographical Listing of Active Members

**ALABAMA**
- **Birmingham**
  - Jordan, William D.
  - Matthews, Thomas C.
  - Passman, Marc A.
  - Patterson, Mark A.
  - Quinney, Brent E.
  - Sampson, James Buchanan
  - Taylor, Steven M.
  - Whitley, W. David
- **Dothan**
  - Pfeiffer, Ralph B.
- **Huntsville**
  - Roberts, Rick M.
- **Mobile**
  - Esses, Glenn E.
  - McPhillips, Frank
- **Winfield**
  - Manord, Jeffrey D.

**ARKANSAS**
- **Little Rock**
  - Ali, Ahsan T.

**ARIZONA**
- **Oro Valley**
  - Westerband, Alex
- **Phoenix**
  - Caparrelli, David J.
  - Carlon, Douglas J.
  - Erickson, Curtis A.
  - Moinuddeen, Khaja
- **Scottsdale**
  - Fowl, Richard
  - Money, Samuel R.
- **Tucson**
  - Berman, Scott S.
  - Hughes, John D.
  - Leon, Luis R.
  - Lucas, Layla C.
  - Mills, Joseph L.
  - Quick, Rhonda C.
  - Trinidad, Magdiel
  - Twena, Mordechai F.

**CALIFORNIA**
- **Burlingame**
  - Lin, Stephanie C.
- **Daly City**
  - Scribner, Robert G.
- **Fresno**
  - Hadcock, William
- **Glendale**
  - Acosta, Ignacio
- **La Jolla**
  - Rayan, Sunil S.
  - Sedwitz, Marc M.
- **Laguna Hills**
  - Duensing, Robert A.
- **Lancaster**
  - Petrik, Pavel
- **Loma Linda**
  - Abou-Zamzam, Ahmed M.
  - Chiriano, Jason T.
  - Teruya, Theodore H.
- **Los Angeles**
  - Cole, C. William
  - DeRubertis, Brian G.
  - Gelabert, Hugh A.
  - Jimenez, Juan Carlos
  - Keushkerian, Simon
  - Ochoa, Christian J.
  - O’Connell, Jessica B.
  - Quinones-Baldrich, William J.
  - Rigberg, David A.
  - Rowe, Vincent L.
  - Wagner, Willis H.
  - Woo, Karen
- **Mather**
  - Noll, Robert E.
Geographical Listing of Active Members

Napa
Goldstein, Lawrence J.
Loftus, John P.
Wolford, Heather Y.

Northridge
Austin, Joseph Patrick

Orange
Ballard, Jeffrey L.
Charney, Kim J.
Fujitani, Roy M.
Lane, John S.

Panorama City
Cerveira, Joaquim J.

Pasadena
Kohl, Roy D.

Rancho Palos Verdes
Torres, Gustavo A.

Riverside
Kim, Sung K.

Sacramento
Carson, John G.
Clouse, W. Darrin
Dawson, David L.
Hedayati, Nasim
Lee, Eugene S.
Pevec, William C.

Salinas
Rudo, Neil D.

San Diego
Angle, Niren
Casey, Kevin M.
Hodgkiss-Harlow, Kelley D.
Kansal, Nikhil
Owens, Erik L.

San Francisco
Conte, Michael S.
Groeger, Eugene C.

San Leandro
Gingery, Robert O.
Paxton, Lamont D.

Santa Monica
Mueller, Mark P.
Wagmeister, Robert

Stanford
Al-Khatib, Weesam Kassim
Harris, E. John
Lee, Jason T.
Mell, Matthew
Zhou, Wei

Torrance
Chauvapun, Joe
Donayre, Carlos E.
Marrocco, Christopher J.

Whittier
Kronson, Jeffrey W.

COLORADO
Aurora
Peyton, Brian

Colorado Springs
Corry, David C.
Crepps, J. Thomas
Hurlbert, Scott N.

Denver
Annest, Stephen J.
Johnnides, Christopher G.
Rehring, Thomas F.

Lakewood
Ziporin, Scott J.

CONNECTICUT
Bloomfield
Greenwald, Lori L.

Danbury
Dietzek, Alan M.

Darien
Gagne, Paul J.
## Geographical Listing of Active Members

**Glastonbury**
- Bulger, Christopher M.

**Hartford**
- Gallagher, James J.
- Ruby, Steven T.

**Manchester**
- Maru, Sandip T.

**New Haven**
- Dardik, Alan
- Indes, Jeffrey
- Ochoa Chaar, Cassius Iyad

**South Weymouth**
- Kwasnik, Edward M.

**DISTRICT OF COLUMBIA**
- Washington
  - Beavers, Frederick P.
  - Deaton, David H.
  - Hughes, Kakra
  - Laredo, James

**DELEWARE**
- Newark
  - Ierardi, Ralph P.

**FLORIDA**
- Aventura
  - Johr, Bernardo

- Bay Pines
  - Wilson, Jeffrey S.

- Del Ray Beach
  - Rosa, Patricio

- Ft. Lauderdale
  - O’Donnell, Sean D.

- Gainesville
  - Feezor, Robert J.
  - Nelson, Peter R.

- Jacksonville
  - Dennis, James W.
  - Ellison, Robert G.
  - Moore, Erin M.

- Maitland
  - Adcock, G. Kendrix
  - Winter, Robert P.

- Melbourne
  - Dovgan, Peter S.
  - Esemuede, Nowokere
  - Ramadan, Fuad M.

- Miami
  - Goldstein, Lee J.

- Ocoee
  - Horowitz, John D.

- Orange Park
  - Rifkin, Kerry V.

- Orlando
  - Thompson, Charles S.
  - Varnagy, David

- Pensacola
  - Harlin, Stuart A.

- Sarasota
  - Lepore, Michael R.

- South Miami
  - Pereda, Juan Carlos

- St. Petersburg
  - Almond, Brett A.
  - Collins, P. Steven
  - Williams, Larry R.

- Tallahassee
  - Brumberg, Robert S.
  - Hoyne, Robert F.
Geographical Listing of Active Members

Tampa
Back, Martin
Gonzalez, Alberto Jose
Illig, Karl A.
Johnson, Brad L.
Kerr, Thomas M.
Shames, Murray L.
Valentin, Marlene D.

West Palm Beach
Cires, Giancarlo

Weston
Grove, Mark K.
King, Terry A.

GEORGIA
Albany
Morgan, Joe H.

Athens
Pearce, Jeffrey D.
Sailors, David M.
Woody, Jonathan D.

Atlanta
Best, Irwin M.
Brewster, Luke P.
Corso, J. Eduardo
Duwayri, Yazan
H’Doubler, Peter B.
Methodius-Rayford, Walaya Chiyem
Miller, Jay S.
Poindexter, James M.
Rajani, Ravi
Reeves, James G.
Rheudasil, J. Mark
Ricotta, Joseph J.
Veeraraghavan, Ravi K

Dalton
Hamilton, Ian N.

Gainesville
Procter, Charles D.

Lawrenceville
Moomey, Charles B.

Macon
Schroder, William B.

Marietta
Wyble, Charles W.

Newnan
Wellons, Eric

Savannah
Cohn, Edward J.

Tucker
Adeduntan, Azeef P.

IOWA
Cedar Rapids
Lawrence, David M.

Cedar Rapids
Lawrence, David M.

Iowa City
Kresowik, Timothy F.
Nicholson, Rachael
Sharafuddin, Mel J.
Sharp, William J.

West Des Moines
Borromeo, Jose R.M.
Matsuura, John H.
Park, W. Michael

IDAHO
Boise
Tullis, Michael J.

ILLINOIS
Abbott Park
Schwartz, Lewis B.

Arlington Heights
Painter, Thomas A.

Buffalo Grove
Clark, Elizabeth T.
Geographical Listing of Active Members

**Chicago**
Durham, Joseph R.
Eskandari, Mark K.
Keldahl, Mark L.
Morasch, Mark D.
Rodriguez, Heron E.

**Decatur**
Trachtenberg, Jeffrey D.

**Downers Grove**
Wright, J. Gordon

**Maywood**
Aulivola, Bernadette
Halandras, Pegge
Milner, Ross

**Mt. Vernon**
Verta, Michael J.

**Northfield**
Golan, John F.

**Rockford**
Klazura, Paul J.

**Skokie**
Desai, Tina R.
Gupta, Navyash
Morcos, Omar C.

**Springfield**
Lambert, Andrew D.

**INDIANA**
Evansville
Patterson, Donald Edward

**Indianapolis**
Cikrit, Dolores F.
Dalsing, Michael C.
Jacob, Dennis M.
McCready, Robert A.
Motaganahalli, Raghunandan L.
Sawchuk, Alan P.
Shafique, Shoaib

**KANSAS**
**Wichita**
Hutchinson, Steven A.

**KENTUCKY**
**Lexington**
Endean, Eric D.
Minion, David J.
Newton, Wm. Dennis
Sorial, Ehab E.
Stewart, John D.
Xenos, Eleftherios

**Louisville**
Bergamini, Thomas M.
George, Salem M.
Jung, Matthew T.
Klammer, Thomas W.
Lambert, Glenn E.
Rachel, Elizabeth S.
Thomas, Bradley G.
Yancey, Andrea E.

**Pikeville**
Poliquin, James R.

**LOUISIANA**
**Baton Rouge**
Conners, Michael S.
McNeil, James W.
Olinde, Andrew J.
Perkowski, Paul E.
Schellack, Jon V.

**Lafayette**
Ingram, James C.

**Mandeville**
Mena, Jose

**Marrero**
Batson, Robert

**New Iberia**
Dauterive, Edward
Geographical Listing of Active Members

New Orleans
Adinolfi, Michael F.
Bazan, Hernan A.
Smith, Taylor A.
Sternbergh, W. Charles

Massachusetts
Boston
Chaikof, Elliot L.
Conrad, Mark F.
Hamdan, Allen D.
Kwolek, Christopher J.
Mackey, William C.
Pomposelli, Frank B.
Schmerhorn, Marc L.

Burlington
Welch, Harold J.

Framingham
Simosa, Hector F.

Lawrence
Muto, Paula M.

North Chelmsford
Burke, Paul M.

Springfield
Hirko, Mark K.
Kaufman, Jeffrey L.
Rhee, San Won

Wellesley
Ciocca, Rocco G.
Iafrati, Mark D.

West Roxbury
Gupta, Naren

Winchester
Breckwoldt, William L.

Worcester
Aiello, Francesco A.
Baril, Donald T.
Robinson, William P.

Maryland
Annapolis
Stanziale, Stephen F.

Baltimore
Black, James H.
Buchbinder, Dale
Coll, David
Freischlag, Julie A.
Guzzo, James L.
Harthun, Nancy L.
Lilly, Michael P.
Lucas, Paul R.
Lum, Ying Wei
Mackrell, Peter J.
Malas, Mahmoud
Monahan, Thomas S.
Queral, Luis
Zatina, Michael A.

Bel Air
Gonze, Mark D.
Reichman, Wayne

Cockeysville
Parra, Jose R.

Columbia
Feinberg, Richard L.

Fredrick
McNeil, Paul M.

Glen Burnie
Neschis, David G.

Owings
Pietropaoli, John A.

Rockville
Salander, James M.

Silver Spring
Fox, Charles J.
### Geographical Listing of Active Members

**MAINE**  
*Bangor*  
Cambria, Robert A.  
Sherwood, Andrew J.

**MICHIGAN**  
*Ann Arbor*  
Criado, Enrique  
Eliason, Jonathan L.  
Escobar, Guillermo A.  
Gallagher, Katherine  
Rectenwald, John E.

*Bingham Farms*  
Brown, O. William

*Detroit*  
Lin, Judith C.  
Rits, Yevgeniy  
Rubin, Jeffrey R.

*Flint*  
Wilson, David B.

*Flushing*  
Shuster, Thomas A.

*Grand Rapids*  
Chambers, Christopher M.  
Cuff, Robert F.  
Mansour, M. Ashraf

*Kalamazoo*  
Jain, Krishna M.  
Munn, John S.  
Vaddineni, Sarat K.

*Lansing*  
Granke, Kenneth

*Norton Shores*  
Smith, Vance H.

*Petoskey*  
Kazmers, Andris

*Pontiac*  
Hernandez, Diego A.

**Royal Oak**  
Shanley, Charles J.

**Southfield**  
Nolan, Kevin D.

**Troy**  
Engle, Jennifer S.

**Ypsilanti**  
Heidenreich, Michael J.

**MINNESOTA**  
*Duluth*  
Bunch, Christopher T.  
Eginton, Mark T.

*Edina*  
Roland, Christopher F.

*Minneapolis*  
Rizvi, Adnan Z.  
Santilli, Steven M.  
Sullivan, Timothy M.

*Rochester*  
Ballinger, Beth Ann  
Bower, Thomas C.  
Duncan, Audra A.  
Fleming, Mark D.  
Oderich, Gustavo S.

**MISSOURI**  
*Liberty*  
Deiparine, Michael K.

*Springfield*  
Schmittling, Zachary C.
Geographical Listing of Active Members

**St. Louis**
Curci, John A.
Geraghty, Patrick J.
Jim, Jeffrey
Pennell, Richard C.
Petersen, Brian G.
Raman, Kathleen G.
Sanchez, Luis A.
Smeds, Matthew R.
Wittgen, Catherine M.
Zakhary, Emad M.A.

**MISSISSIPPI**
**Greenville**
Trotter, Michael C.

**Hattiesburg**
Thompson, J. Keith

**Jackson**
Baldwin, Zachary K.
O’Mara, Charles S.
Rushton, Fred W.

**Vicksburg**
Ferris, Eugene B.

**NORTH CAROLINA**
**Asheville**
Douglas, Michael G.

**Chapel Hill**
Farber, Mark A.

**Charlotte**
Arko, Frank R.
Roush, Timothy S.

**Durham**
Cox, Mitchell Wayne
Mureebe, Leila
O’Brien, Patrick Joshua
Shortell, Cynthia K.

**Fayetteville**
Roulhac, Maurice R.

**Gastonia**
Eze, Augustine R.

**Greensboro**
Dickson, Christopher S.
Early, Todd F.
Hayes, P. Gregory

**Greenville**
Bogey, William M.
Stoner, Michael C.

**Lenoir**
Purcell, Peter N.

**New Bern**
Bell, William H.

**Pinehurst**
Atkinson, Clinton K.

**Winston-Salem**
Corriere, Matthew A.
Edwards, Matthew S.
Hansen, Kimberly J.
Hurie, Justin
Moore, Phillip S.
Thomason, Robert Bradley

**NORTH DAKOTA**
**Fargo**
Bakken, Andrew

**NEBRASKA**
**Omaha**
Baxter, B. Timothy
Johanning, Jason Michael
Longo, Gernon Matthew
Ramos, Tammy K.
Waltke, Eugene A.
Wattenhofer, Scott P.

**NEW HAMPSHIRE**
**Lebanon**
Goodney, Philip P
Nolan, Brian W.

**Nashua**
Rodriguez, Christian C.
# Geographical Listing of Active Members

**NEW JERSEY**

- **Browns Mills**
  - Winkler, Gabor A.

- **Camden**
  - Alexander, James B.

- **Gradell**
  - Geuder, James W.

- **Hackensack**
  - Simonian, Gregory T.
  - Wilderman, Michael J.

- **Monroe Township**
  - Franco, Charles D.

- **Montclair**
  - Weiswasser, Jonathan M.

- **Morristown**
  - Ombrellino, Michael

- **New Brunswick**
  - Graham, Alan M.
  - Haser, Paul B.
  - Rao, Niranjan V.
  - Vogel, Todd R.

- **Newark**
  - Curi, Michael A.
  - Padberg, Frank T.

- **Princetown**
  - Goldman, Kenneth A.

- **Short Hills**
  - Sales, Clifford M.

- **Somers Point**
  - Gosin, Jeffrey S.
  - Herrington, James W.

- **Somerville**
  - Drascher, Gary A.

- **Toms River**
  - Haque, Shahid N.

- **Westfield**
  - Levison, Jonathan A.

**NEW MEXICO**

- **Albuquerque**
  - Goff, James M.
  - Ketteler, Erika
  - Langsfeld, Mark
  - Marek, John M.
  - Paolini, David J.

**NEVADA**

- **Las Vegas**
  - Luh, Eddy H.

- **Nellis AFB**
  - Jones, Wilmer T.

**NEW YORK**

- **Albany**
  - Chang, Benjamin B.
  - Darling, R. Clement
  - Hnath, Jeffrey C.
  - Kreienberg, Paul B.
  - Mehta, Manish
  - Ozsvath, Kathleen J.
  - Paty, Philip S.K.
  - Roddy, Sean P.
  - Saltzberg, Stephanie
  - Sternbach, Yaron
  - Taggert, John B.

- **Bronx**
  - Greenstein, Stuart
  - Lipsitz, Evan C.
  - Suggs, William D.

- **Brooklyn**
  - D’Ayala, Marcus
  - Hingorani, Anil
  - Shah, Hemal

- **Buffalo**
  - Cherr, Gregory S.
  - Dosluoglu, Hasan H.
Geographical Listing of Active Members

**Cooperstown**
Cooper, Shelby

**Fayetteville**
Surowiec, Scott M.

**Flushing**
Landis, Gregg S.

**Great Neck**
Panetta, Thomas
Purtill, William A.

**Greenlawn**
Gennaro, Mark

**Hawthorne**
Laskowski, Igor A.

**Lake Success**
Doscher, William
Frankini, Larry A.
Rosca, Mihai
Schwartz, Mark A

**Mineolo**
Wain, Reese A.

**Mount Kisco**
Sun, Lucy

**New Hyde Park**
Giangola, Gary

**New Rochelle**
Karanfillian, Richard

**New York**
Adelman, Mark A.
Benvenisty, Alan I.
Berland, Todd
Bernik, Thomas R.
Cayne, Neal S.
Connolly, Peter
Dayal, Rajeev
Fantini, Gary A.
Faries, Peter L.
Fishman, Eric
Harrington, Elizabeth
Jacobowitz, Glenn R.
Lantis, John C.
Maldonado, Thomas
Marin, Michael L.
McKinsey, James F.
Mendes, Donna M.
Morrissey, Nicholas J.
Mussa, Firas F.
Nalbandian, Matthew M.
Rockman, Caron B.
Schneider, Darren B.
Yang, Paul M.

**Port Washington**
Patetsios, Peter

**Rochester**
Chandra, Ankur
Ellis, Jennifer
Gargiulo, Nicholas J.
Geary, Kevin J.
Gillespie, David L.
Kim, Jason K.
Rhodes, Jeffrey M.
Riggs, Patrick N.
Singh, Michael J.

**Setayjet**
Kvilekval, Kara H.V.

**Staten Island**
Deitch, Jonathan S.
Schor, Jonathan A.

**Stony Brook**
Tassiopoulos, Apostolos K.

**Syracuse**
Amankwah, Kwame S.
Costanza, Michael J.
Gahtan, Vivian

**Utica**
Lauterbach, Stephen R.

**OHIO**
Chillicothe
Jepsen, Stephen J.
Geographical Listing of Active Members

Cincinnati
Annenberg, Alan J.
Giglia, Joseph S.
Lohr, Joann M.
Muck, Patrick E.
Zenni, Gregory C.

Cleveland
Clair, Daniel G.
Eagleton, Matthew J.
Greenberg, Roy K.
Kashyap, Vikram S.
Kelso, Rebecca L.
Lyden, Sean P.
Mastracci, Tara M.
McLaughlin, Daniel J.
Moise, Mireille A.
O’Hara, Patrick J.
Srivastava, Sunita D.

Columbus
Franz, Randall W.
Go, Michael R.
Haurani, Mounir J.
Kulwicki, Aaron D.
Litzendorf, Maria E.
Pin, Richard

Duncan Falls
Katz, Sherman A.

Garfield Heights
Alvarez-Tostado, Javier A.

Lancaster
Mannava, Krishna

Marietta
Parmer, Shane S.

Maumee
Whalen, Ralph C.

Mayfield Heights
Rizzo, Anthony

Toledo
Comerota, Anthony J.
Nazzal, Munier
Pigott, John P.
Russell, Todd E.
Seiwert, Andrew J.

Willoughby
Rollins, David L.

Youngstown
Delatore, Jason R.
Kollipara, Venkata S.K.

Zanesville
Campbell, Jessica B.

OKLAHOMA
Edmund
Foteh, Koustia I.

Tulsa
Yeary, II, Edwin C.

OREGON
Portland
Mitchell, Erica L.

Silverton
Waters, Harris J.

PENNSYLVANIA
Abington
Sullivan, Theodore R.

Allentown
Berger, Alan
Goodreau, James J.
McCullough, James L.
Welkie, John F.

Belleville
Simoni, Eugene J.

Bethlehem
Ivarsson, Bengt
Rosenfeld, Joel C.
Geographical Listing of Active Members

Camphill
Razzino, Richard A.

Danville
Elmore, James R.
Franklin, David P.

Easton
Fisher, Jay B.
Lipscomb, Amy L.

Hershey
Aziz, Faisal
Han, David C.
Reed, Amy B.

Philadelphia
DiMuzio, Paul J.
Eisenberg, Joshua A.
Soundararajan, Krish
Weingarten, Michael S.

Pittsburgh
Chaer, Rabih A.
Healy, Dean A.
Jeyabal, Geetha
Muluk, Satish C.
Rhee, Robert Y.
Tillman, Bryan W.
Wu, Timothy

Plains
Yavorski, Chester C.

Sayre
Larson, Robert A.
Marica, Silviu C.
Sampson, Lawrence N.

West Reading
Brigham, Robert A.
Coffey, James A.
Jaxheimer, Eric C.

Wilkes-Barre
Obmann, Melissa A.

Williamsport
Adams, Eric D.

Wynnewood
Bigatel, David A.

PUERTO RICO
Coto Laurel
Martinez, Jorge L.

RHODE ISLAND
Providence
Carney, Wilfred I.
Garcia-Toca, Manuel
Marcaccio, Edward J.
Patterson, Robert B.
Slaiby, Jeffrey M.

SOUTH CAROLINA
Charleston
Garg, Nitin
Hart, Joseph P.
Keefer, Adam James
Morrison, Edward C.
Tonnessen, Britt H.

Florence
Stonerock, Charles E.

Greenville
Carsten, Christopher G.
Cull, David L.
Langan, Eugene M.
Taylor, Spence M.
York, John W.

Greenwood
Hobson, John R.
Lanford, Jeffrey E.

Rock Hill
Taormina, Martin V.

Spartanburg
Calton, William Cuyler

SOUTH DAKOTA
Rapid City
Orecchia, Paul M.
Geographical Listing of Active Members

**TENNESSEE**

**Alcoa**
Reisser, John

**Chattanooga**
Collins, David E.
Collins, John T.
Hogan, Michael B.
Joels, Charles S.
Phade, Sachin V.
Sprouse, Larry R.

**Columbia**
Piercy, K. Todd
Richardson, James W.

**Franklin**
Pulliam, Cary W.

**Jellico**
Wilkens, Todd H.

**Knoxville**
Akers, Donald L.

**Nashville**
Dattilo, Jeffery B.
Edwards, William
Faulk, JimBob
Naslund, Thomas C.

**Oak Ridge**
Long, David D.

**TEXAS**

**Amarillo**
Irwin, Chance L.

**Arlington**
Senkowsky, F. Jon

**Austin**
Apple, Jeffrey M.
Church, Phillip J.
Politz, John K.
Seidel, Scott A.
Stewart, Mark T.

**Dallas**
Gable, Dennis R.
Grimsley, Bradley R.
Iliya, Charles A.
Kohn, James S.
Shutze, William P.

**Denton**
Ortega, Raul E.

**El Paso**
Cook, Patrick

**Fort Sam Houston (San Antonio)**
Arthurs, Zachary M.
Kauvar, David
Rasmussen, Todd E.

**Fort Worth**
Bloemendal, Lee C.
Paladugu, Ramesh

**Fredericksburg**
Bowser, Andrew

**Galveston**
Choi, Lorraine

**Garland**
Stephanian, Edic

**Houston**
Barshes, Neal R.
Bechara, Carlos F.
Bismuth, Jean
Coselli, Joseph S.
Davies, Mark G.
El-Sayed, Hosam F.
Gilani, Ramyar
Huynh, Tam Thi Thanh
Kougias, Panos
Lin, Peter H.
Lumsden, Alan B.
Naoum, Joseph J.
Peden, Eric K.
Geographical Listing of Active Members

Humble
Bhatia, Devinder S.
Coogan, Sheila M.
Pickett, Taylor K.

Lackland AFB
Crutchley, Teresa A.

Nacogdoches
Brown, Lyle L.
Randel, Mark A.

Round Rock
Bush, Ruth L.

San Antonio
Davenport, Phyllis
Macris, Demetrios N.
Pearce, Benjamin J.
Peck, Michael A.
Sheehan, Maureen K.
Sykes, Mellick T.
Tamez, Daniel D.
Toursarkissian, Boulos

Temple
Bohannon, W. Todd
Warren, Thomas R.

UTAH
Murray
Whitten, Matthew G.
Wirthlin, Douglas J.

Provo
Smilanich, Robert

Salt Lake City
Goodman, Greg R.
Ihnat, Daniel M.
Kraiss, Larry W.

South Ogden
Erdoes, Luke S.

VIRGINIA
Christiansburg
Downing, Lamiere J.

Falls Church
Busuttil, Steven J.

Hampton
Deshmukh, Deepak

Lynchburg
Widmeyer, Jeffrey H.

Mechanicsville
Brown, Jeff A.

Norfolk
Panneton, Jean M.

Richmond
Bosher, L. Paul
Levy, Mark M.
Makhoul, Raymond G.

Virginia Beach
Parent, F. Noel

WASHINGTON
Bellevue
Ferris, Brian L.

Bellingham
Sohn, Michelle E.

Bremerton
Sundaram, Shankar M.

Milton
Andersen, Charles A.

Puyallup
Osborne, Robert

Renton
Kasirajan, Karthik

Seattle
Meissner, Mark H.
Quigley, Terence M.
Quiroga, Elina
Starnes, Benjamin W.
Geographical Listing of Active Members

**Spokane**
LaSalle, Andre

**Tacoma**
Singh, Niten

**WISCONSIN**
**Appleton**
Vogt, Philip A.

**Green Bay**
Grazziotin, Marcelo U.
Hutto, John D.

**Madison**
Hoch, John R.
Tefera, Girma

**Milwaukee**
Brown, Kellie R.
Rossi, Peter J.
Seabrook, Gary

**Waukesha**
Schmitt, David D.

**WEST VIRGINIA**
**Charleston**
Stone, Patrick A.

**AUSTRALIA**
**Bedford Park**
Puckridge, Phillip J.

**St. Leonards**
Mohabbat, Walid

**CANADA**
**Barrie, Ontario**
McDonald, Sandy I.

**London, Ontario**
De Rose, Guy
Forbes, Thomas L.

**New Market, Ontario**
Lossing, Alan G.
Gupta, Deepak

**Niagra Falls, Ontario**
Rammohan, Surianarayanan

**Ottawa, Ontario**
Harris, Kenneth A.
Hill, Andrew B.

**Toronto, Ontario**
Huseynova, Khumar

**COLOMBIA**
**Bogota**
Molina, Alejandro

**EGYPT**
**October City**
Bassiouney, Hisham

**FRANCE**
**Paris**
Koskas, Fabien F.

**IRELAND**
**Galway**
Sultan, Sherif

**ISRAEL**
**Jerusalem**
Rubinstein, Chen
Geographical Listing of Active Members

NETHERLANDS
Utrecht
Moll, Frans L.

PERU
Lima
Zuniga, Carlos

PUERTO RICO
San Juan
de Jesus, Gustavo Alberto
Joglar, Fernando L.

SWEDEN
Stockholm
Wahlgren, Carl-Magnus

TRINIDAD AND TOBAGO
St. Joseph
Maharaj, Dale A.

TURKEY
Istanbul
Calik, Mustafa K.

Mugla
Yolyapan, Aykut

UNITED KINGDOM
Hull
Chetter, Ian C.
PVSS Bylaws

Article I - Name
The name of this organization shall be the "Peripheral Vascular Surgery Society" (hereinafter the "Society").

Article II - Objectives
1) The objectives of this Society shall be:
   a) To improve the science and art of vascular surgery and endovascular therapies and the interchange of medical knowledge and information thereon;
   b) To promote basic and clinical research for improving the quality and safety of vascular surgical and endovascular procedures and vascular care in general;
   c) To engage in scientific or educational purposes, and to promote important issues, as the Executive Committee, from time to time, may determine to be beneficial to the membership as a whole or to society in general;
   d) To provide a forum for the young vascular surgeon (active members, see Article IV) to promote the field of vascular and endovascular surgery through education, scholarship, advocacy, and leadership.
   e) To do any and all things which may be necessary or incidental to these Bylaws.

2) The Society shall not carry on any other activities not permitted to be carried on:
   a) By a corporation exempt from Federal income tax under Section 501 (C) (3), of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law), or:
   b) By a corporation, contributions to which are deductible under Section 170; Furthermore, no part of the net income of the Society or its property or assets shall at any time inure to the benefit of any individual member, or of any private individual, or be used to promote the candidacy of any person seeking political office.

Article III - Meeting
The annual meeting of the Society shall be held at the time and place, which shall be designated by the Executive Committee. Special meetings may be called at any time by the president, or a simple majority of the Executive Committee, or by a written call signed by no less than one hundred (100) members.

Article IV - Membership
1) Active Membership of this Society shall be limited to physicians of good professional standing who have completed an ACGME-approved vascular surgical residency or fellowship, or equivalent foreign advanced training, who have a sustained major interest and active practice in peripheral vascular surgery and who are certified by the American Board of Surgery or its equivalent.

2) There shall be five types of membership:
   a) Active
   b) Senior
   c) Honorary
   d) Candidate; see Article XV
   e) Associate
PVSS Bylaws

Membership will be granted to senior surgeons who have been in practice for greater than 15 years. Active members who become senior members after 15 years can also choose to remain active.

Active Senior Members complete terms of elected office, receive Society correspondence, pay dues, attend meetings, sponsor papers for fellows and residents, participate in the business meeting as well as vote, but do not present papers and are not eligible for election as Peripheral Vascular Surgery Society officers.

Inactive Senior Members receive no correspondence, pay no dues, do not attend meetings, do not propose new members and do not sponsor papers and presentations. Inactive Senior Members may become Active Senior Members by requesting in writing reactivation and paying all back dues or three times the current year’s dues.

Associate members of this society shall be limited to non-vascular trained physicians and surgeons with either an MD or DO degree, scientists active in vascular medicine or surgical research, physician extenders in vascular specialties (RN’s, PA’s, NP’s) and vascular technologists. These members shall pay half dues, have no voting rights, cannot be elected as officers of the society, but may submit abstracts and papers to the meetings.

The Executive Committee may select honorary members.

Article V - Election of Members
The process of election of active members to the Society shall be as follows:
1) The society office shall supply application forms for membership.
2) Completed application forms signed by the candidate shall be sent to the Society office by March 1 of the year before the Spring meeting at which time the candidate shall be considered for election. One letter of recommendation from an active society member is required to complete the application.
3) The names of the candidates recommended for membership by the Executive Committee shall be submitted to the members at the annual meeting.
4) Election to membership shall be by secret ballot, by a three-fourths (3/4) affirmative vote of the membership present.
5) A candidate who fails to be elected at one meeting may be reconsidered at the next two annual meetings of the Society.

Article VI - Officers: Elections and Duties
1) The officers of this Society shall consist of a president, president-elect, secretary, treasurer, and recorder; all to be elected as provided in these bylaws.
2) The president shall preside at Executive Committee meetings and the annual meeting. Successors to vacated offices of the Peripheral Vascular Surgery Society shall be appointed by the president until the position is filled at the next annual meeting.
3) The president and president-elect of the Peripheral Vascular Surgery Society shall be elected for terms of one year each. The secretary, treasurer, recorder, and councilors-at-large shall be elected for three-year terms.
4) The president-elect, in the absence or incapacity of the president, shall perform the duties of the president’s office.
5) In the absence of both the president and president-elect, the chair shall be assumed by a president pro tem, elected by such members of the Executive Committee as are present.
PVSS Bylaws

6) The secretary shall keep minutes at the meetings of the Peripheral Vascular Surgery Society and the Executive Committee, update the executive committee on membership database and new applicant files and conduct correspondence of the Peripheral Vascular Surgery Society. The secretary will issue an annual written report at the annual meeting.

7) The treasurer shall receive all monies and funds belonging to the Peripheral Vascular Surgery Society, pay all bills, render bills for dues and assessments, and report to the membership at the annual meeting. The treasurer will prepare an annual report for audit.

8) The recorder shall receive all papers presented before the Society. The recorder shall be responsible for assuring prompt editorial review of manuscripts in concert with other Society members.

9) The councilors-at-large shall be elected for three-year terms, with election of one councilor occurring annually so as to provide overlapping terms.

Article VII - Executive Committee

1) There shall be an Executive Committee consisting of the president, president-elect, secretary, treasurer, recorder, councilors-at-large, and the two most recent past presidents.

2) The program committee chairman, the scholarship committee chairman, the fund raising committee chairman, membership committee chairman, by-laws committee chairman, and the communications committee chairman shall be non-voting members of the Executive Committee.

3) The Executive Committee shall be the governing body of the Society and shall have full power to manage and act on all affairs of the Society.

4) Executive Committee meetings shall be held at the call of the president of the Peripheral Vascular Surgery Society.

5) A majority of the members of the Executive Committee shall constitute a quorum for the transaction of business.

6) The Executive Committee will meet prior to the annual meeting to nominate officers, councilors, representatives and other committee members for presentation to the membership at the annual meeting.

7) The Executive Committee will appoint a program chairman at its June meeting for the annual meeting, which will take place in two years. The program chairman will be a non-voting member of the Executive Committee through the appointed annual meeting.

Article VIII – Committees and Representatives

1) Standing committees of the Society shall consist of a nominating committee, a program committee, a scholarship committee, a fund raising committee, a bylaws committee, a membership committee, and a communications committee.

2) The nominating committee shall consist of the current president in office, the president-elect and the two most recent past presidents. Its function shall be to make up a slate of officers, committee members and representatives to be presented to the executive committee at the annual meeting.

3) The program committee shall solicit papers and other presentations from members and other individuals and make up the program for the upcoming meeting. The winter program chairman shall be the president-elect (or other designate). The executive committee as per Article VII, item 7, shall appoint the spring program committee chairman. Each program chairman will select six other society members to assist in this task. The Spring meeting program chair shall serve for 2 years. Three
PVSS Bylaws

new program committee members shall be selected each year to serve a 2 year-term for a total of 6 program members in addition to one chair.

4) The scholarship committee shall consist of six members, a chairman, selected by the nominating committee, 3 Councilors-at-Large, and 2 remaining at-large committee members selected by the committee chairman. This committee shall serve for two years. Its function shall be to review educational grant award applications and to report award recipients to the executive committee at the annual meeting.

5) The fund raising committee shall consist of ten members. Its function shall be to research and implement comprehensive fundraising campaigns to support the society, organize and sponsor programs to enhance the awareness and treatment of vascular disease, to evaluate diagnostic and therapeutic tools manufactured by industry, and to enhance the rapid and proficient transfer of new knowledge and techniques to its members with assistance from our industry partners. A committee chairman shall be appointed by the nominating committee at the annual spring meeting to serve a three-year term. The chairman will also serve on the executive committee for the duration of the appointed term. Other committee members shall be the president-elect, the treasurer, the secretary and the newly appointed councilor-at-large. The committee chairman will select up to 4 additional society members to assist with this task. In addition, the current society president shall be an Ex-Officio member.

6) The bylaws committee shall consist of three members to serve overlapping terms of three years each. A new member shall be appointed annually by the President. The most senior member of the By-Laws Committee shall serve as Chair. The By- Laws Committee shall review By-Laws from time to time as directed by the Council and when appropriate, make recommendations regarding amendments.

7) The membership development committee shall consist of four members to serve overlapping terms of four years each. The Secretary shall serve as ex-officio. A new member shall be appointed annually by the President. The most senior member of the Membership Committee shall serve as Chair. The committee shall review all applications for membership and shall present their nominations for Active, Associate and Candidate membership to the Executive Committee for review and ratification at the Annual Business Meeting. The Membership Development Committee shall also assist the Secretary with membership development and expansion campaigns.

8) The communications committee shall consist of one Chair serving a three year term, and is responsible for organizing, coordinating, and implementing all communication to the PVSS membership and along with the Secretary will oversee subcommittee functions. The Communication Chair is appointed by the Nominating Committee for a maximum three year term renewed annually. The Communication Committee shall consist of three subcommittees: 1) Website sub-committee consisting of one chair serving a two year term and two sub-committee members appointed for 2 year terms, and is responsible for all web-based and electronic communication, and maintenance of the Society website. 2) Newsletter sub-committee consisting of one chair serving a two year term and a minimum of two sub-committee members appointed for 2 year terms, and is responsible for a membership newsletter at intervals defined by the Communication Chair. 3) Correspondence sub-committee consisting of one chair serving a two year term and two sub-committee members appointed for 2 year terms, and is responsible for organizing, coordinating and implementing all membership correspondence. All Communication Sub-Committee members shall be appointed by the President at appropriate intervals and renewed annually.
PVSS Bylaws

9) Representatives shall be appointed by the nominating committee in concert with the executive committee to serve on American College of Surgeons Board of Governors, American College of Surgeons Advisory Council for Surgical Specialties and the council of the American Association for Vascular Surgery. Each representative shall serve a three-year term unless otherwise noted by the executive committee at its annual Spring meeting. From time to time, other organizations may seek representation from the Society. Additional representatives shall be appointed in the same manner outlined above.

Article IX - Meetings
1) The annual meeting of the Peripheral Vascular Surgery Society shall be held at a time and place selected by the Executive Committee.
2) The business meeting of the Peripheral Vascular Surgery Society shall be conducted during the annual meeting. Officers of the Peripheral Vascular Surgery Society shall be elected by a majority vote of active members present at the business meeting.
3) All active members are encouraged to attend the annual meeting one year out of every three years. There is no attendance requirement for honorary or senior members.
4) A local arrangements chairman shall be appointed by the executive committee to serve in this capacity for the annual spring meeting to be held two years later. The immediate past president will serve as local arrangements chairman for the following winter meeting.

Article X - Dues and Fees
1) Dues and assessments shall be levied by the Executive Committee and approved by the membership at the annual meeting.
2) Any member whose dues remain unpaid for a period of two years shall be dropped from membership, provided that notification of such lapse is given at least three months prior to its effective date. The member may be reinstated on approval of the Executive Committee following payment of the dues in arrears.

Article XI - Resignations, Expulsions
1) Resignations of members otherwise in good standing shall be accepted by a majority vote of the Executive Committee.
2) Charges of unprofessional or unethical conduct against any member of the Peripheral Vascular Surgery Society, if proffered in writing and submitted to the Executive Committee, must be acted upon within one year. The Executive Committee's concurrence of disallowance of the charges shall be presented to the membership at the annual meeting. The three-fourths (3/4) affirmative vote of the members present shall be required for expulsion.

Article XII - Quorum
1) The members present at any official meeting of the society shall constitute a quorum necessary to change the constitution and bylaws of the Peripheral Vascular Surgery Society, to make assessments, to authorize appropriations or expenditures of money other than those required in the routine business of the Peripheral Vascular Surgery Society, to elect officers and members, and to expel members.

Article XIII - Alterations, Repeal
Bylaws may be altered or repealed at the annual meeting by a two-thirds (2/3) affirmative vote
PVSS Bylaws

of the members present.

**Article XIV - Procedure**
Proceedings of the Peripheral Vascular Surgery shall be conducted under Robert’s Rules of Order.

**Article XV - Candidate Group**
There will be a Candidate group of the society consisting of participants who are in good professional standing in an RRC accredited general surgery, vascular surgery residency, or other vascular residency recognized by the Peripheral Vascular Surgery Society. Also students in accredited osteopathic and allopathic medical schools can participate in this membership group. Participants in the Candidate Group will submit an application to the society office including the name and email address of an active PVSS member who endorses the application and may attend the scientific meetings at no cost as well as:

1) Present papers, if sponsored by a Society member
2) Attend the annual banquet.
3) Receive meeting notices and routine correspondence.
4) Have no voting rights

Candidate members shall be promoted to active membership upon completion of their vascular surgery residency (or equivalent) and upon receipt by the society office of a copy of the vascular surgery training certificate (or equivalent). At this time, the newly promoted active member will be bound by the requirements of active membership in the society.

*Amended – June, 2012*
Travel Award

2003  Thomas F. Lindsay, MD
      Toronto General Hospital, Toronto, Ontario, Canada

2004  Vikram S. Kashyap, MD
      Cleveland Clinic Foundation, Cleveland, OH

2005  Vivian Gahtan, MD
      Upstate Medical University, Syracuse, NY

2011  Judith Lin, MD
      Henry Ford Hospital, Detroit, MI

2012  Karen Woo, MD
      University of Southern California, Los Angeles, CA
Academic Award

2007  
**Brian W. Nolan, MD**  
Dartmouth-Hitchcock Medical Center, Lebanon, NH

2008  
**FACULTY**  
**Philip Goodney, MD**  
Dartmouth-Hitchcock Medical Center, Lebanon, NH  
**RESIDENT**  
**Matthew Corriere, MD**  
Wake Forest University School of Medicine, Winston-Salem, NC

2009  
**FACULTY**  
**Eugene Lee, MD**  
University of California, Davis, Sacramento, CA  
**RESIDENT**  
**Keri Seymour, MD**  
SUNY Upstate Medical University, Syracuse, NY

2010  
**FACULTY**  
**Tara Marie Mastracci, MD**  
Cleveland Clinic, Cleveland, OH  
**RESIDENT**  
**Sara Runge, MD**  
UCSF, San Francisco, CA

2011  
**FACULTY**  
**Guillermo A. Escobar, MD**  
University of Michigan, Ann Arbor, MI  
**RESIDENT**  
**Bjoern Suckow, MD**  
University of Utah, Salt Lake City, UT

2012  
**FACULTY**  
**John Curci, MD**  
Washington University, St. Louis, MO  
**RESIDENT**  
**Kathleen Lamb, MD**  
Thomas Jefferson University Hospital, Philadelphia, PA
Norman M. Rich Military Vascular Surgery Award

2009  
Cpt. Wayne Causey, MD  
Madigan Army Medical Center, Tacoma, WA  
Vascular Surgery Knowledge and Exposure Obtained During Medical School and the Potential Impact On Career Decisions

2010  
Cpt. Heather Hancock, MD  
Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, TX  
Dose Response To Hind Limb Ischemia Reperfusion In A Porcine Model of Functional Limb Salvage

2011  
Cpt. Marlin Wayne Causey, MD  
Madigan Army Medical Center, Tacoma, WA  
Microarray and Functional Cluster Analysis Implicates Transforming Growth Factor Beta 1 In A Swine Hemorrhagic Shock Model

2012  
Cpt. Carole Villamaria, MD  
U.S. Army Institute for Surgical Research, Ft. Sam Houston, TX  
Microvascular Porcine Model For the Optimization of Composite Tissue Autotransplantation
Member Update Form

Please help the PVSS keep your membership information current. We require an email address from all members for communication purposes, as well as your preferred mailing address.

Please return to the PVSS Registration Desk or fax to the National Office at 978-927-7872.

**MEMBER INFORMATION (Required For All Members)**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
</tr>
<tr>
<td>Email Address</td>
</tr>
</tbody>
</table>

**MAILING INFORMATION**

Preferred Mailing Address: □ Work □ Home

Please provide preferred mailing address below:

<table>
<thead>
<tr>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address (cont.)</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Daytime Telephone</td>
</tr>
</tbody>
</table>

Thank you!