Bivalirudin, Aspirin, Clopidogrel, Brilinta, and MP use, did not contribute to VCs.

CONCLUSION Risk of VCs in women from FAA has reduced to that of men in contemporary era in the setting of unchanged total VC rate a decade ago. VCD use continues to reduce the incidence of VCs. The use of fluoroscopic marking prior to access, smaller sheath size, and being a high femoral volume center may have contributed to the reduced incidence of VCs in women.

CRT-200.28

The Use of the Perclose Proglide Suture Mediated Closure (SMC) Device for Vein Artery Access Site Closure Up To 24F Sheaths

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BACKGROUND Evaluate the safety and performance of ProGlide in closure of venous access site in subjects with a large-caliber femoral vein sheath (24F).

MATERIALS AND METHODS This was a prospective analysis of retrospective data from the EVEREST II REALISM (REALISM) MitraClip study population who had received either ProGlide or manual compression (MC) as the intended method for venous accesssite closure. Seven (7) high frequency vessel closure device usage sites from the REALISM study were selected as the study sites. The primary analysis cohort (ProGlide group) was defined as subjects who received at least one (1) ProGlide as the intended femoral vein access-site closure device. The primary analysis was the evaluation of ProGlide against an acceptance criterion of ≥90% for the rate of freedom from major femoral vein access-site related complications at 30 days post-procedure.

RESULTS A total of 159 subjects from five of the seven high-frequency VCD sites were included in this analysis. Two high-frequency VCD sites did not use any ProGlide for the femoral vein access site closure. The subjects enrolled were elderly with a mean age of 76 years, 53% were male with multiple comorbidities. The largest venous sheath for the MitraClip access site was 24 French (F). The primary endpoint of the rate of freedom from major femoral vein access-site related complication at 30 days was 98.1% (95% CI [94.6%, 99.6%]), meeting the predefined acceptance safety criterion of 90%. Of the 159 cases in which ProGlide was used, 144 used 2 ProGlides and 15 used 1 ProGlide. In the ProGlide cohort, 69.2% (110/159) of the subjects received ProGlide only as the intended hemostasis method; 17.6% achieved hemostasis with ProGlide plus MC, and 12.6% used secondary closure methods (subcutaneous stitch) along with ProGlide. Hemostasis at the time of the index procedure using ProGlide was achieved in an average time of 5.92 ± 6.19 minutes.

CONCLUSION The study results have demonstrated that the safety assessment of ProGlide met the predefined acceptance safety criterion. The use of ProGlide in venous closure of 24F was associated with a low 30-day major complication rate.

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Carotid Artery Endarterectomy vs. Carotid Artery Stenting For Restenosis After Carotid Artery Endarterectomy: A Systematic Review and Meta-analysis

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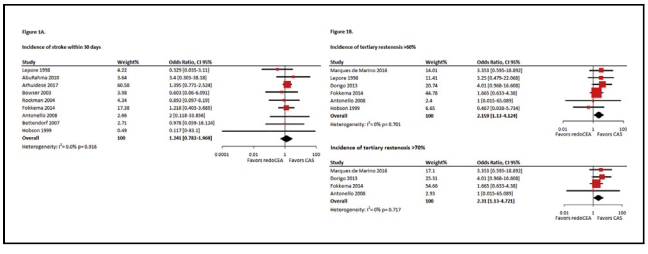
OBJECTIVE Carotid artery restenosis may occur after ipsilateral carotid endarterectomy (CEA). It remains unclear whether carotid artery stenting (CAS) or a repeat CEA (redoCEA) is the best treatment strategy for carotid artery restenosis.

MATERIALS & METHODS This study was performed according to the PRISMA and MOOSE guidelines. Eligible studies were identified through a comprehensive search of PubMed, Scopus and Cochrane Central until July 20, 2017. A meta-analysis was conducted with the use of random effects modeling. I-square was used to assess for heterogeneity.

RESULTS Thirteen studies involving 4163 patients were included. Periprocedural (within 30 days) stroke, transient ischemic attack (TIA), myocardial infarction (MI), and death rates were similar between the two revascularization approaches. However, the risk for cranial nerve (CN) injuries was higher in the redoCEA group (OR: 9.84; 95% CI: 3.73 - 25.94; I2 =0%). CAS was associated with significantly lower risk for long-term recurrent carotid restenosis, when defined as stenosis >60% (OR: 2.15; 95% CI: 1.13 - 4.12; I2 =0%) or as stenosis >70% (OR: 2.31; 95% CI: 1.13 - 4.72; I2 =0%). No difference was identified in long-term target lesion revascularization rates between redoCEA and CAS.

CONCLUSIONS Patients with carotid restenosis after CEA can safely undergo both CAS and CEA with similar risks of periprocedural stroke, TIA, MI and death. However, patients treated with CAS have a lower risk for a new restenosis and periprocedural CN injury.



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