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operations by orthopedic and plastic surgery after the accident. In postoperative first month, a pulsatile mass was recognized on the front of the right thigh. There was large defect of the skin. Doppler ultrasonography revealed a 3x4 cm pseudoaneurysm of anterior tibial artery and lower extremity angiography was performed for better assessment. Pseudoaneurysm was detected by angiography and compression therapy was tried. But it failed; so surgical therapy was planned. A 23-years old male patient was operated for tibial implant placement by orthopedic because of the tibial fracture after exterior vehicle traffic accident. After 3 months, the pulsatile mass was recognized on the front of the right thigh. Doppler ultrasonography revealed a 3,5x2 cm pseudoaneurysm of anterior tibial artery, and compression therapy by angiography was planned.

Results. After compression treatment failure, surgical therapy was planned for the first patient. Reconstructive surgery was considered primarily because ATA was patent. Pseudoaneurysm sac was opened and a large arterial defect was observed. So resection was not preferred and patchplasty of ATA with autolog venous patch was performed. Operation was successful, postoperative course was uneventful and postoperative second day the patient was transferred to orthopedic clinic. Second patient underwent angiography for compression therapy. 3 mm balloon was used for compression therapy and after one minute, it was detected that pseudoaneurysm was thrombosed. Postoperative first day the patient was discharged from the hospital uneventfully.

Conclusion. Pseudoaneurysms of the anterior tibial artery are rare vascular disorders. Pathology is usually treated with surgical measures by resection of the pseudoaneurysm and ligation of the anterior tibial artery. But when a healthy ATA was detected, arterial reconstruction should be thought. Surgery is definitive treatment modality but in minor arterial defects and pseudoaneurysms compression therapy should be considered as an useful and easy treatment modality.

Key words: Anterior tibial artery; Pseudoaneurysm; Compression therapy; Resection; Surgical treatment.

PP-291
Transposition Versus Elevation: A Comparative Study Of Two Different Techniques For Basilic Vein Superficialization

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Objective. Transposition and elevation are two different techniques of superficialization of the basilic vein. The aim of this study was to compare outcomes and patency rates of the brachial basilic fistula in transposition and elevation techniques.

Methods. This was a comparative retrospective study about 60 consecutive patients who have had a superficialization of the basilic vein between September 2012 and April 2014. The vein was transposed in 29 patients (group 1) and elevated in 31 patients (group 2). The assignment of the technique had not been randomized. All patients had a two-stage procedure. The mean time from fistula creation to superficialization was 57.28±5.3 days [12-204].

Results. Patients characteristics were similar in the two-groups. The mean age was 60.10 vs 59.29 years (P=.843) and the male gender 55.2% vs 61.3% (P=.631) in group 1 and 2 respectively. However, the follow-up period was significantly higher in group 1 (13.28 vs 6.15 months, P=.000). Only 3 patients (5%) were lost to follow-up, one in group 1 and two in group 2 (P=1.00). No deaths were observed in group 1 where the survival was significantly higher (100% vs 86,3% at 6 months, P<.05). The overall morbidity rate was 51.7% vs 41.9% (P=.448) and the early morbidity rate was 20.7% vs 22.6% (P=.859) in group 1 and 2 respectively. The most frequent early complications were hematoma (10.3%) in group 1 and infection (12.9%) in group 2. The late morbidity rate was 34.5% in group 1 and 25.9% in group 2 (P=.487). Thrombosis (13.8% vs 11.1%, P=1.00) then stenosis (10.3% vs 7.4%, P=1.00) were the most frequent late complications in both groups. Only one primary failure was observed in each group (P=1.00). Primary functional patency was not significantly different between the two groups (92.7% vs 89% at 6 months, P=.879). Indemnity for stenosis or thrombosis was better in group 1 (96.3% vs 86.1% at 6 months, P=.245) while the indemnity for reintervention was better in group 2 (89.7% vs 92.4% at 6 months, P=.727), but the differences were not statistically significant.

Conclusion. According to this study, it seems not to be a difference of patency or outcomes between transposition and elevation techniques. Nevertheless, randomized studies are needed to be sure of the real absence of significant difference between both techniques.

Key words: Transposition, elevation, superficialization, brachial basilic fistula, vascular access, hemodialysis.

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Management of Large Carotid Body Tumor: Case Report

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Objective. Carotid body tumor (CBT) is a slow growing, highly vascularized tumor and the most common type of the paraganglioma of the head and neck. CBT is very rare in more than 95% of cases benign tumor with incidence rate of 0,00003%. Radiotherapy as a primary modality of treatment for CBT is controversial and heavily debated, occasionally recommended only for very large sized tumors, recurrent tumors or for those patients who are poor surgical candidates. Surgery for young and healthy patients is the first choice of treatment. In small countries only few surgeons will encounter substantial number of cases during their career. Especially large Shamblin type III tumors (greater than 5 cm) are real surgical challenge. Management of such tumors carries a high risk of increased mortality and morbidity rates regarding to neurovascular complications.

Case 1.—A 52-year-old male with 5 years history of slow-growing, asymptomatic, right lateral neck mass. Ultrasonography (US) demonstrated cervical mass beyond the angle of mandible. MRI combined with CT scanning showed large (62x54x41mm) highly vascularized soft-tissue mass completely surrounding the right carotid bifurcation, with compressive effect to larynx and internal jugular vein. Patients underwent surgery under general anesthesia by a multidisciplinary team. During procedure Near-infrared spectroscopy monitoring of the continuous regional oxygen saturation (rSO2) was measured with a cerebral oximeter (Somanetics Invos cerebral oximeter). Through a transverse cervical incision all neurovascular

structures were identified and periadventitial. Proximal and distal control established, ECA was ligated and dissected, ICA and CCA cross clamped. Complete and safe tumor resection achieved. CCA to ICA was reconstructed by a termino-terminal anastomosis using ePTFE 6/4 vascular graft. Postoperatively, a transient swallowing difficulties and ipsilateral tongue deviation developed.
Conclusion. Larger CBT need a multidisciplinary centralized approach as the best choice, including combined competent vascular, maxillofacial, radiology and otolaryngology team.

Key words: Large carotid body tumor, Multidisciplinary team

PP-293
Giant Popliteal Arterial True Aneurysm: Case Report

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Peripheral arterial aneurysms are seen rarely. Popliteal arterial aneurysms, which are occasionally caused by atherosclerosis, are the most common type of peripheral arterial aneurysms. Other causes are trauma, mycosis, arteritis, popliteal arterial entrapment syndrome. Although popliteal arterial aneurysms are seen rarely, they can be extremity threatening with acute thrombotic or embolic occlusions. In this paper, we aimed to present a 54-year-old patient with 7cm true popliteal arterial aneurysm (Figure 1). He admitted with digital embolism in his right foot, and we performed early surgery for the aneurysm. There are different techniques in open surgery. Aneurysm sac may be ligated from proximal and distal ends and bypass procedure may be performed with saphenous vein or graft, on the other hand, aneurysm sac may be removed especially if compression symptoms are present. In our case, there were no compression symptoms but we removed the aneurysm sac since it was big. We preferred saphenous vein as infragenual bypass was planned. There has been lots of papers supporting endovascular procedure in recent years. We think that, endovascular treatments will be better in the future following development in stent graft technologies but nowadays, we think that a open surgery is a feasible and safe method especially in popliteal aneurysms around knee joint.

Key words: Popliteal artery, Aneurysms.

Figure 1.—Intraoperative imaging.

PP-294
Design and Internal Validation of a New Risk Score in Critical Lower Limb Ischemia: The Ericva Score

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Objective. Critical lower limb ischemia is associated with a high rate of death and /or major amputation. It is also difficult to establish which patients will benefit from revascularization, which is the treatment of choice. Risk scores can provide objectivity in decision-making, but those established so far in revascularization for critical limb ischemia have not been validated sufficiently. The aim of this work is to design a new risk score (which will be referred as ERICVA) and compare their predictive power (major amputation-free survival at a year) with the PREVENT III and Finnvasc scores.
Methods. An observational retrospective study of patients, who underwent revascularization for critical ischemia in the Hospital Clínico of Valladolid between 1/1/2005 and 30/6/2010, was designed. The sample was divided into two subgroups, one for the development of the score and the other for internal validation of it, and comparison with other models. From the development sample, after an analysis of Kaplan-Meier followed by Cox regression, a number of variables associated with death and /or major amputation at one year were selected, creating the risk model ERICVA with these. From the validation sample, an internal validation of the developed model was performed, and compared with the PREVENT III and Finnvasc scales using receiver operating curves.
Results. 672 cases with an average surveillance of 778 days were included in the study; 561 formed the derivation sample or ERICVA score and the other the internal validation sample. The major amputation free survival was 84.8% at 30 days and 63.1% at a year. The variables associated with death and/or major amputation at a year in Cox regression were: cerebrovascular disease, prior contralateral major amputation, diabetes mellitus, dialysis, COPD/asthma, active neoplasm in the last five years, hematocrit less than 30%, neutrophils/ lymphocyte ratio exceeding 5, absence of distal flow, emergency admission and Rutherford 6 stage; these variables were used for ERICVA score design. Scores were applied to the validation sample, ERICVA scale achieving an area under the curve of 0.708 ($p < 0.001$), simplified ERICVA 0.763 ($p < 0.001$), PREVENT III 0.707 ($p < 0.001$) and Finnvasc 0.541 ($p = 0.478$).
Conclusion. We have designed a risk model, ERICVA, which has a good predictive capacity of death and/or major amputation in our clinical setting, slightly above the PREVENT III level and above Finnvasc.

Key words: Critical limb ischaemia, revascularization, perioperative risk, risk score

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Impact of Arterial Calcinosis in Revascularization of Patients with Critical Limb Ischaemia

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Objective. Arterial calcinosis is a marker of poor prognosis in cardiovascular disease; however, has not yet been convincingly established its involvement in the results after arterial surgery of the lower limb. This paper evaluates the impact of arterial calcino-