

influence on their hospital experience and 82% recommended the application.

Conclusions: Patients were satisfied with the use of the patient education tool, and use of the program significantly improved knowledge retention. No changes in patient activation measure or medical complications were seen in this small sample; however, further studies are warranted to evaluate the effects of this study on long-term postoperative outcomes.

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The Worst of Wifi: Limb Salvage Results in Patients Requiring Revascularization and Foot Reconstruction



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Objectives: There are limited data on the surgical reconstruction of open foot wounds after lower extremity bypass. This study looks at the outcomes of early primary closure of foot wounds after revascularization in patients at high risk of major amputation based on the wound, ischemia, and foot infection (Wifi) classification.

Methods: A single-institution, single-surgeon retrospective review was conducted of the records of 78 consecutive patients between January 1, 2006, and May 31, 2014, who had partial foot amputations with primary closure after revascularization.

Results: All patients had a Wifi score designating high risk of amputation at 1 year. All patients underwent autogenous vein bypass for revascularization, and the median time between revascularization and foot closure was 5.5 days (range, 1-76 days). Forty patients (51%) had amputation and primary closure of one or more toes and distal metatarsals, while 31 (40%) underwent transmetatarsal amputation. Eleven patients (14%) returned to the operating room for further débridement within 30 days of closure. Ultimately, five patients underwent major amputation; however, only two occurred prior to complete healing. In both the bypass had to be ligated secondary to wound problems. Freedom of major amputation was 90.2% at 5 years. Wound and infection scores from Wifi did not correlate with major amputation. None of the 15 dialysis patients required amputation. There was no association between Wifi scores or timing of foot closure and major amputation. Overall survival was 82% at 1 year and 48% at 5 years.

Conclusions: Patients at high risk for major amputation by Wifi classification can safely undergo revascularization and early closure of foot wounds with excellent results.

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First Experience With the New Nexus Stent Graft for the Arch



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Objectives: This study presents our first experience with the Nexus stent graft (SG) by Endospan currently under investigation, which is indicated for aneurysms and dissections of the arch. We will describe the case focusing on the underlying challenging anatomy, the preoperative planning, the procedure itself (which is particular because this graft is completely different from the other branched graft for the arch), and the technical difficulties we encountered.

Methods: Nexus SG is an innovative device with one branch for the innominate artery (from which the deployment starts) and two fenestrations, one for the LCA and one to be connected with the ascending module. We selected for the first implantation a 65-year-old patient with a large 72-mm aneurysm of the distal arch/descending aorta that involved the left subclavian artery ostium. He was at high risk for open repair because of a previous surgical repair of the ascending aorta and three coronary artery bypasses with vein from the surgical graft.

Results: After a carotid subclavian bypass we were ready to perform the thoracic endovascular aortic repair. The implantation was technically successful although quite challenging. During the procedure, the most critical step was the cannulation of the LCA fenestration. This issue prompted us to propose to Endospan engineers a modification of the graft design with a precannulated LCA fenestration.

Conclusions: We believe that this graft will play a large role in the treatment of arch pathologies.

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Mycotic Celiac Artery Aneurysm: A Case Report, Approach Options, and Review of the Literature



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Objectives: Mycotic celiac artery aneurysm (MCAA) is extremely rare. Only eight cases have been reported in the literature to date, and five of those were secondary to endocarditis. We describe a MCAA case, secondary to infective endocarditis, managed with a staged surgical treatment. We also present a review of the literature and a discussion of current treatment options for MCAA.

Methods: A 56-year-old man was admitted with infective endocarditis following a dental procedure, with severe mitral regurgitation that required mitral valve replacement. Abdominal imaging studies did not show abnormalities of his native vessels. He was discharged with negative blood cultures after a 2-month admission on long-term antibiotics. One month after his hospital discharge, the patient presented to the emergency department with new-onset fevers and hypotension. New blood cultures were positive for methicillin-resistant *Staphylococcus aureus*, however, trans-thoracic echocardiography was negative for endocarditis. Abdominal imaging study revealed a celiac aneurysm measuring 4.0 × 3.2 cm.

Results: A two-staged approach was proposed due to the size of the aneurysm and relative challenge of safely ligating the aneurysmal celiac trunk from the