Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
group 2 experienced a stroke (P = .110). Thrombosis of the prosthesis was registered in the early postoperative period for one patient, and 2 patients experienced ipsilateral stroke without loss of graft patency. Two patients in group 1 also developed cranial nerve neuropathy. The total number of postoperative complications was higher in group 1 than in group 2 (n = 9 [45.5%] and n = 2 [10.2%], respectively, P = .001). In the 30-day period after hospitalization, stroke and myocardial infarction were not recorded in either group. In the long-term period, the results of treatment were followed for 60 patients in group 1 and 104 patients in group 2. Long-term survival was significantly higher in the CEA group (P = .007). The long-term freedom from stroke also differed between the two groups and was better in the CEA group (P = .02). In one patient, after 36 months, restenosis of the proximal anastomosis with the CCA was recorded, which required carotid artery stenting. In 18 patients in group 1 who had experienced stroke, only 6 had developed prosthetic thrombosis in the long term.

Conclusions: Replacement ICA should be used only in cases for which evasion CEA is not possible because the immediate- and long-term results were better with CEA.

Author Disclosures: I. Muchamadeev: Nothing to disclose. A. Oborin: Nothing to disclose.

IP109.

TCAR Can Safely Be Performed With Regional Anesthesia and No ICU Stay

Mathew Wooster, Veena Mehta, Peyton Tharp, Courtney Caruthers, Agenor Paulino Dias. Medical University of South Carolina, Charleston, SC

Objectives: Hospital resource usage is under constant review, and the extent and intensity of postoperative care requirements for vascular surgical procedures has been especially relevant in the setting of the COVID-19 (coronavirus disease 2019) pandemic and its impact on staff intensive care unit (ICU) beds. We evaluated the feasibility of regional anesthesia and low-intensity postoperative care for patients undergoing transcarotid artery revascularization (TCAR) at our institution.

Methods: All patients at high risk for carotid endarterectomy undergoing TCAR at a single institution from 2018 to 2020 were reviewed. Perioperative management was standardized by the use of an institutional protocol that included hemodynamic parameters and requisite medications, anticoagulation and/or antplatelet regimens, neurovascular examination guidelines, and nursing instructions. The anesthetic modality was at the surgeon’s preference. Patients were transferred to the postanesthesia care unit (PACU) for 2 hours (with a 1:1 or 1:2 nursing ratio) followed by the step-down unit (1:4 nursing ratio) for 4 hours, followed by transfer to the floor (1:6 ratio) or, alternatively, were transferred to the ICU (1:1 ratio). Intravenous (IV) blood pressure medications could be administered in all environments, except for the floor. The recovery location and length of stay were recorded.

Results: A total of 83 patients had undergone TCAR during the study period. The mean age was 72 ± 9 years, 59% were men, and 36% were symptomatic. Regional anesthesia was used for 84%, with none converted to general anesthesia intraoperatively. Postoperatively, only seven patients (8%) had required monitoring in the ICU overnight (decided perioperatively). This was mostly for patients with prior neurologic symptoms but for one patient because of a postoperative neurologic event and for another patient because of pulseless electrical activity arrest. Of the 83 patients, 76 (92%) had been monitored in the PACU, with 8 transferred to the floor after 4 hours and 13 discharged directly from the PACU (owing to limited bed availability). Of the patients in the PACU, 35 were transferred to the step-down unit after 2 hours and discharged from there. Six patients had required IV antihypertensive agents, and eight had required IV vasoactive support postoperatively. The mean length of stay in the ICU was 3.7 days (range, 1-15 days). The mean length of hospital stay was 1.8 ± 2.3 days (3.7 ± 5.4 days for those requiring the ICU and 1.4 ± 12 days for those not requiring the ICU). The incidence of stroke, death, and myocardial infarction was 2.4%. There was one postoperative stroke considered to be a recrudescence of a prior stroke, and one respiratory arrest fatality in a frail patient with a neck hematoma, both of whom had been treated under general anesthesia.

Conclusions: Using perioperative care protocols, TCAR can safely be performed while avoiding both general anesthesia and an ICU stay for most patients.

Author Disclosures: C. Caruthers: Nothing to disclose. V. Mehta: Nothing to disclose. A. Paulino Dias: Nothing to disclose. P. Tharp: Nothing to disclose. M. Wooster: Cook Medical. Speaker’s Bureau. Gore. Speaker’s Bureau. Medtronic. Speaker’s Bureau. Penumbra. Speaker’s Bureau. Shockwave. Speaker’s Bureau.

IP111.

Symptom Status Affects Outcomes After Transcarotid Artery Revascularization, Carotid Artery Endarterectomy, and Transfemoral Carotid Artery Stenting in Female Patients

Priya B. Patel, MPH,1 Christina L. Marcaccio, MPH,1 Aderike C. Anjorin, MPH,1 Kayla Isbell,2 Patric Liang,3 Young Erben,4 Grace Wang,5 Raghul L. Motaganahalli,6 Mahmoud B. Malas, MHS, Brian Nolan,7 Vikram S. Kashyap,1 Marc L. Schermerhorn,1 Beth Israel Deaconess Medical Center. Harvard Medical School, Boston, MA; 1Beth Israel Deaconess Medical Center, Boston, MA; 2Hospital of the University of Pennsylvania, Philadelphia, PA; 3Indiana University School of Medicine, Indianapolis, IN; 4University of California, San Diego, San Diego, CA; 5University Hospitals Cleveland Medical Center, Cleveland, OH; 6NYP-Columbia University Medical Center, New York, NY; 7Mayo Clinic, Jacksonville, FL; 8Maine Medical Center, Portland, ME

Objectives: Female patients have derived less benefit from some common vascular procedures compared with male patients. Recent studies have shown comparable perioperative outcomes after transcarotid artery revascularization (TCAR) and carotid endarterectomy (CEA) for carotid artery stenosis and improved outcomes following TCAR compared with transfemoral carotid artery stenting (tCAS). To examine whether these benefits extend to female patients, we compared the effect of carotid revascularization technique (TCAR, CEA, or tCAS) on the in-hospital outcomes in female patients.

Methods: We identified all patients within the Vascular Quality Initiative who had undergone TCAR, CEA, or tCAS for atherosclerotic disease between 2016 and 2021. Our primary outcome of interest was a composite of in-hospital stroke/death. The patients were stratified by symptom status. Propensity scores were calculated using demographics, comorbidities, carotid symptom status, anatomic characteristics, and preoperative medication use. Inverse probability-weighted logistic regression was used to compare the outcomes after TCAR vs CEA and TCAR vs tCAS.

Results: A total of 22,619 TCAR, 96,882 CEA, and 20,814 tCAS patients were identified. Female patients had undergone 8262 TCAR, 38,040 CEA, and 7436 tCAS procedures, of whom 30%, 37%, and 38% were...