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complications, including infection and thrombosis, clustered toward the higher quartiles of this range, indicating a propensity for macrovascular and microvascular thrombotic events compared with patients with reduced aggregation. Thromboelastography with platelet mapping might provide integral insight into an individual’s platelet response to treatment and an opportunity to augment management with a patient-specific approach.

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**Table.** Quartile values of platelet aggregation

| ADP aggregation | Number | Q1 | Median | Q3 | Maximum | IQR |
|-----------------|--------|----|--------|----|---------|-----|
| All patients    | 211    | 53.6 | 79     | 89.3 | 100     | 35.7|
| MAPT            | 158    | 66.6 | 80.5   | 90.1 | 100     | 23.5|
| DAPT            | 55     | 38.7 | 61.5   | 82.3 | 100     | 43.6|

ADP: Adenosine diphosphate. DAPT: dual antiplatelet therapy. IQR: Interquartile range. MAPT: mono-antiplatelet therapy. Q1: quartile 1. Q3: quartile 3.

**Conclusions:** The formula for gaming and collegial discussion of aortic cases reported was proved valid and attractive in a period of the full COVID-19 pandemic. The variability of the results demonstrated for sizing and planning highlight the importance of second opinions.

**Author Disclosures:** E. Chisci: Nothing to disclose. S. Michelagnoli: Nothing to disclose.

**IPC01.**

The New Educational Project “TELEVASCULAR GAMES” During COVID-19 Pandemic

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**Objectives:** To report the method and first-year results of the New Educational Project called “TELEVASCULAR GAMES” during the COVID-19 (coronavirus disease 2019) pandemic.

**Methods:** Complex aneurysmal aortic disease was discussed during a 2-hour competition webinar according to three modalities: (1) planning case competition (PCC): two to four angio-computed tomography angiography (CTA) scans of a selected case already performed were submitted for the competition. CTA scans were unanimously uploaded without any reference to either the center or surgeon who had performed the case. Competitors were required to prepare a presentation of how they would have diagnosed, sized, planned, treated, and followed up the case; the medical therapy used; and the bail-out maneuvers. (2) Challenging case competition (CCC): the competitor produced a presentation of a case already treated on an aortic topic discussing sizing, planning, treatment, possible bail-out maneuvers, and the results obtained. For the CCC and PCC, the four best scored competitors were selected to present and discuss during the webinars. (3) Quiz competition (QZ): two to six angio-CTA scans of selected aortic cases already performed were submitted for the competition. A quiz with multiple choice questions was answered by the competitors. The four best competitors selected for the webinars then discussed the cases during the webinar. Finally, at the end of the case discussion, the real case solution and follow-up were presented. A final winner was chosen by televoting using six preestablished criteria.

**Results:** Between October 2020 and December 2021, there were 12 Italian and 1 international webinars with 1695 participants overall (mean, 150; range, 86-177). The Fig shows the distribution of the participants. Competitors were 54 (mean age, 27 years; range, 22-38 years). Two editions were CCBs, two were QCs, and nine were PCCs. The reliability of the interobserver sizing of the competitors was kappa = 0.43 and kappa = 0.62 for the proximal and distal sealing measurements, respectively, and very good (kappa = 0.88-0.95) in the evaluation of the orientation of the vessels and presence of angulations, calcifications, and thrombus. The sizing discrepancy resulted in a significant variability in the planning (kappa = 0.45). The project was endorsed by the International Union of Angiology, Italian, and Society for Vascular Surgery and ranked using a 10-point rating scale at 9.6.

**Conclusion:** The formula for gaming and collegial discussion of aortic cases reported was proved valid and attractive in a period of the full COVID-19 pandemic. The variability of the results demonstrated for sizing and planning highlight the importance of second opinions.

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**IPC02.**

Clinical Utility of Peripheral Calcium Scoring in Evaluating Peripheral Arterial Disease Severity

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**Objectives:** Lower extremity calcium scoring (LECS) is an emerging tool that can be used to risk stratify patients with peripheral arterial disease (PAD). This study aimed to determine the association between LECS and disease severity in patients with PAD.

**Methods:** A multi-institutional retrospective database was queried for all patients with a diagnosis of PAD who had undergone multidetector computed tomography of the aorta and bilateral lower extremity runoffs from 2016 to 2020 (Fig). Patients who had undergone prior balloon angioplasty without stenting or atherectomy were included. Those with prior surgical bypass, atherectomy, or stenting were excluded. Demographics, medications, and procedure type were recorded. The aorta through the lower extremities was calcium scored using the Agatston calcium scoring method. A descriptive analysis of patients with claudication and wounds (toe, forefoot, heel) was performed. Welch’s t test was used to calculate the difference in the average total LECS between the two groups. Multivariate analysis of the association between the total LECS and claudication and wounds was performed. A threshold of a total LECS >10,000 was identified based on prior literature. Fisher’s exact test was performed to compare the difference in the proportions of patients with a total LECS >10,000 among those with and without claudication/wounds.

**Results:** A total of 143 patients were included. 44 with claudication and 33 with lower extremity wounds (Tables I and II). Of those with claudication, 81.8% had hyperlipidemia compared with 60.8% of those without claudication (P < .05). In contrast, 51.5% of patients with wounds had had type 2 diabetes compared with 26.9% without wounds (P < .05). On univariate analysis, the mean total LECS was significantly different between those with and without claudication (LECS, 33.55 vs 21.806; P = .02) and between those with and without wounds (LECS, 42.200 vs 20.239; P < .05). On multivariate analysis, there was a trend toward significance in the association between the total LECS and claudication.