EVAR FOR RUPTURED ANEURYSMS: ALSO AN OPTION FOR CHALLENGING ANATOMIES ?

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Disclosure

Speaker name:

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I have the following potential conflicts of interest to report:

- ■ Consulting **Cook**, **Gore**, **Terumo Aortic**
- ☐ Employment in industry
- ☐ Stockholder of a healthcare company
- ☐ Owner of a healthcare company
- ☐ Other(s)

☐ I do not have any potential conflict of interest

CONTEXT / BACKGROUND

- Ruptured AAA is always an emergency
- Needs to be refered in a large volume center
- Remains a clinical drama is large part of cases
- Technique not (yet) determined

TECHNICAL ASPECT

- TREATMENT DEPENDS ON:
  - Emergency – patient stable/unstable
  - Previous investigations (angioCT scan !) / time for it !
  - Global clinical status of the patient / age / patient willingness
  - Challenging case or not
    - Iliac accesses ?
    - Hostile abdomen ?
    - Proximal neck
      - Sufficient length ?
      - Angulated ?
    - Distal landing/suture

TECHNICAL ASPECT

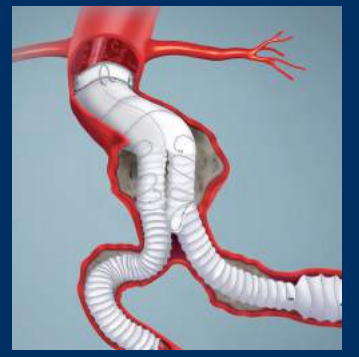
- During last 10 years many trials and studies have compared EVAR and Open surgery for rAAA
- Mortality at 1 year : 38.6% EVAR Vs 42.8% Open p = .209 NS

Sweeting MJ, Ulug P, Powell JT, **Desgranges P**, Balm R; Ruptured Aneurysm Trialists.Sweeting MJ, et al. Among authors: **desgranges p**. Eur J Vasc Endovasc Surg. 2015 Sep;50(3):297-302. doi: 10.1016/j.ejvs.2015.04.015. Epub 2015 May 15.

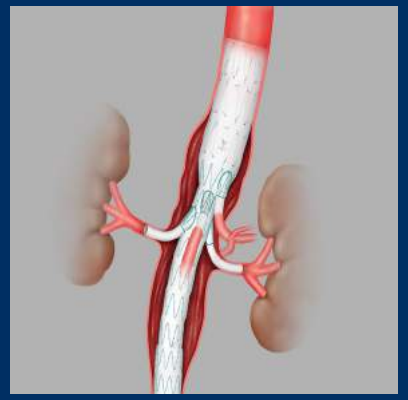
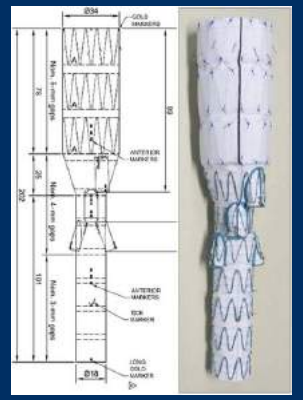
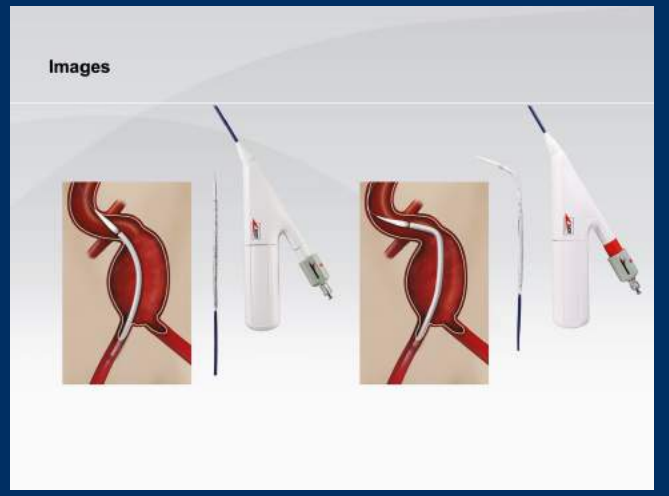
- But:
  - Physicians are in progress !
  - Centers are more and more dedicated for specific (endovascular) treatment
  - Devices are in progress !

NEW DEVICES

- TERUMO AORTIC
  - For angulated proximal neck : up to 90°
  - Not dedicated for challenging accesses: 20 to 23 Fr
- GORE Excluder® conformable Active Control
  - For angulated (90°) and short neck (10 mm)
  - Very precise delivery
- COOK
  - T-Branch
  - Rare indications for rTAA





EXAMPLE

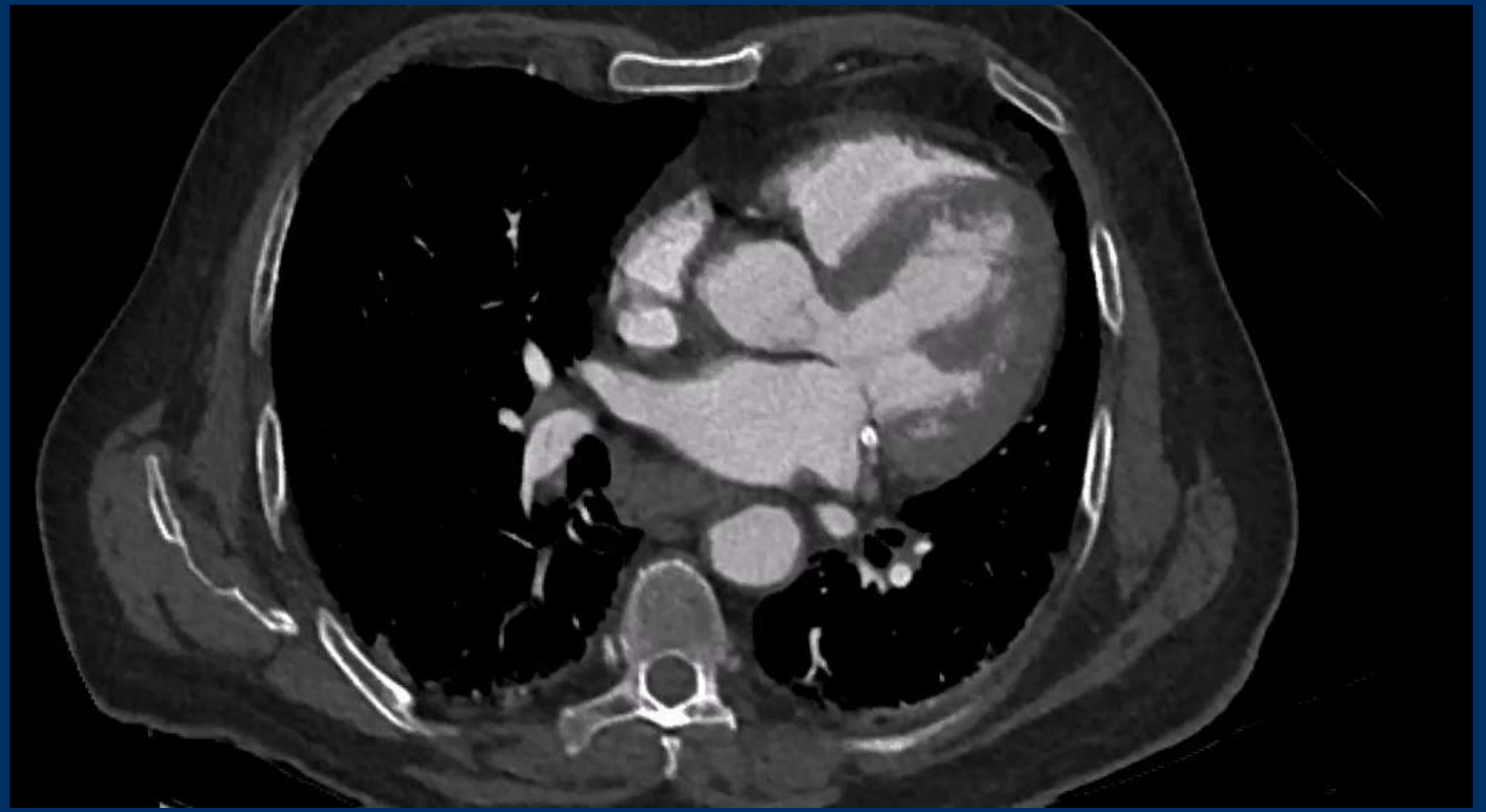
- Man 80 Y. old, demand for transfer from a 200 km center

Patient unstable: declined – not dedicated for (long) endo treatment

BACK to CLINICAL ASPECT

- Each case is unique !
- Each case depends on so many (challenging) parameters
- One of the most recent case
  - Male 83 Y.old
  - Adbominal pain
  - +/- stable haemodynamicaly
  - Angio CT scan at emergency ward

BACK to CLINICAL ASPECT



BACK to CLINICAL ASPECT

- First challenge: no proximal neck !
- Second challenge :

Not the ideal candidate for a surgical approach !

CRUCIAL KEYS

- 1 #: preparation with clam and all devices / situations prepared

CRUCIAL KEYS

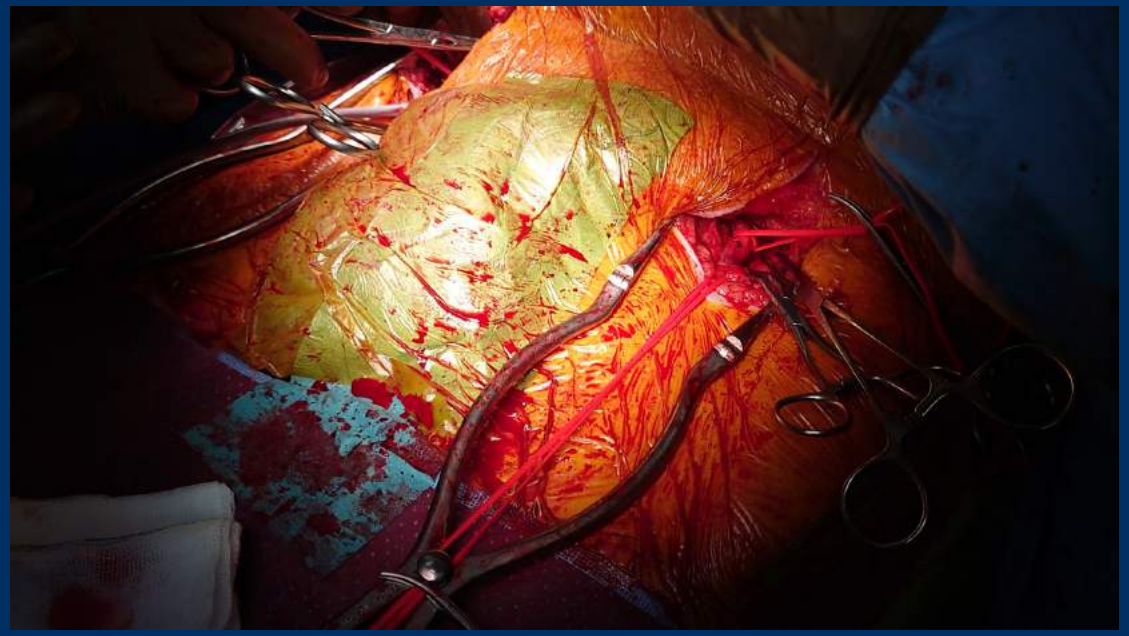
- 2# - endoclamping rapidly
  - Percutaneous or surgical groin management
  - Endoclamping with Coda® balloon at mid or < part of thoracic aorta
  - Stabilization with long sheath
  - Sequentialization for declamping
    - Every 8-10 minutes
    - During few secondes to 2 minutes

CRUCIAL KEYS

- 3# device prepare quickly before/during endoclamping
  - Main body
  - Ancillary stents
  - Legs

CRUCIAL KEYS

- 4# Treat as fast as possible
  - Exclude as fast as possible the ruptured sac
  - Deploy legs on iliacs fast
  - Catheterise targeted arteries if required
  - Close the patient as fast as possible !



CRUCIAL KEYS

- 5# management of the compartimental syndrom
  - Survey the IVP
  - If any doubt: laparostomy !!

CONCLUSION

- rAAA treatment remains an emergency
- Endovascular treatment IS a good option Vs open surgery ALSO for challenging anatomies BUT:
  - Depends on stability of patient
  - Depends on expertise of physician(s)
  - Depends on environment / large volume center
  - Could be a multi disciplinary decision/treatment

THANK YOU FOR YOUR ATTENTION