Best Practice for EVAR of Ruptured Aortic Aneurysms

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Disclosure

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I have the following potential conflicts of interest to report:

Consulting:

Abbott, Bard/BD, Cook, Cordis, Reflow Medical, Upstream Peripheral
Between Dore and Hybrid OR

- In case of hemodynamic instability balloon-clamping
- Graft-sizing in rAAA with hypovolemia / permissive hypotension:
  - To avoid intraoperative or late type-Ia-endoleak:
    - 30% oversizing recommended


- Bifurcated graft preferred over aorto-unii-iliac device

Wanhainen et al. ESVS 2019 Clinical Practice Guidelines AAA, EJVES 2019
General Setting for EVAR in rAAA

- Local anaesthesia
- No sedation
- No heparin,
  - Potentially heparinization after EVAR
- Percutaneous approach
- Preloading of Proglide-systems both groins (?)
The Double-Balloon Technique for rAAA

1. Reliant-balloon via right groin

12 Fr. – 45cm sheath

Graft via left groin
2. Reliant-balloon via left groin
The Double-Balloon Technique for rAAA

Balloon remains inflated until graft / contralateral limb is fully deployed

Nakayama et al. Ann Thorac Cardiovasc Surg 2019
Groin-Closure after EVAR

From MP van Wiechen, et al. Interv Cardiol 2019
“Postclosing” with Proglide after EVAR

Uei Pua. J Vasc Interv Radiol 2015
Aneurysm-Anatomy often more hostile rAAA

rAAA-emergency-kit should contain: Palmaz-Stent

Result
EVAR for Hostile Neck / No-Neck rAAA?

One Hundred percent of rAAA can be treated endovascularly if adjunct techniques are used such as chimneys, periscopes and embolization.

CHEVAR for rAAA

Typ Ia-endolak after EVAR + Chimney and periscope of a pararenal ruptured AA

Immediate gutter-coiling
Physician modified stentgrafts for juxtarenal rAAA?

- Not for acute rupture / unstable patients

- Considered for contained / impending rupture