SYMPOSIUM:
Strategies for treating long-segment aortoiliac artery occlusions

INTRODUCTION

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Associate Professor
Vascular Surgery
University of Siena
Italy
Conflict of interest

Speaker’s name: Gianmarco de Donato

I have the following potential conflicts of interest to report:

- Research contracts
- Travel & educational grants (Endologix, Gore, Penumbra)
- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company
- Other(s)

I do not have any potential conflict of interest
SYMPOSIUM: Strategies for treating long-segment aortoiliac artery occlusions

supported by Gore & Associates

Moderator: Gianmarco de Donato
Panel: Michele Antonello, Tomislav Stojanovic, Jorge Fernández Noya

18:00 - 18:05
Introduction
Gianmarco de Donato

18:05 - 18:20
Aortoiliac occlusive complex disease: how to treat TASC CD
Michele Antonello

18:20 - 18:35
Challenging iliac occlusive cases treated with covered stents
Tomislav Stojanovic

18:35 - 18:50
Recorded case: iliac occlusive disease treated with GORE® VIABAHN® VBX balloon expandable endoprosthesis
Jorge Fernández Noya

18:50 - 19:00
Discussion and conclusion
How should we treat....

According to TASC II recommendations.....

TASC II. EJVES 2007
### 2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in collaboration with the European Society for Vascular Surgery (ESVS)

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>An endovascular-first strategy is recommended for short (i.e. &lt;5 cm) occlusive lesions.</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>In patients fit for surgery, aorto-(bi)femoral bypass should be considered in aorto-iliac occlusions.</td>
<td>Ila</td>
<td>B</td>
</tr>
<tr>
<td>An endovascular-first strategy should be considered in long and/or bilateral lesions in patients with severe comorbidities.</td>
<td>Ila</td>
<td>B</td>
</tr>
<tr>
<td>An endovascular-first strategy may be considered for aorto-iliac occlusive lesions if done by an experienced team and if it does not compromise subsequent surgical options.</td>
<td>Iib</td>
<td>B</td>
</tr>
<tr>
<td>Primary stent implantation rather than provisional stenting should be considered.</td>
<td>Ila</td>
<td>B</td>
</tr>
<tr>
<td>Open surgery should be considered in fit patients with an aortic occlusion extending up to the renal arteries.</td>
<td>Ila</td>
<td>C</td>
</tr>
<tr>
<td>In the case of ilio-femoral occlusive lesions, a hybrid procedure combining iliac stenting and femoral endarterectomy or bypass should be considered.</td>
<td>Ila</td>
<td>C</td>
</tr>
<tr>
<td>Extra-anatomical bypass may be indicated for patients with no other alternatives for revascularization.</td>
<td>Iib</td>
<td>C</td>
</tr>
</tbody>
</table>

**Legend:**

- **Class:**
  - I: Strong recommendation
  - IIa: Moderate recommendation
  - IIb: Weak recommendation

- **Level:**
  - C: High confidence level
  - B: Moderate confidence level

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*a* Class of recommendation.  
*b* Level of evidence.  
*c* These recommendations apply for patients with intermittent claudication and severe chronic limb ischaemia.
Global Vascular Guidelines on the Management of Chronic Limb-Threatening Ischemia

6.25 Use an endovascular-first approach for treatment of CLTI patients with moderate to severe (eg, GLASS stage IA) AI disease, depending on the history of prior intervention.

<table>
<thead>
<tr>
<th>Grade</th>
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<th>Key references</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Strong)</td>
<td>B (Moderate)</td>
<td>Jongkind,82 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ye,83 2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deloose,84 2017</td>
</tr>
</tbody>
</table>

6.26 Consider surgical reconstruction for the treatment of average-risk CLTI patients with extensive (eg, GLASS stage II) AI disease or after failed endovascular intervention.

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<thead>
<tr>
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<th>Key references</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (Weak)</td>
<td>C (Low)</td>
<td>Ricco,85 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chiu,86 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indes,87 2013</td>
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18:00 - 19:00, Main Arena 1

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**Introduction**

Gianmarco de Donato

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18:05 - 18:20

**Aortoiliac occlusive complex disease: how to treat TASC CD**

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**Recorded case: iliac occlusive disease treated with GORE® VIABAHN® VBX balloon expandable endoprosthesis**

Jorge Fernández Noya

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18:50 - 19:00

**Discussion and conclusion**
Complex iliac occlusive disease: 
*be aware of potential complication*
Complex iliac occlusive disease: treatment with BMS

Artery rupture after bare metal stenting
Complex iliac occlusive disease: be aware of potential complication

Viabahn 9/50
<table>
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• Long iliac occlusion

• Aorto-iliac occlusion
Long iliac occlusion

- Pre-op planning
- Pre-op planning

Kissing stent

BE covered stent

SE covered stent

sagittal plane
Antegrade recanalization
A thin fluoropolymer/elastomer film covers the percutaneous balloon on the delivery catheter to ensure stent-graft retention during tracking and balloon inflation.

Crossing the occlusion (without pre-dilatation)

Trackable delivery system (retention)
Stent deployment: Accuracy (compliance cards) - length

VBX 7/79

VBX 7/59

Viabahn SE 7/100
Long iliac occlusion

- Combination of BE & SE covered stent (occasionally, semi-covered stent to preserve hypogastric)
• Long iliac occlusion

• Aorto-iliac occlusion
Aorto-iliac occlusive lesions

Aortic bifurcation

Infrarenal aorta

Juxtarenal aorta
Aorto-iliac configuration

- CERAB
- Kissing covered stent
Leriche Syndrome – endovascular tx

1. Antegrade recanalization (brachial access)
2. GW rendez-vous at CFA
3. Kissing covered stents (femoral access)
1. Antegrade recanalization, percutaneous brachial access (5F sheath, 90cm)
2. CFA puncture under fluoroscopy & GW rendez-vous
3. Kissing stents

Viabahn (SE and BX)

Tigris

*CBAS Heparin Surface for lasting thromboresistence*
Aorto-iliac endovascular recanalization with IMA preservation
Please, text any comment & question during the session