SYMPOSIUM:
Strategies for treating long-segment aortoiliac artery occlusions

CONCLUSION

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Prime time for endovascular reconstruction

Importance of stent grafts (Self exp. vs. Balloon exp.)

The Gore VSX & VBX Stent Grafts demonstrates a notable, unique combination of technical features beneficial
  * Radial strength (VBX)
  * Flexibility (VSX & VBX)
  * Accuracy (VBX compliance cards)
    * Length
    * Trackable delivery system (VBX retention)
  * Thromboresistance (VSX & VBX)

Conclusion: long-segment aortoiliac artery occlusions
Endo first line for all aorto-iliac lesion by covered stents

Keys for success:
- pre-op planning
- correct technique
- correct materials (covered BE & SE stents)

Is this then the right time to also offer endovascular reconstruction of aortoiliac occlusion to normal-risk patients? In the early 1990s when endovascular aneurysm repair (EVAR) was still experimental, no one could have imagined how stent-graft technology would evolve. In only 2 decades, EVAR was transformed from a procedure exclusively confined to high-risk patients to a primary choice and preferred method for most patients with infrarenal abdominal aortic aneurysm. Open aneurysm repairs have been progressively restricted to patients anatomically unsuitable for EVAR (i.e., short neck) or after EVAR failure. More recently, the evolution of fenestrated and branched endografts has afforded a less invasive means of repair in even these patient groups.
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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&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Level&lt;sup&gt;b&lt;/sup&gt;</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>
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<tr>
<td>In patients fit for surgery, aorto-(bi)femoral bypass should be considered in aorto-iliac occlusions.</td>
<td>IIA</td>
<td>B</td>
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<tr>
<td>An endovascular-first strategy should be considered in long and/or bilateral lesions in patients with severe comorbidities.</td>
<td>IIA</td>
<td>B</td>
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<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>IIIB</td>
<td>B</td>
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<td>Primary stent implantation rather than provisional stenting should be considered.</td>
<td>IIA</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>IIA</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>IIA</td>
<td>C</td>
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<tr>
<td>Extra-anatomical bypass may be indicated for patients with no other alternatives for revascularization.</td>
<td>IIIB</td>
<td>C</td>
</tr>
</tbody>
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<sup>a</sup> Class of recommendation.

<sup>b</sup> Level of evidence.

<sup>c</sup> These recommendations apply for patients with intermittent claudication and severe chronic limb ischaemia.
<table>
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<tr>
<th>Time</th>
<th>Session</th>
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| 18:00 - 19:00, Main Arena 1 | **SYMPOSIUM: Strategies for treating long-segment aortoiliac artery occlusions**<br>supported by Gore & Associates
Moderator: Gianmarco de Donato<br>Panel: Michele Antonello, Tomislav Stojanovic, Jorge Fernández Noya |
| **Introduction** | Gianmarco de Donato<br>18:00 - 18:05 |
| **Aortoiliac occlusive complex disease: how to treat TASC CD** | Michele Antonello<br>18:05 - 18:20 |
| **Challenging iliac occlusive cases treated with covered stents** | Tomislav Stojanovic<br>18:20 - 18:35 |
| **Recorded case: iliac occlusive disease treated with GORE® VIABAHN® VBX balloon expandable endoprosthesis** | Jorge Fernández Noya<br>18:35 - 18:50 |
| **Discussion and conclusion** | 18:50 - 19:00 |