

Case Report : Large thoracoabdominal aneurysm with narrow access vessels

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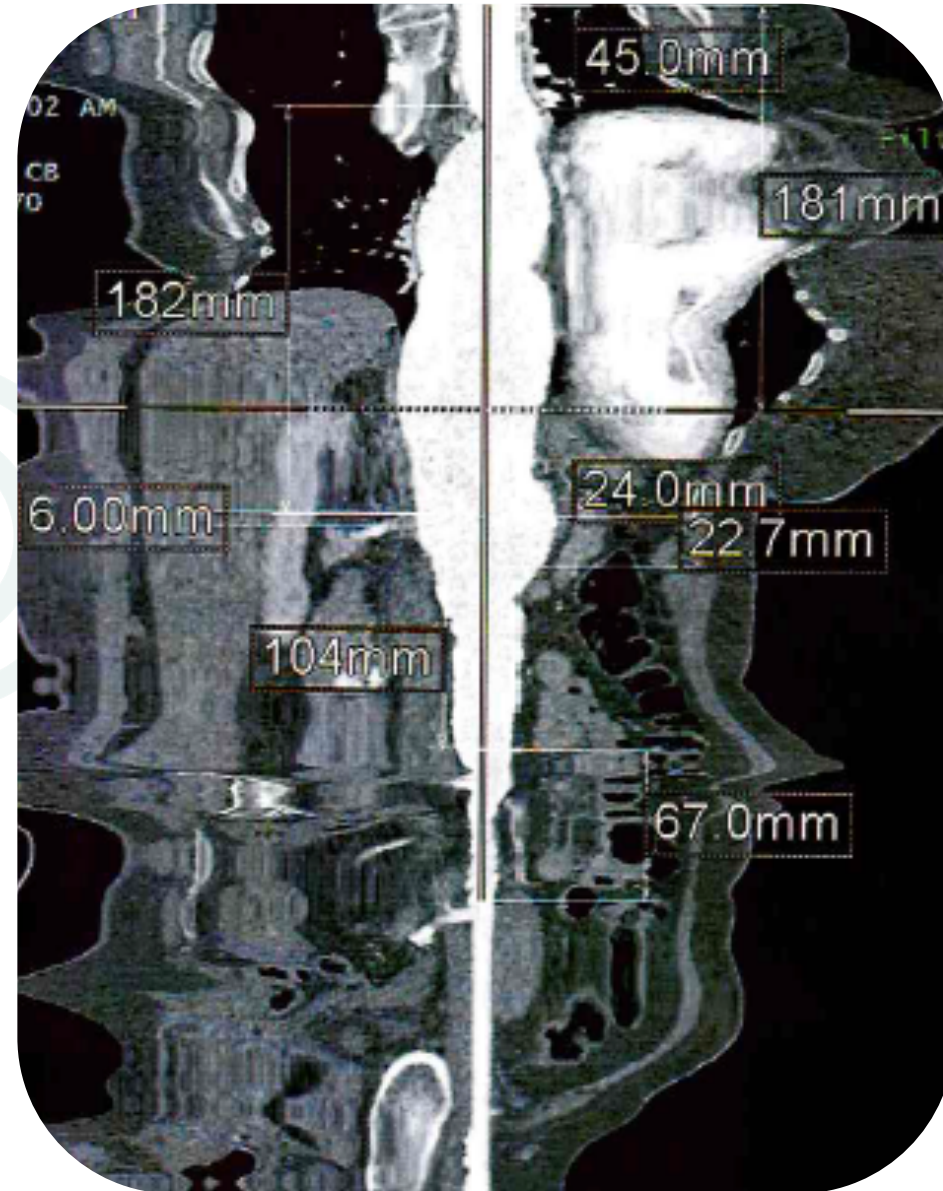
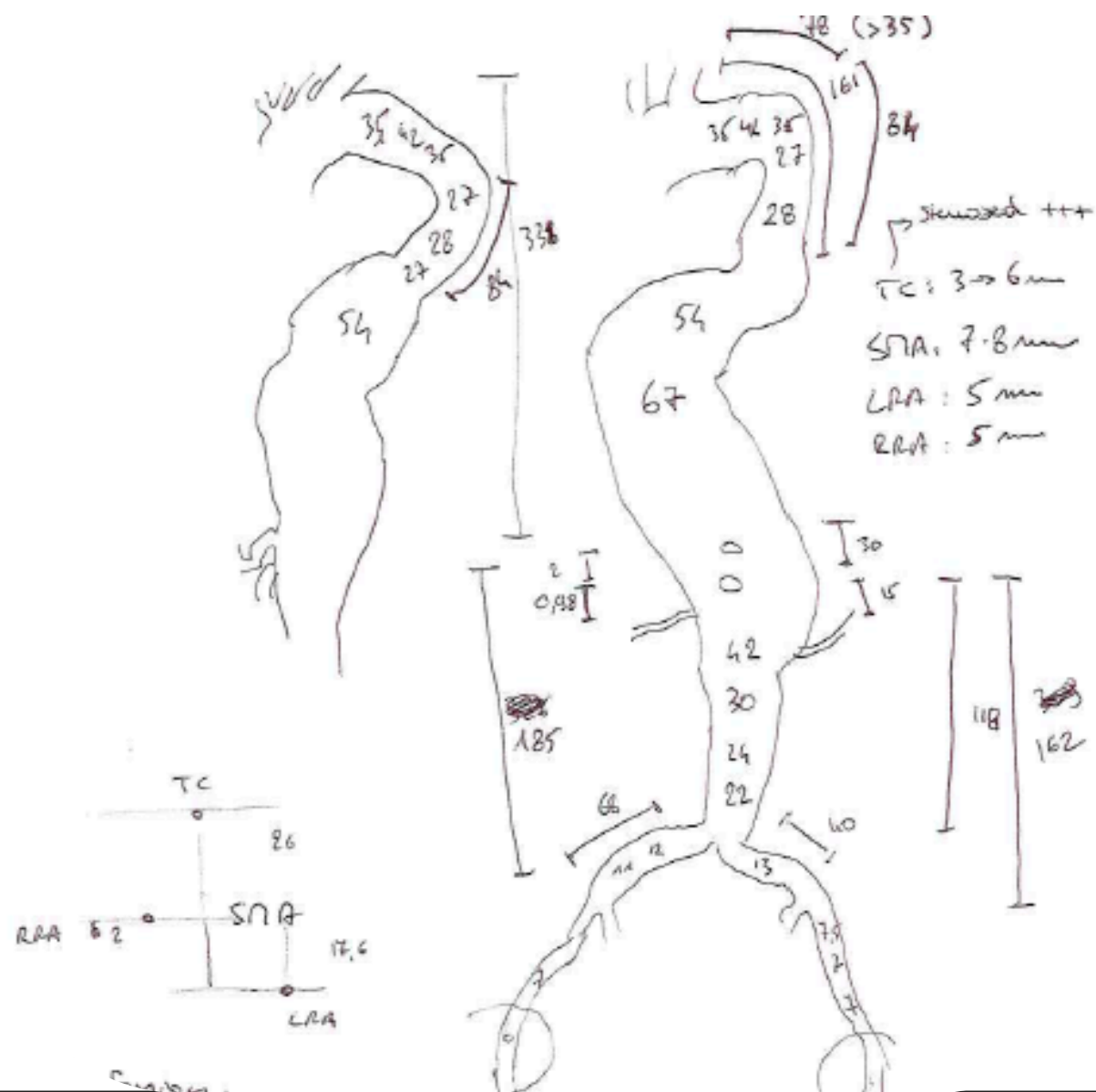
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Patient details

- 80 y, female
- Arterial hypertension
- coronary heart disease, previous CABG
- COPD Gold III
- Thoracoabdominal aneurysm 67mm
- External iliac : 6-7mm diameter



Planning



What would be your treatment strategy?

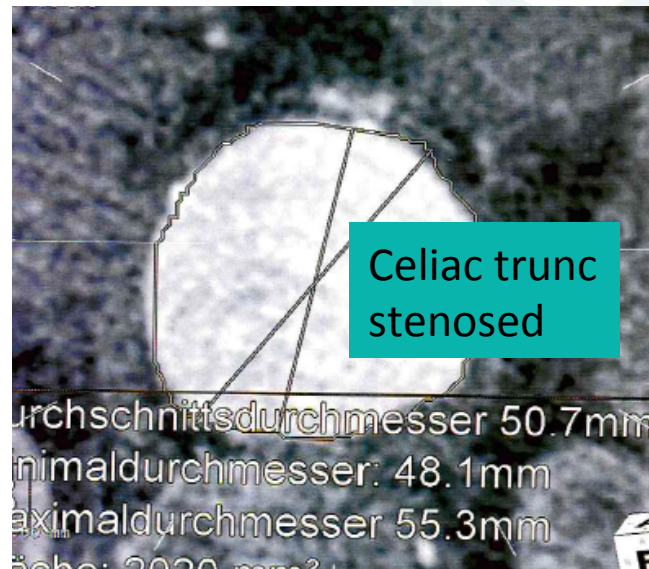
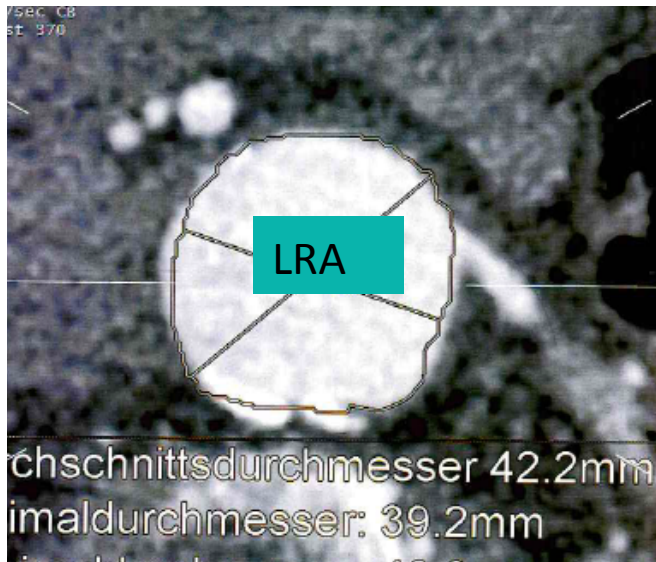
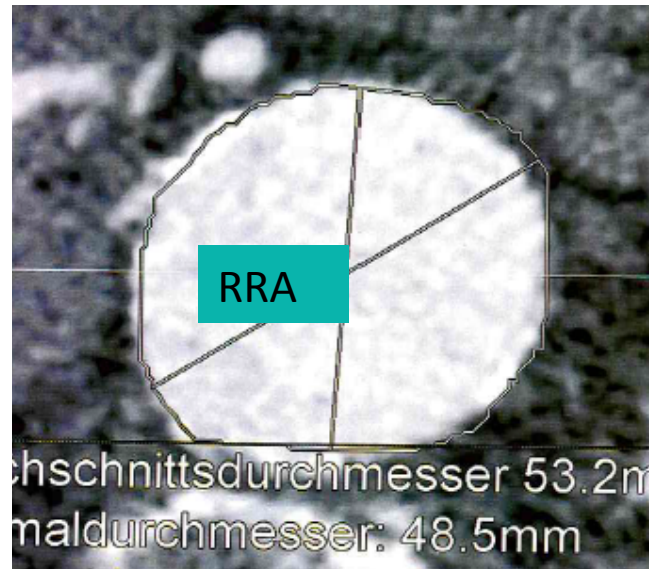
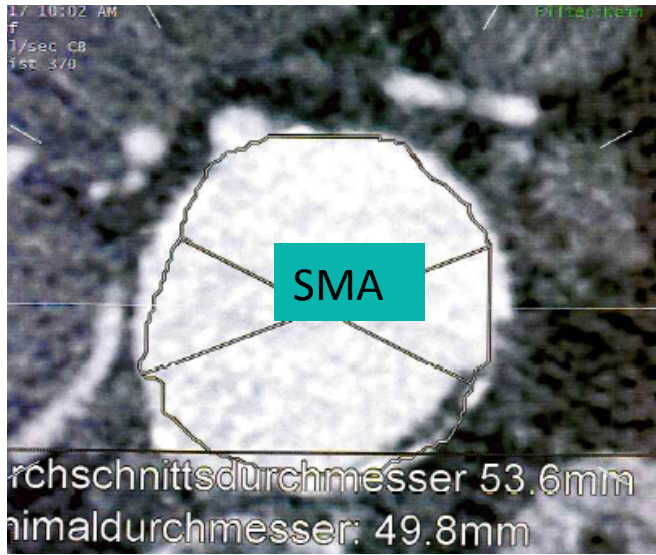
- Open repair
- Conservative treatment
- Chimney/ Sandwich EVAR
- Off-the-shelf branched endograft
- Custom-made-branched endograft
- Custom-made-fenestrated endograft
- Other option ...

Our concept

2 sessions to reduce paraplegia risk

- 1. TEVAR starting at the level of the left subclavian artery to approximately 2 cm proximal of the celiac trunc
- 2. custom made branched endograft, low-profile device (18F) due to narrow iliacs

Planning



Date: _____
 Hospital: _____
 Patient ID: _____
 Physician Name: _____
 Physician Phone: _____
 Physician Email: _____
 Date of Procedure: 7/9/11
 PO Number: _____

→ LP 18F

- UNIBODY - 22 - ZT *esd*
 ZSLE - 16 - 70 - ZT *esd*
 ZSLE - 16 - 70 - ZT *esd*

Additional components required:
Back up:
 ZSLE 16 24

Please 18F LP-Device! because of hard access *esd!*

esd!

on one gno.

UNIBODY 22

81
98
115
132

Step 6
 Select the size of the Universal Distal Body. The contralateral limb should be no more than 15 mm above the aortic bifurcation.

Step 7
 Select the Spiral-2™ Iliac Leg.
 Contralateral: ZSLE - - - ZT

20
70
80
90
100
110
120
130
140
150
160
170
180

79 *62*

	Body	Distal
<input checked="" type="checkbox"/> CT	1°	6!
<input checked="" type="checkbox"/> S72	12°	8
<input checked="" type="checkbox"/> R22	10°	6
<input checked="" type="checkbox"/> L22	2°	6

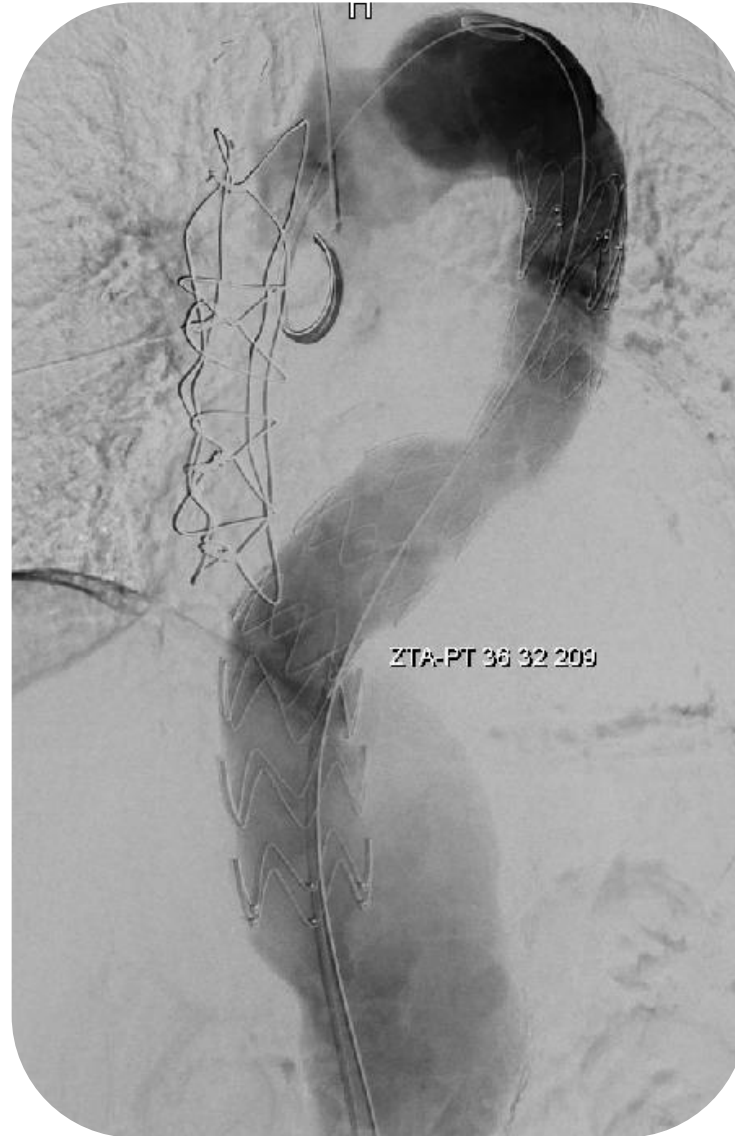
Boniers / Pus

- Staged procedure in order to reduce paraplegia risk:

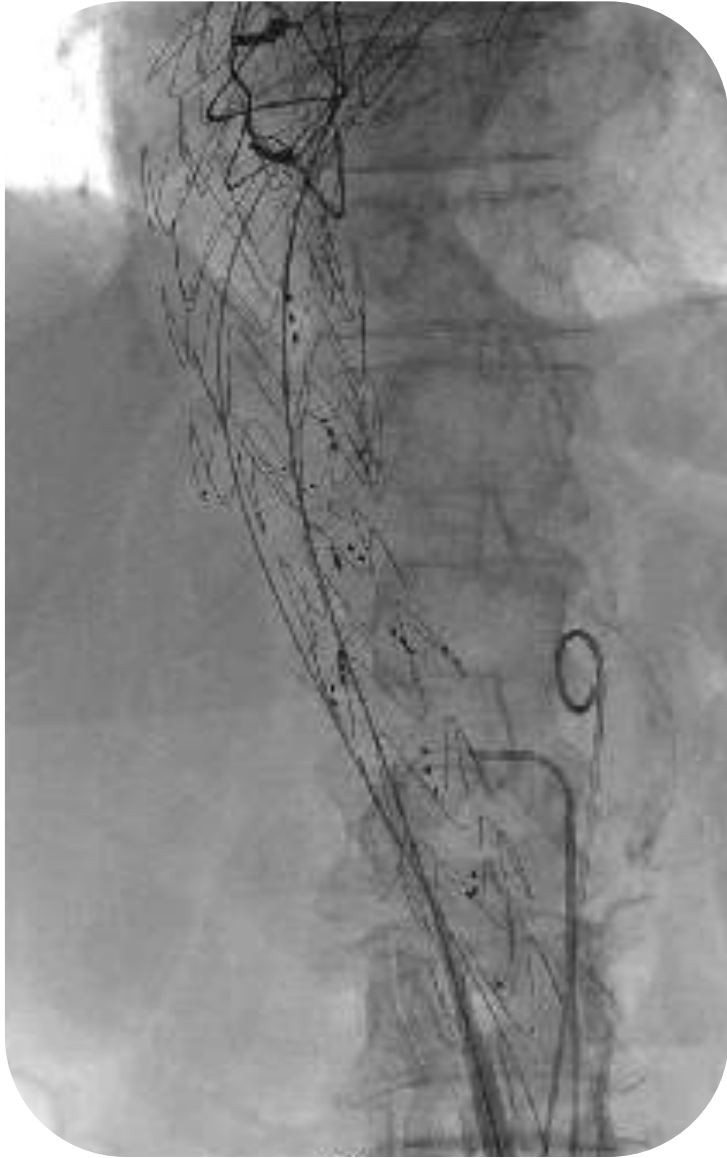
1. Session: TEVAR (Zenith alpha, Cook)

ZTA-PT-36-32-209

2. Session: custom made low profile (18F) device (Cook) 4 branches and bifurcated endograft ; 8 weeks later



First Session : TEVAR

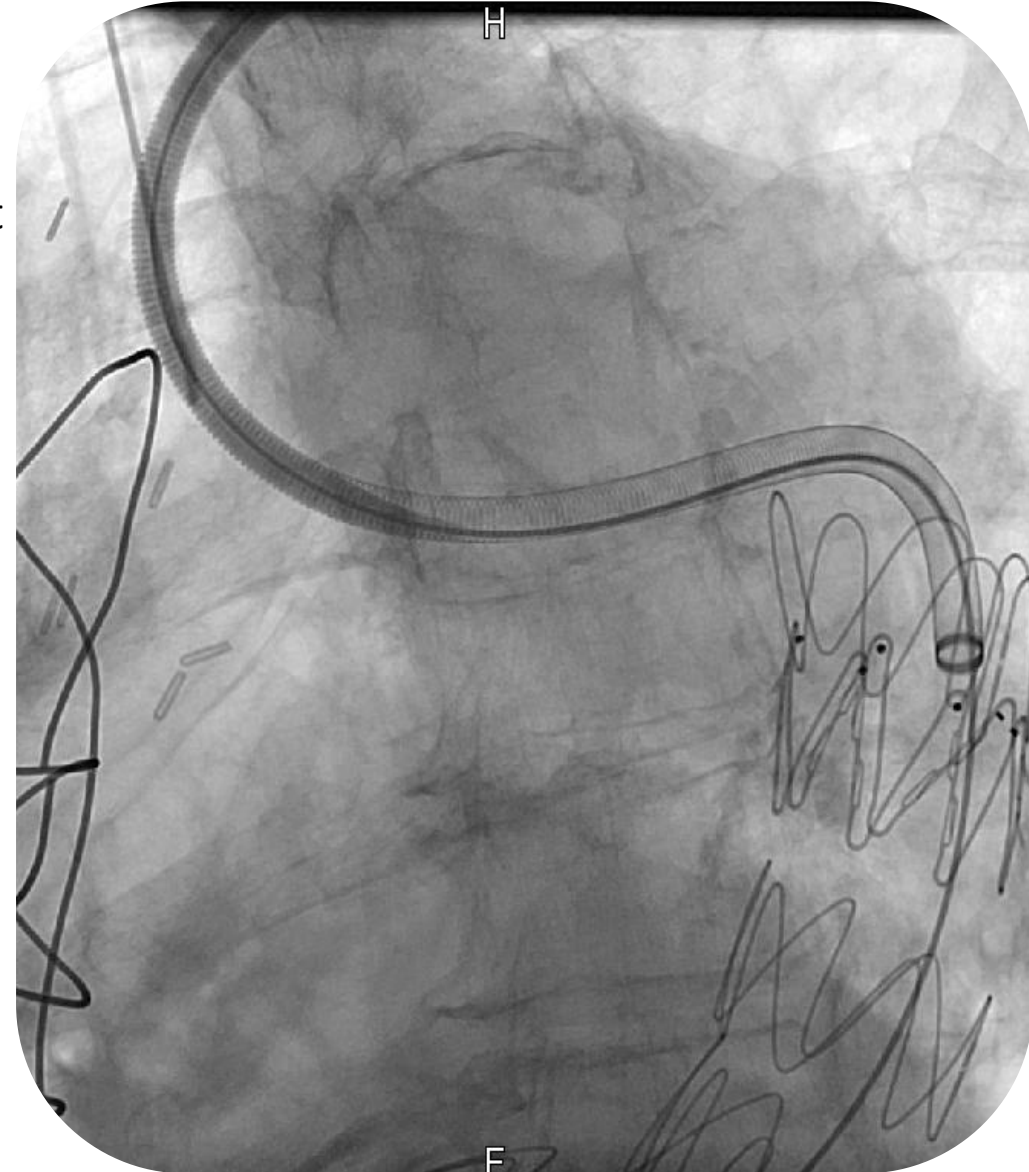


Step 1:
deploying CMD branched endograft
(Cook)

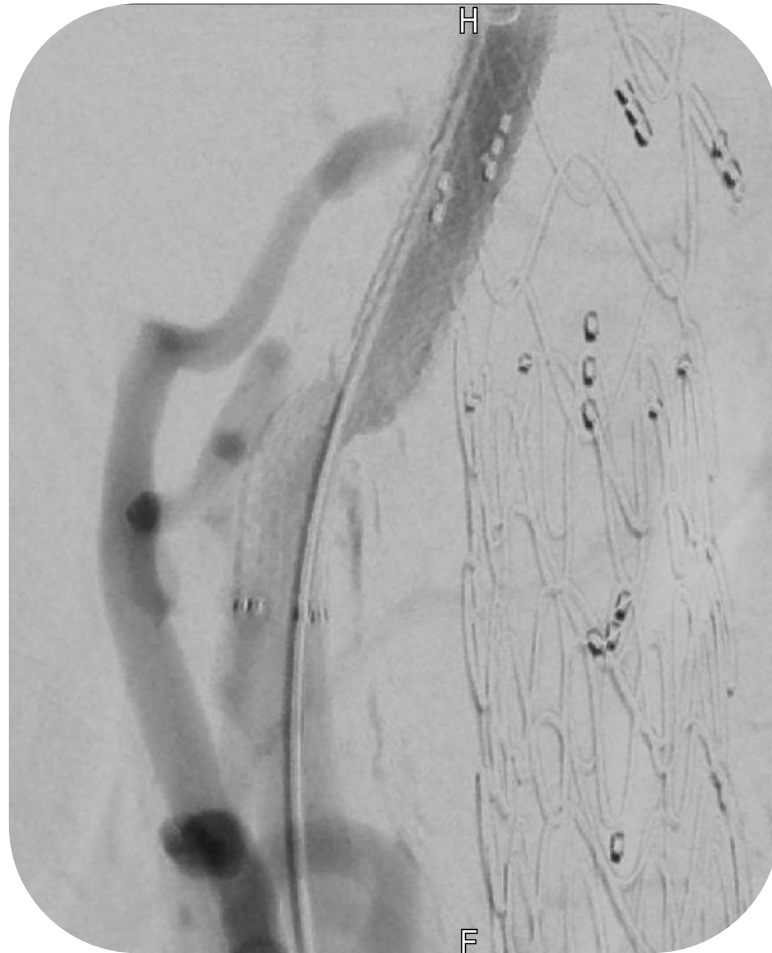
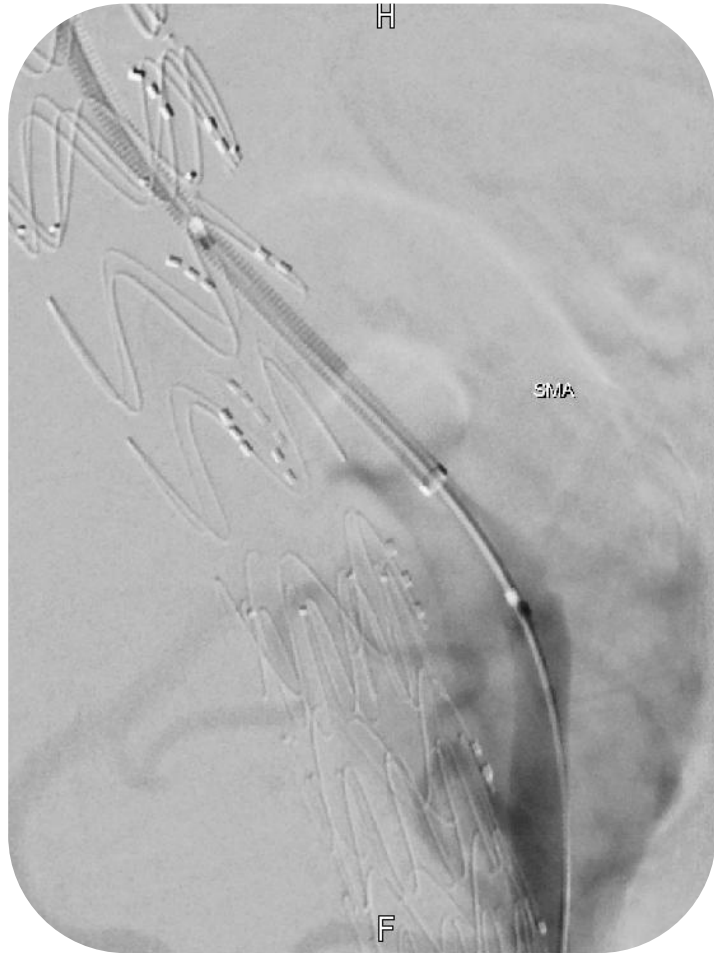
Step 2:
distal completion with bifurcated
endograft

Step 3:
groin closure (ProStar XL Abbott)

Step 4:
12 F flexor sheath
(Cook) from transaxillary approach
Followed by 8F sheath (Cook)



Treatment: attaching SMA

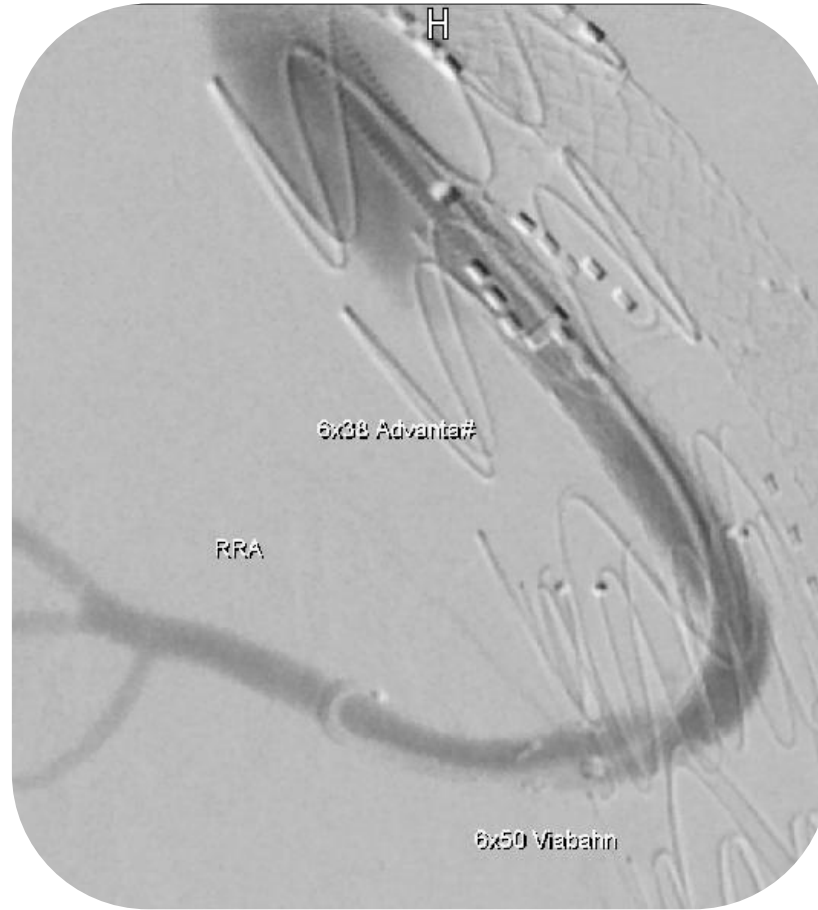


8x59mm Advanta (Maquet) + 10x50mm Viabahn (Gore)

Treatment: attaching right renal artery



Upward facing RRA



6x38mm Advanta (Maquet) + 6x50mm Viabahn (Gore)



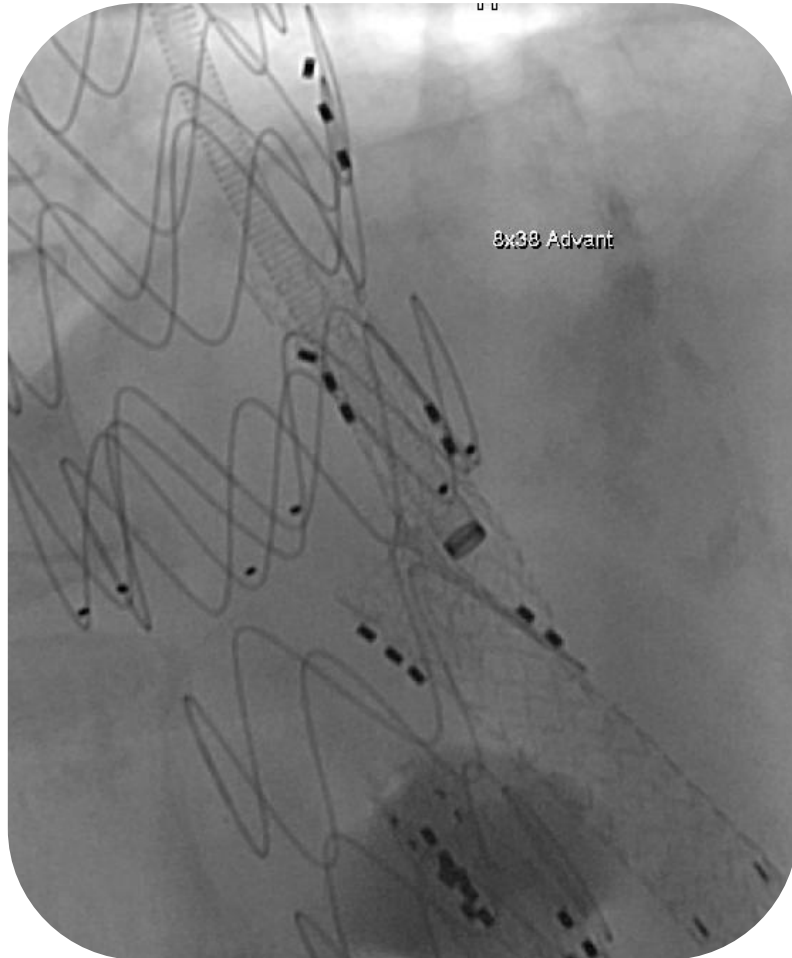
Treatment: attaching left renal artery



6x38mm Advanta (Maquet) + 6x100mm Viabahn (Gore)

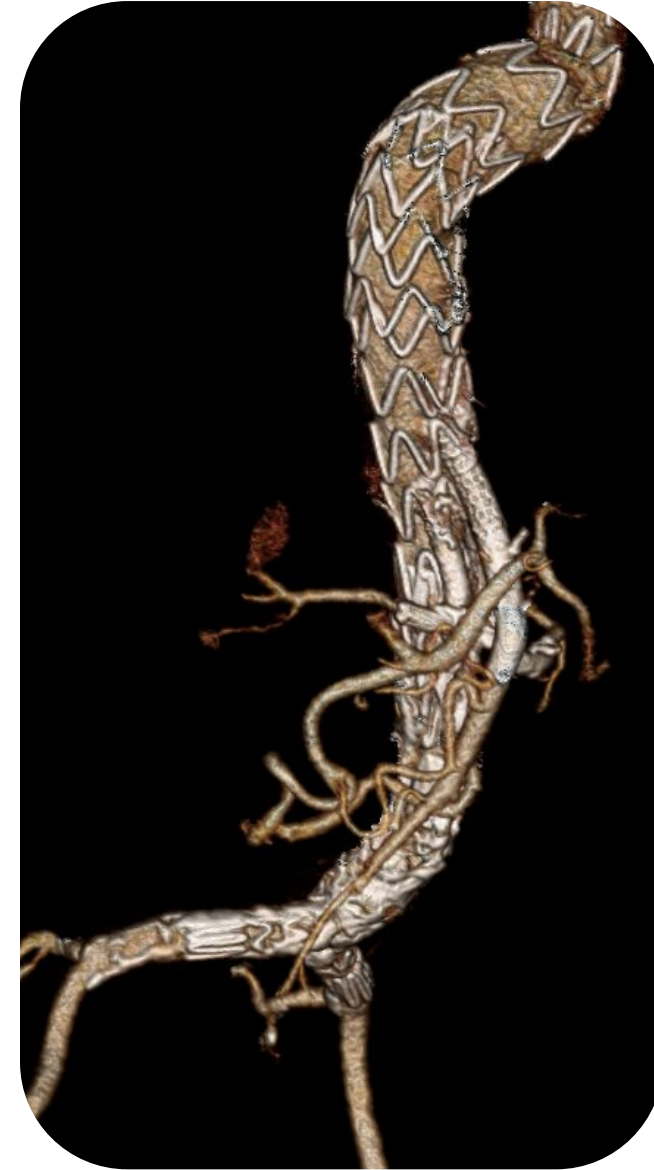
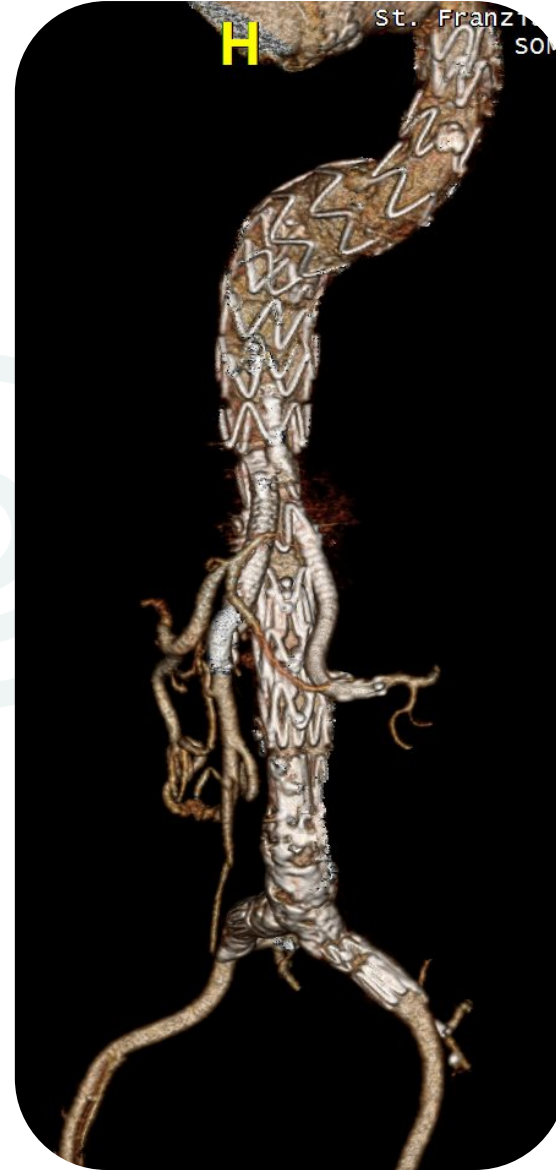
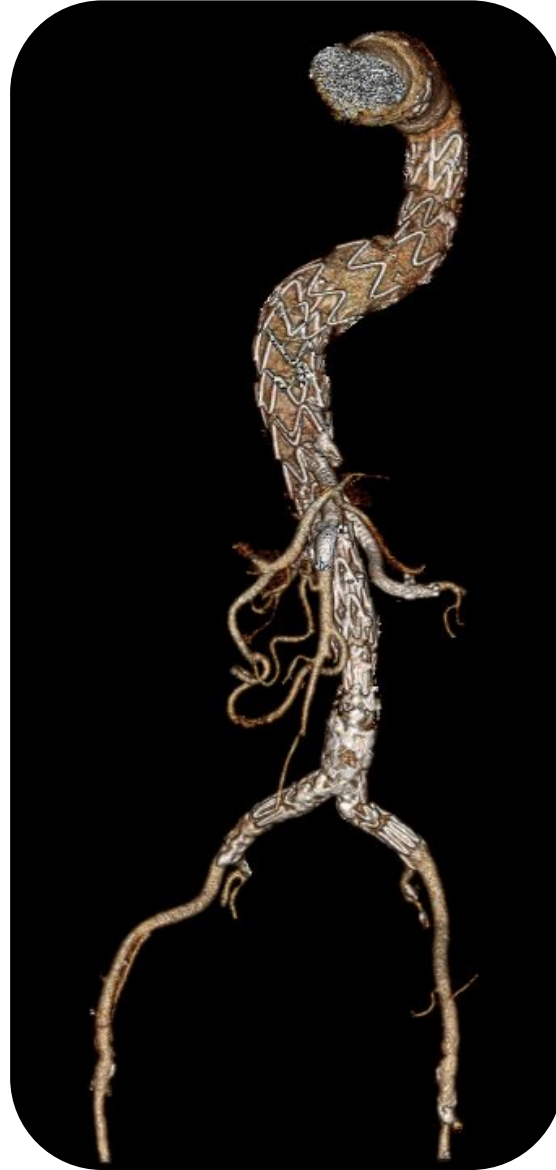
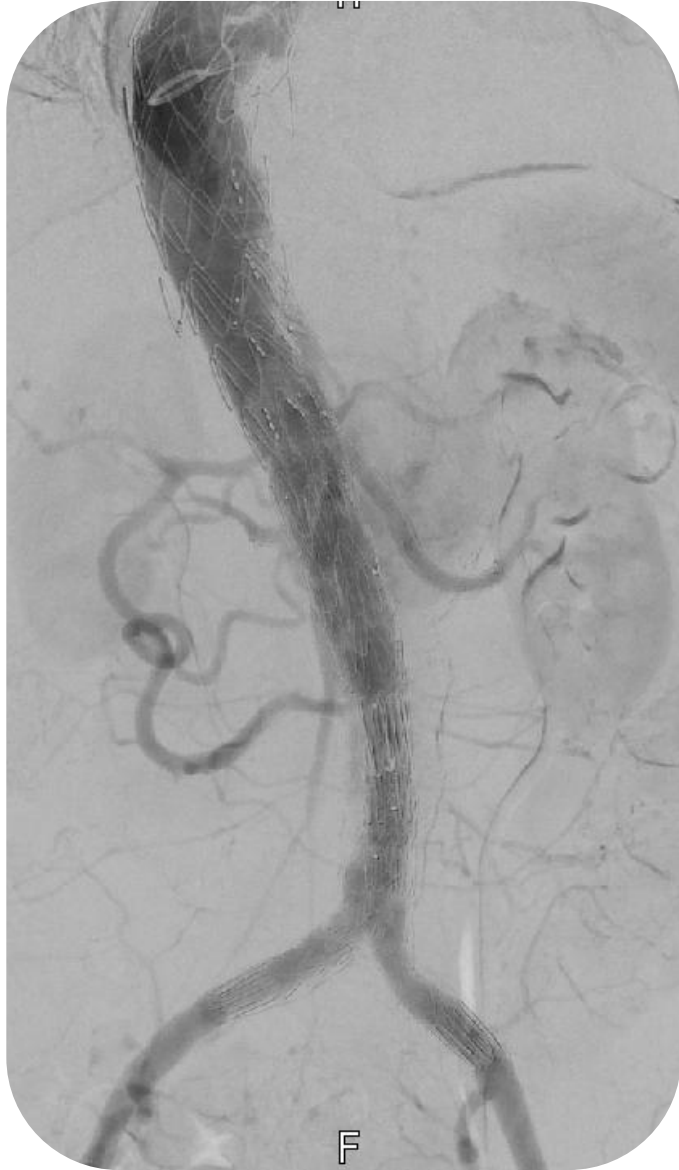
Treatment: attaching celiac trunc

Subtotal stenosed + excellent collateralisation via SMA



- 8x38mm Advanta (Maquet)
- 10mm Amplatzer Plug (St. Jude Medical) for branch occlusion

Result



- 2 days at Intensive care unit (standard at our institution)
- No paraplegia/ paraparesis
- Discharge postop day 7
- CT-Scan postop + follow up (12 months):
No endoleak; Patent branches

Questions to Vascupedians

- What is your preferred bridging stent graft in upward facing renal arteries ?
- Do you generally treat octogenarians with TAAA ?
- What is your treatment strategy to reduce paraplegia risk
- Should branched endografts only be performed in specialized centers?