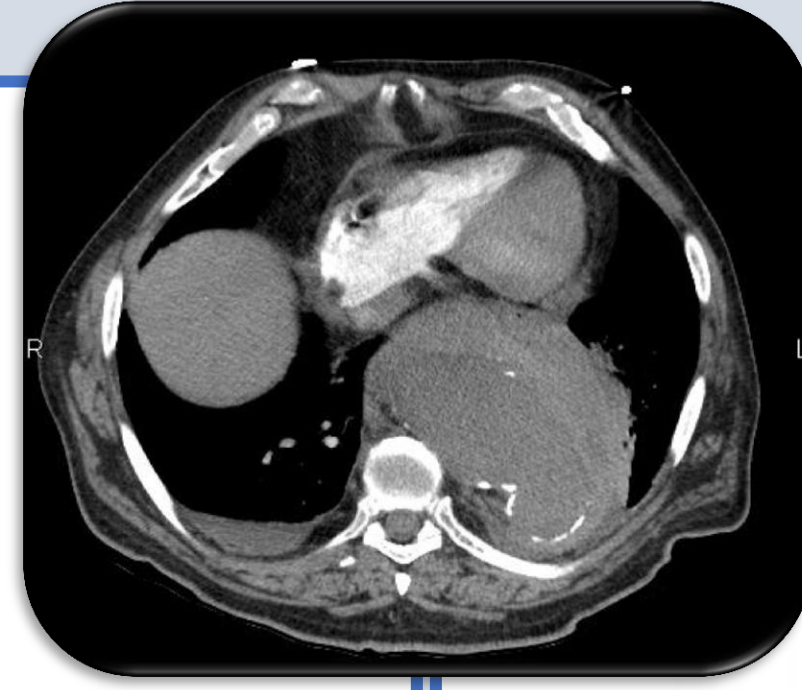


Introduction

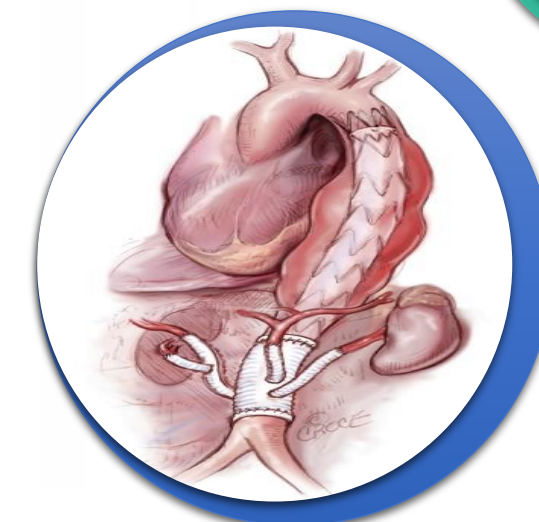
The **incidence of endoleaks** post-TEVAR varies between 0 and 30% with type 1 endoleak being the most common. About 5% of patients will present with more than one type of endoleak. We know that the risk of spinal ischemia after TEVAR is higher in patients who have previous abdominal aneurysms (up to 18%). This risk is also correlated with the length of aorta coverage, operation time, coverage of left subclavian artery, intra-operative hypotension and absence of cerebrospinal fluid drainage.

Case Report

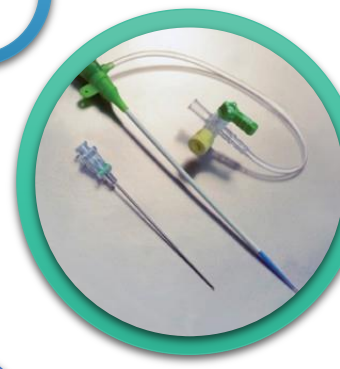
A 73-year old patient who previously underwent an open infrarenal AAA repair presented with a **ruptured thoracic aorta aneurysm**. An **emergency endovascular exclusion** using two C-TAG (WLGore) endoprotheses was performed. Preoperatively, a spinal drain was put in place.



Hybrid



Watchfull waiting



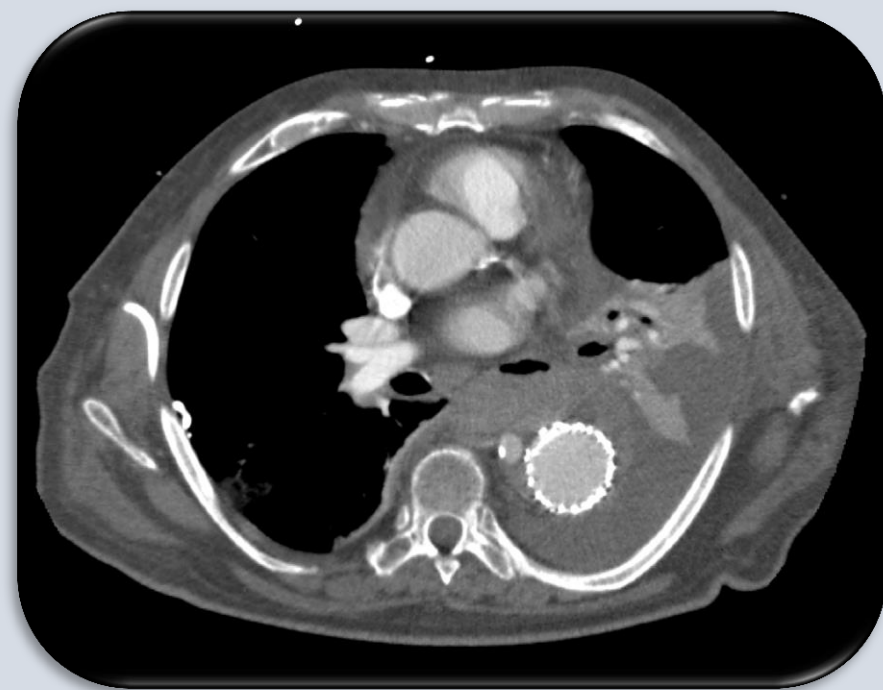
Endovascular



Open Repair

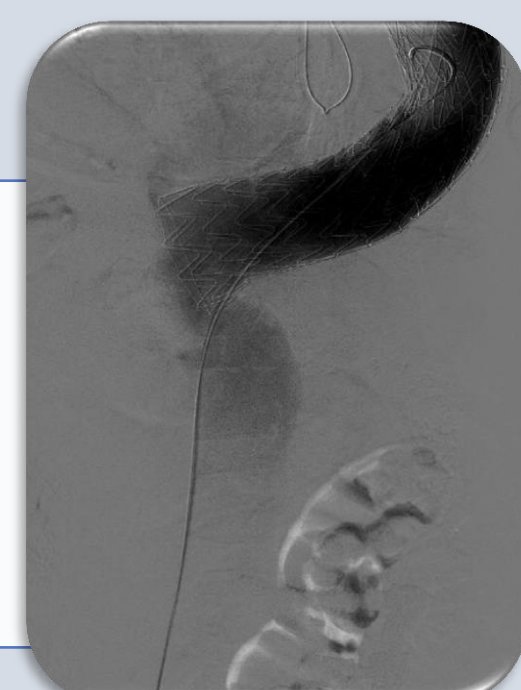
2 days postop

- Type II endoleak (dorsal artery)
- Pulmonary embolism (heparin treatment)

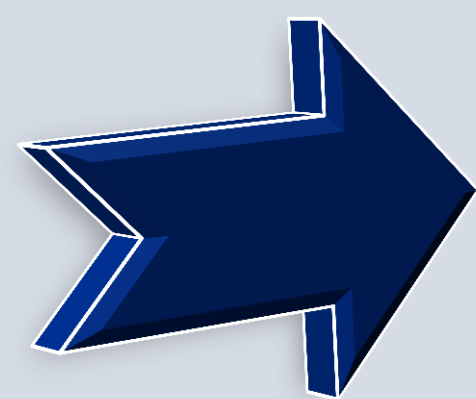


4 months later

- Aneurysmal sac expansion
- Type IB endoleak

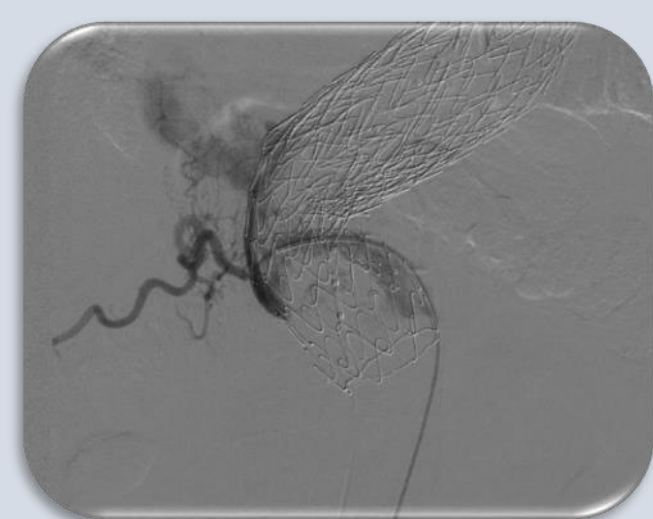


Extension Gore TAG 4040150
No endoleak on completion angiogram



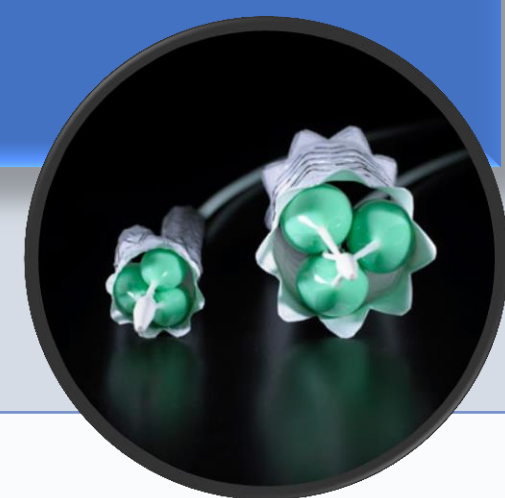
8 months later

- Aneurysmal sac expansion
- Type III endoleak
- Type IB endoleak
- Type II endoleak



Symptomatic due to compression left atrium

Relining and elongation
Gore TAG 4545200
Moulding distal landing zone Tri-Lobe

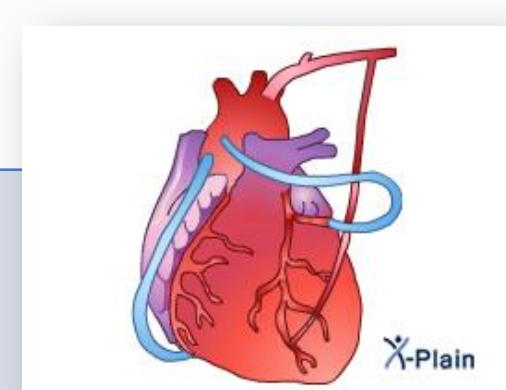


- Decreased type IB and type II endoleak
- Expansion aneurysmal sac



15 months later

- Semi-urgent CABG



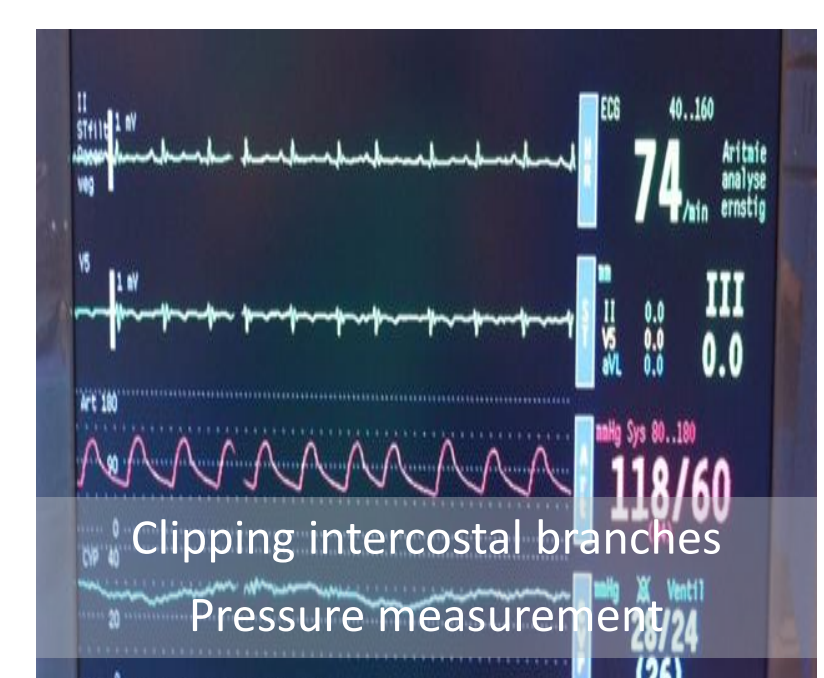
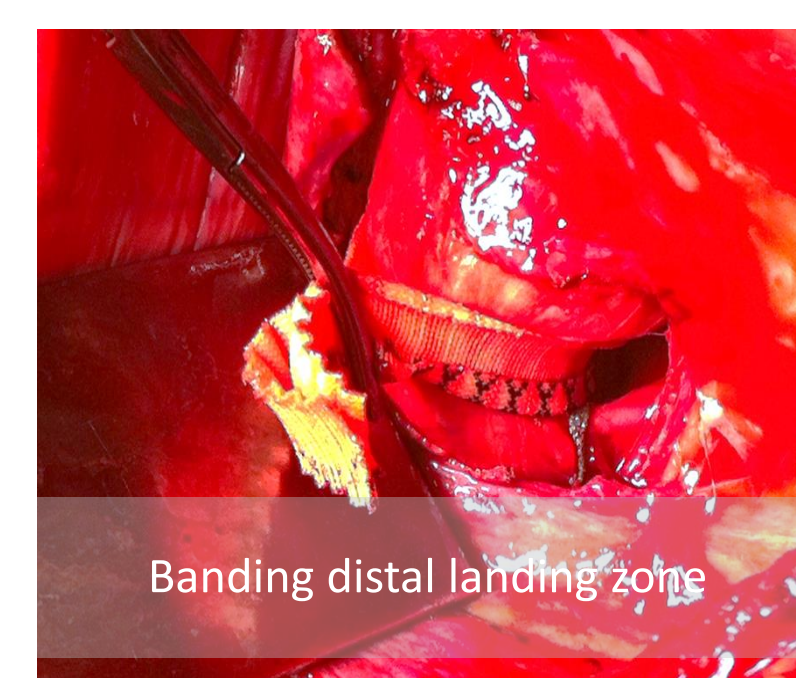
2 years later

- Further expansion



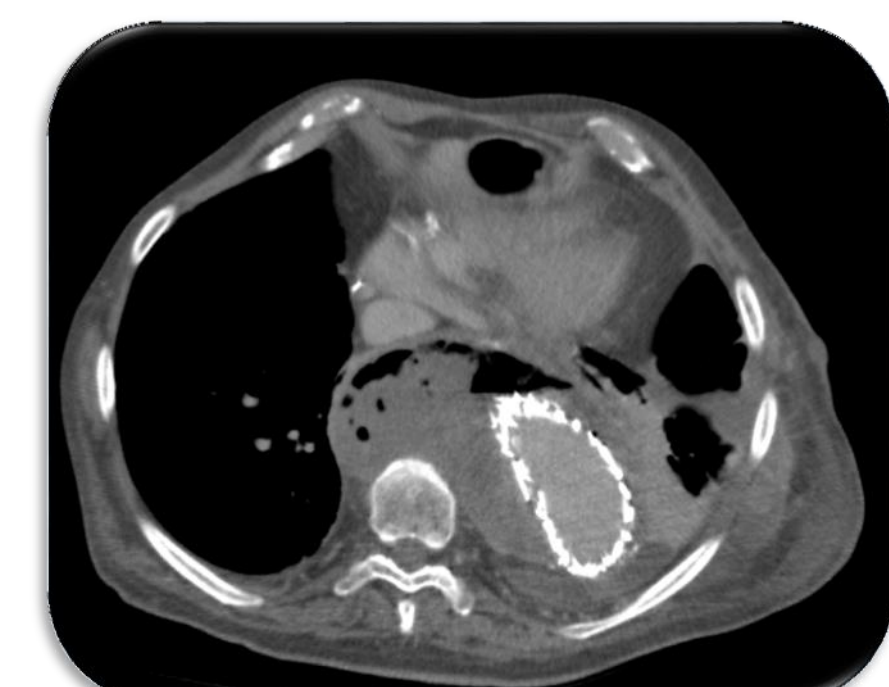
Case Report

We planned our patient for a **semi-invasive** procedure. A large aneurysmal sac was noted just above the diaphragm. We started with a **banding** of the distal landing zone with a gelsoft prosthesis. **Intercostal branches** were clipped. Before opening the aneurysmal sac, we ensured that the sac was **depressurised**. After opening of the aneurysmal sac, old blood clots were removed and no active bleeding was found. To finish, a **plicature** of the aneurysmal sac was performed



Unfortunately, the anesthesiologist was unable to place a spinal drain and our patient experienced weakness of the left lower limb. However, this has resolved and he is able to walk again.

4 months postoperatively, there is **no residual endoleak** and the aneurysmal sac is depressurized.



Conclusion

Aortic banding is **feasible** and may be a compromise between minimal invasive endovascular treatment and extensive surgical repair. It can however be complicated by transient or permanent **paraplegia**.

References

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- Parmer et al. J. Vasc Surg 2006 Sep;44(3):447-52
- Alsac et al. Ann Vasc Surg 2011 Apr;25(3):345-51. doi: 10.1016/j.avsg.2010.08.002. Epub 2010 Oct 6
- Makaroun et al Ann Vasc Surg 2006
- Images courtesy of WLGORE®