



i-MEET

NEXT GENERATION

Multidisciplinary European Endovascular Therapy

Type III endoleaks, Fotis A. Markatis MD, PhD

Greece

Vascular Surgeon

Disclosure of Interest

Speaker name: Fotis A. Markatis

- I do not have any potential conflict of interest

J Vasc Surg. 2017 Oct;66(4):1056-1064.

Incidence, etiology, and management of type III endoleak after endovascular aortic repair.

[Geert Maleux, MD, PhD](#), [Lien Poorteman, MD](#), [Annouschka Laenen, PhD](#), [Bertrand Saint-Lèbes, MD](#), [Sabrina Houthoofd, MD](#), [Inge Fourneau, MD, PhD](#), [Hervé Rousseau, MD, PhD](#)

965 EVAR procedures

first- and second-generation (n = 79)

third-generation (n = 886)

Twenty patients (2.1%) were identified with 25 type III endoleaks

[12.7%] for first- and second-generation [1.2%] for third-generation

$P < .001$

endovascular techniques (n = 22 [88%])

open surgical conversion (n = 3 [12%])

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Incidence, etiology, and management of type III endoleak after endovascular aortic repair.

Conclusions:

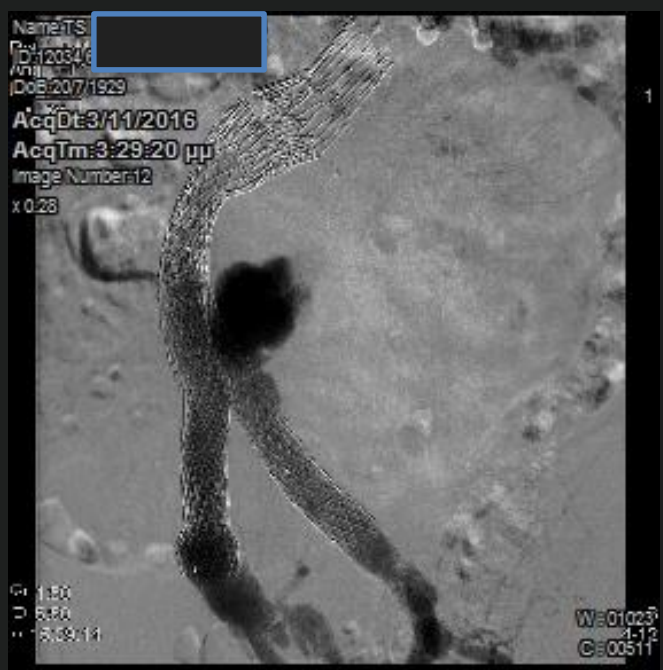
1. Most endoleaks appear on 1st and 2nd generation grafts
2. Type III endoleak is a rare finding on post-EVAR surveillance
3. The majority of endoleaks can be treated by endovascular means
4. The majority of endoleaks occurs due to component disconnection than fabric defect ($p < .001$)

Case report

- Male patient 69 yrs old
- Infrarenal 3A (1999), d=60mm
- Treated in USA with an AneuRx device successfully
- The patient discontinued surveillance 3yrs post- EVAR

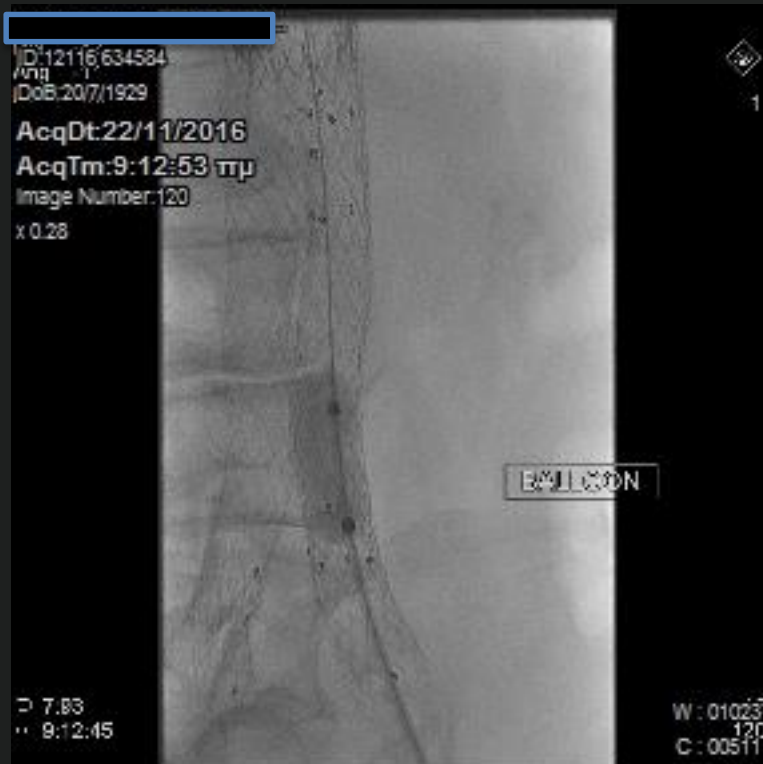
- 19 yrs later... (2016)
- CTA: INCREASED 3A diameter 11cm
- Type Ia endoleak (report from the hospital admission)
- Treated with 2 TALENT proximal cuffs
- Exit report > Successful treatment of Type Ia-endoleak

- 6 months follow-up:
Type III endoleak on the left side



- What is the possible mechanism of type III ???

- Obvious what to do but please participate



- 2018, admission to our hospital due to sudden loss of consciousness

Image size: 512 x 512
View size: 1230 x 1230
WL: 126 WW: 633

A

0000634584 (88 y , 88 y)
Vascular BodyAngio3D_M (Adult)
BodyAngio3D_M
8



Zoom: 240% Angle: 0

Im: 2/782 S (S -> I)

Uncompressed

Thickness: 1.00 mm Location: -372.70 mm P

29/03/2018, 14:37:08

Made In Horos

Image size: 512 x 512

View size: 1230 x 1230

WL: 50 WW: 350

0000634584 (88 y , 88 y)

Vascular BodyAngio3D_M (Adult)

BodyAngio3D_M

1

R

L

Zoom: 240% Angle: 0

Im: 1/1

Uncompressed

Position: HFS

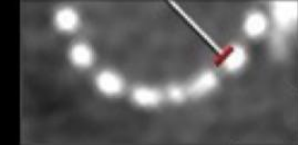
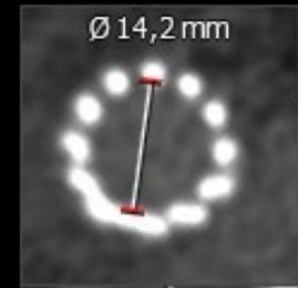
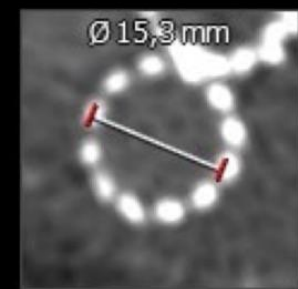


I

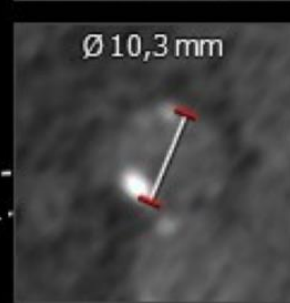
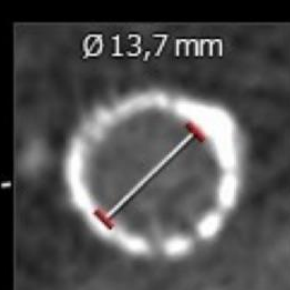
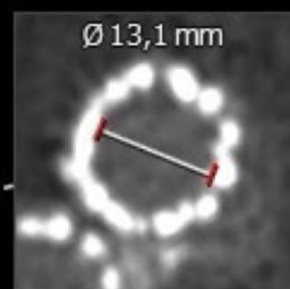
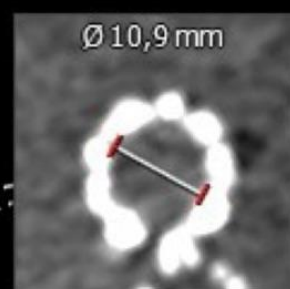
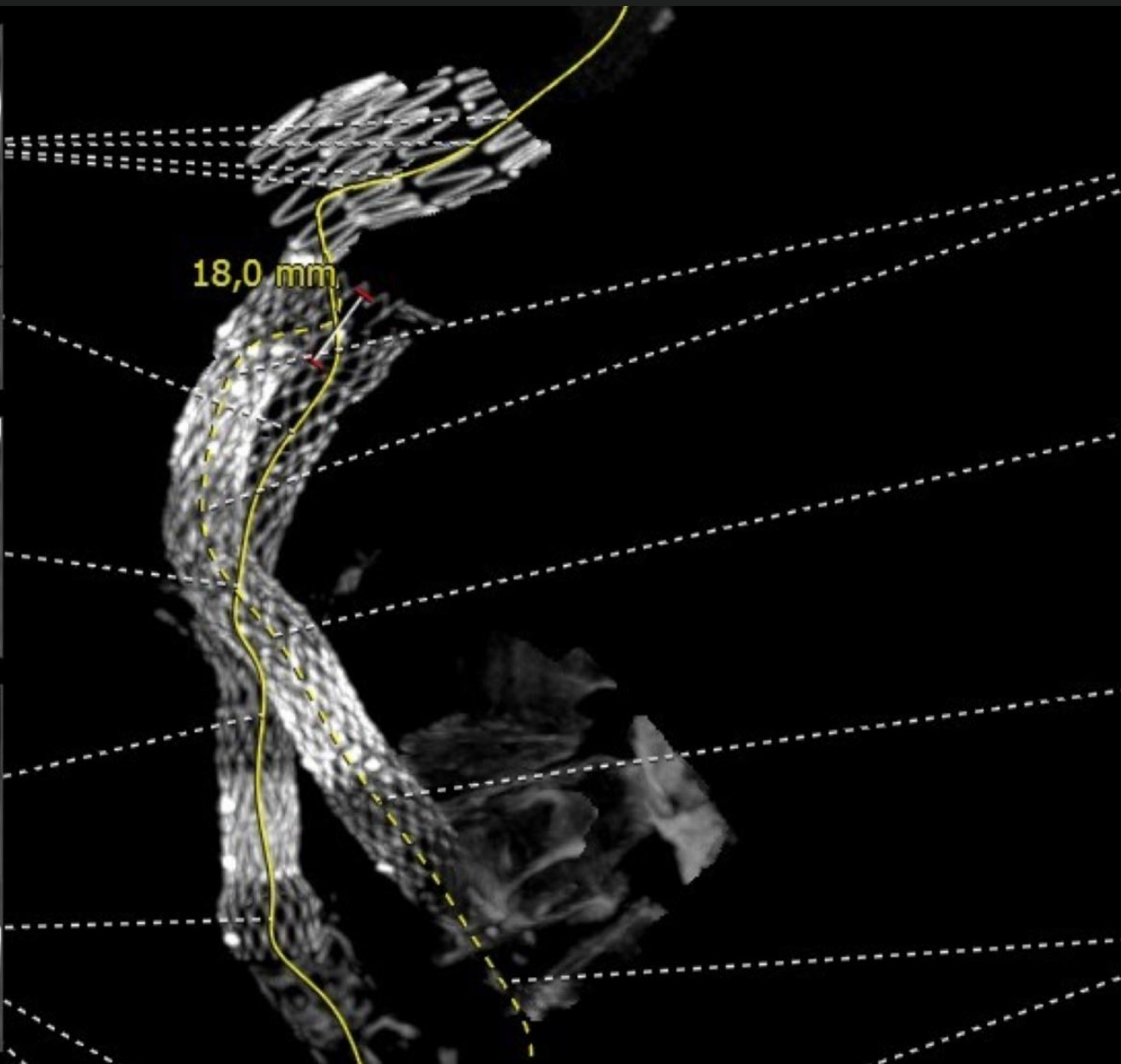
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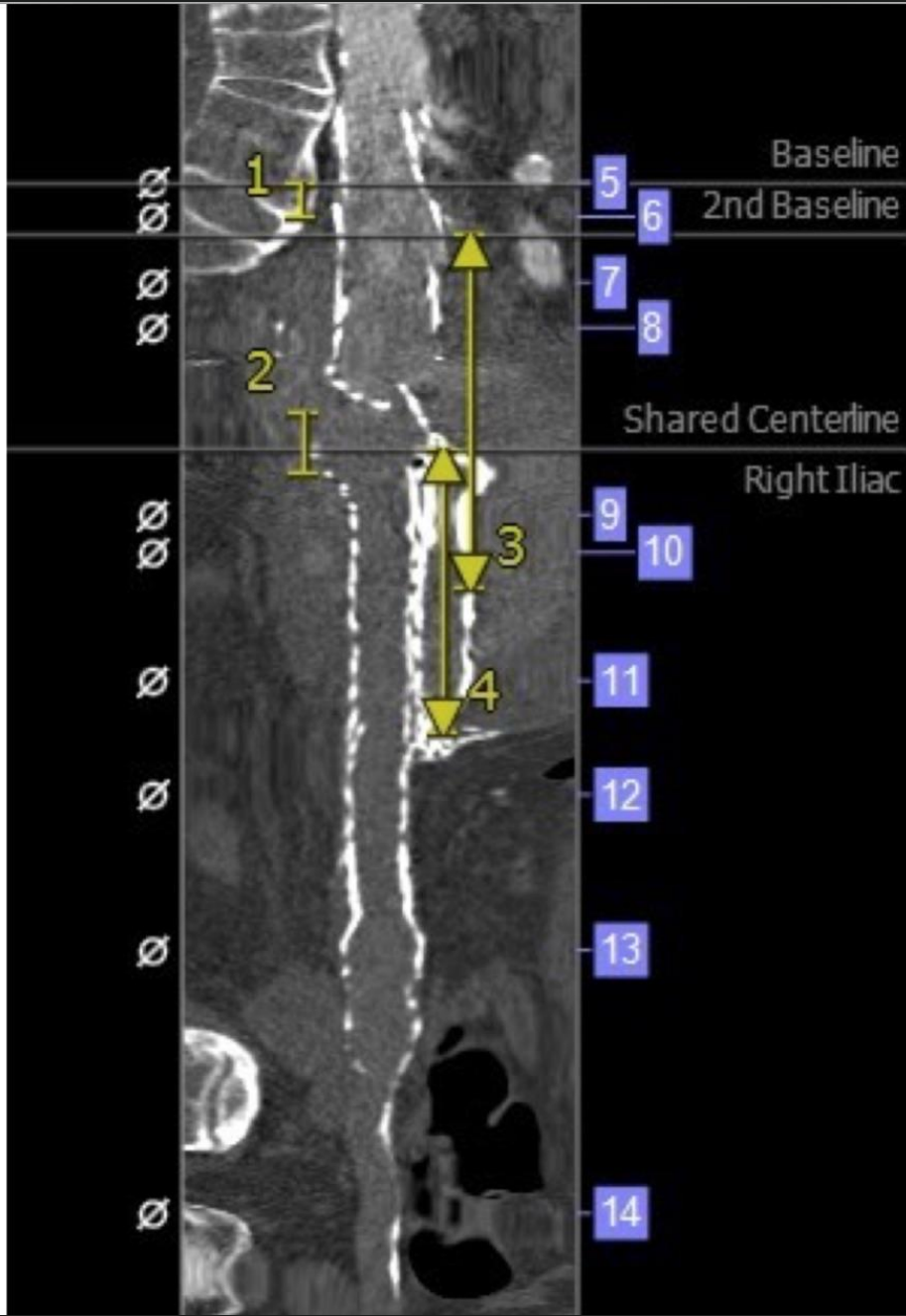
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LAO: 67°
Caudal: 7°



18,0 mm



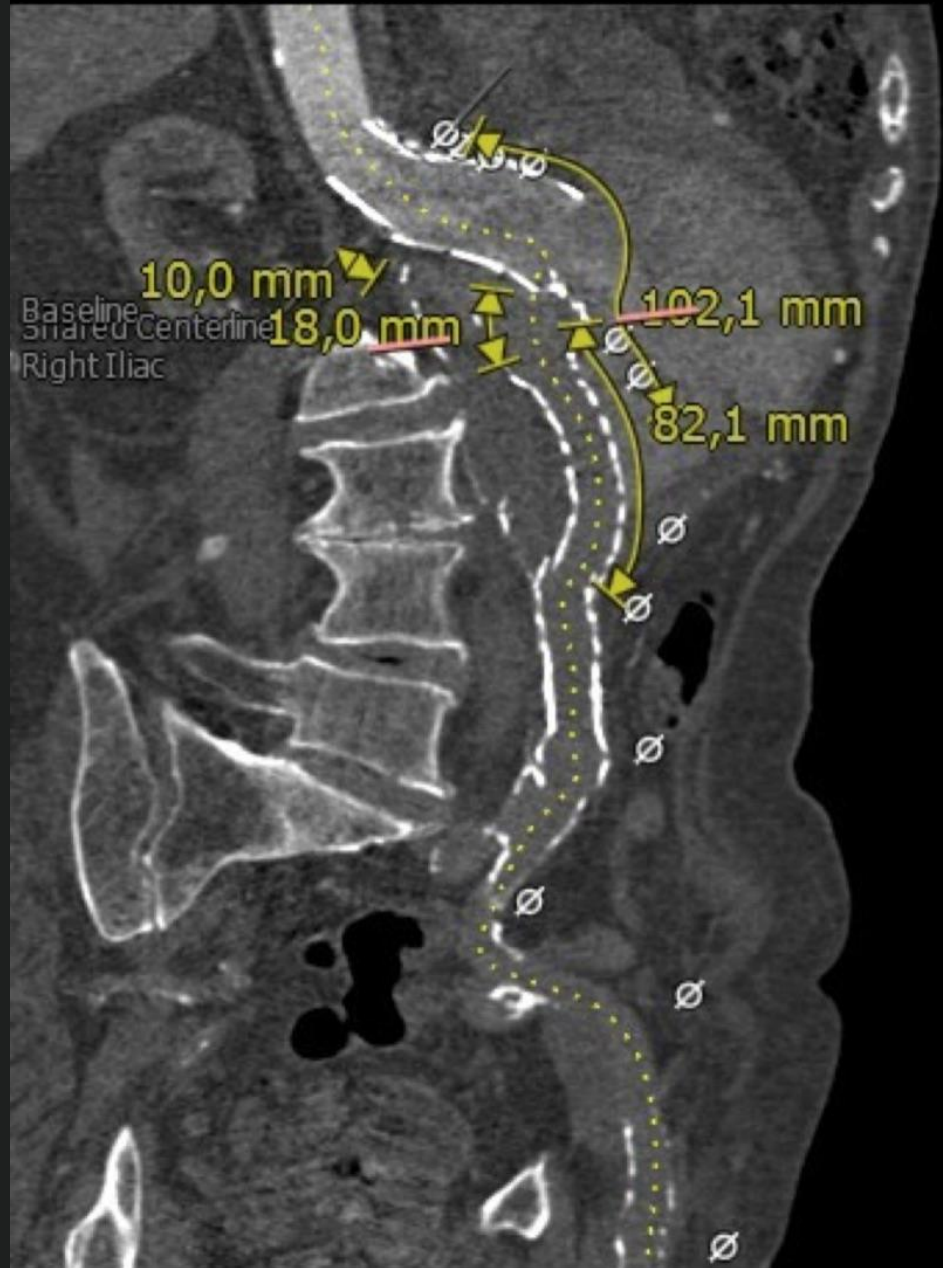


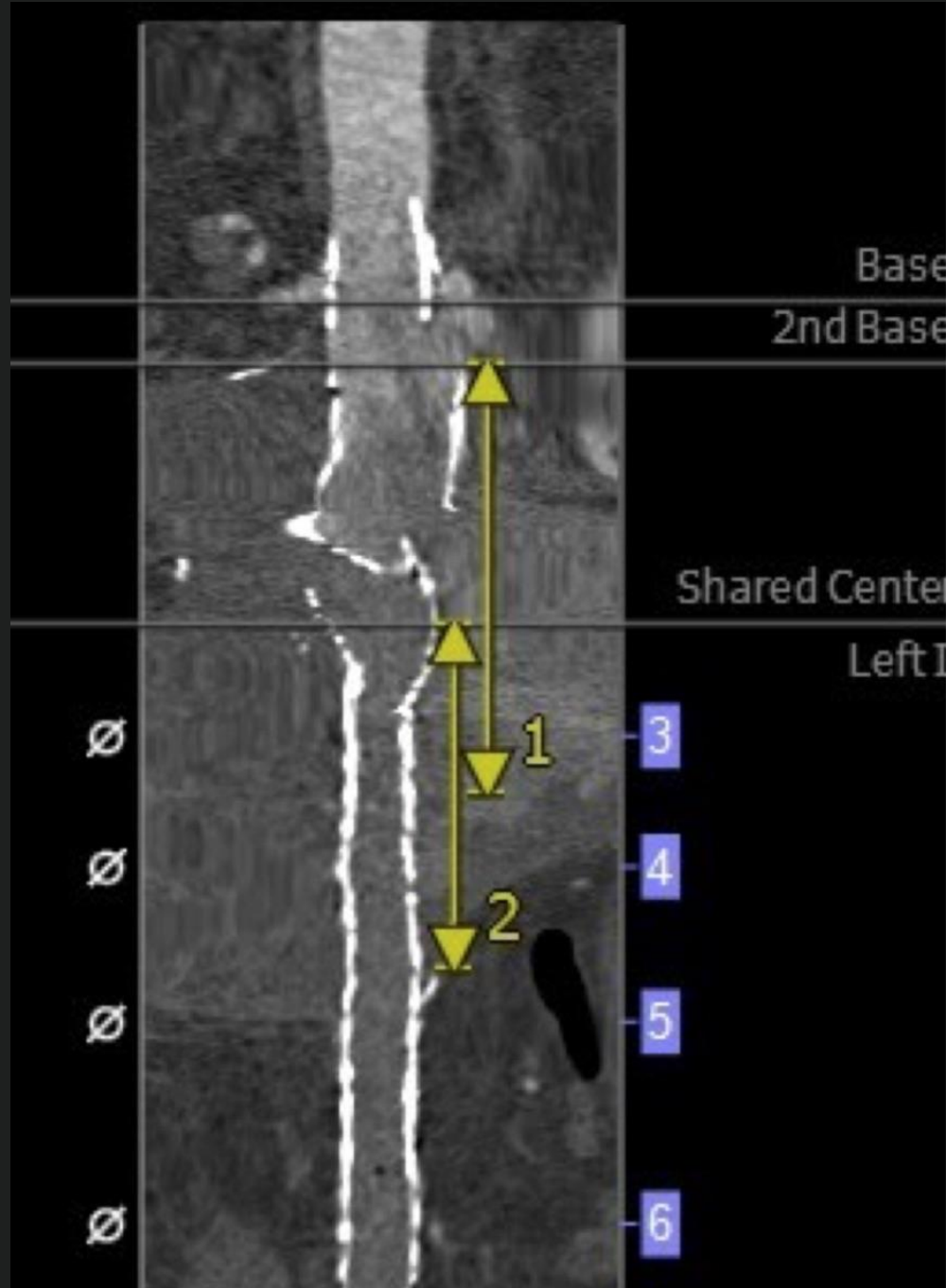
1	Vessel Length	Length 1	10,0 m
2	Vessel Length	Length 2	18,0 m
3	Vessel Length	Length 3	102,1 m
4	Vessel Length	Length 5	82,1 m

Diameters

ID	Distance	Label	Value
5	0,0 mm	Diameter	22,4 m
6	10,0 mm	Diameter	29,3 m
7	29,0 mm	Diameter	29,2 m
8	42,0 mm	Diameter	26,8 m
9	96,1 mm	Diameter	12,8 m
10	107,1 mm	Diameter	13,9 m
11	144,1 mm	Diameter	15,3 m
12	177,1 mm	Diameter	14,2 m
13	222,2 mm	Diameter	18,8 m
14	298,2 mm	Diameter	11,4 m
15	346,3 mm	Diameter	12,4 m
16	411,3 mm	Diameter	11,8 m

Comments:





3mensio

Report Details

Creation Date:	25-4-2018	Physician:	WORKLIST
Created By:	TvdK	Hospital:	
Received Date:	25-04-2018	City:	
Reviewed Date:	25-074-2018	Country:	

Patient Information

Name:	TSIROZIDIS AIMILIANOS	Study Description:	Vascular^BodyAngio3D_M (Adult)
Sex:	Male	Study Date:	29-3-2018 14:31
Year Of Birth (Age):	1929 (88)		

Comments:

Patient with AneuRx bifurcated stentgraft in situ. Cranial extensions with -most likely- two Talent extension cuffs. The talent cuffs have correct overlap.

The connection with the AneuRx is completely disconnected.
According the product specifications for teh AneuRx the body should be 30 mm long.
I can only measure a length of 18 mm. Something has happened with the graft integrity, resulting in a shortening of the body.

The body is too short to use for a new extension/ tube graft.

Remaining option is conversion to an Aorto Uniliac system.

Access through the different graftcomponents will be difficult which is the reason to leave the access site right or left open to which is succesfull. The contralateral side could then be used for an Amplatzer plug.

Preferably AUI from the right side because the diameter in the distal sealzone is a bit bigger compared to the left side.

I suggest to start the AUI graft-fabric \pm 15 mm caudal from the renal artery level in order to limit the amount of metal in front of the renal artery ostia.

ETUF3214C102EE with extension ETLW1616C82EE.

Amplatzer plug in the contralateral limb an dfem-fem.

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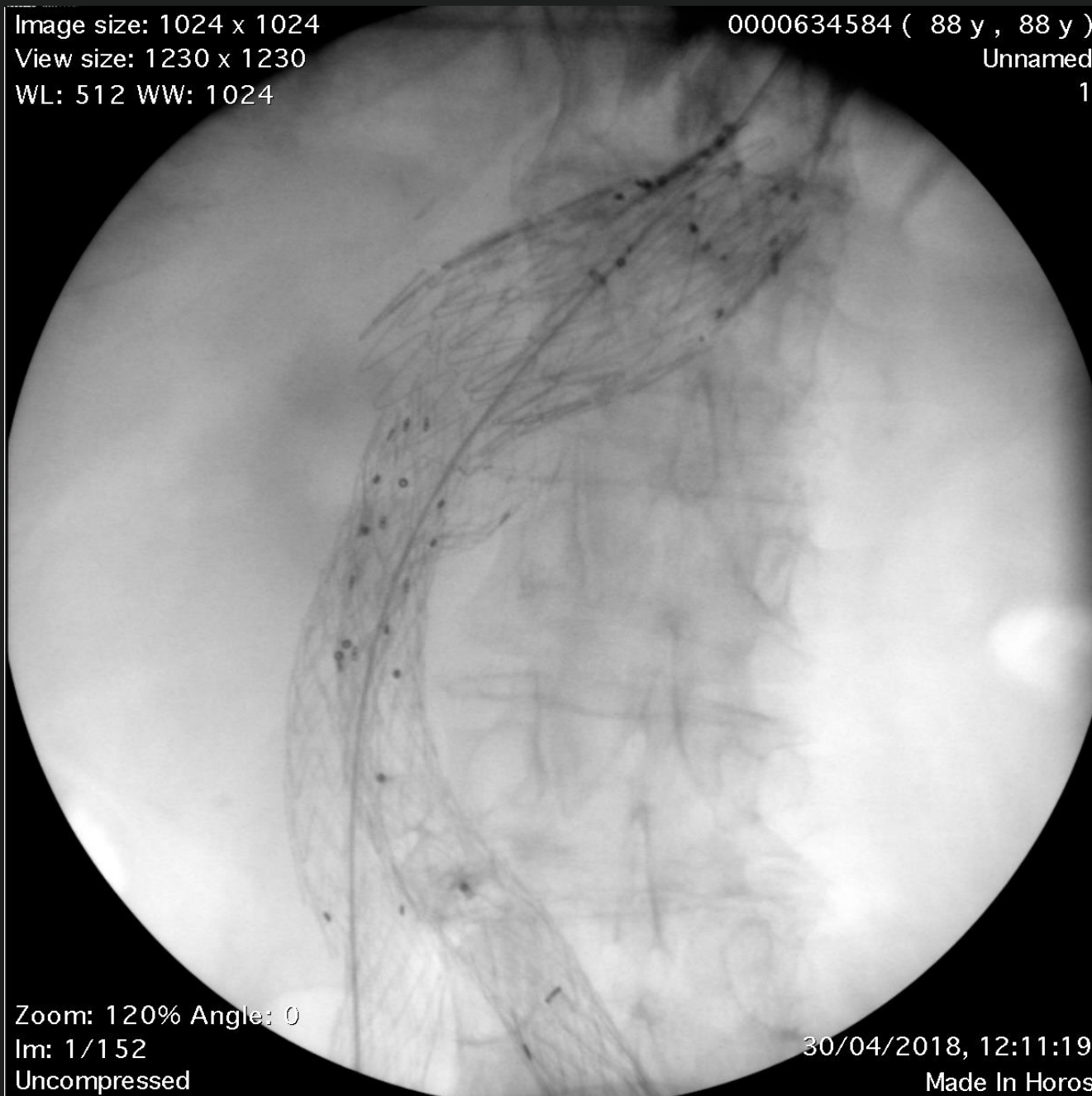
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Image size: 1024 x 1024
View size: 1230 x 1230
WL: 512 WW: 1024

0000634584 (88 y , 88 y)
Unnamed
1



Zoom: 120% Angle: 0
Im: 1/152
Uncompressed

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Thank you for your attention...