



Universitäres
Herz- und Gefäßzentrum
UKE Hamburg

GERMAN
AORTIC CENTER
HAMBURG



My coolest CASE #2:
using suture to help with sheath orientation.

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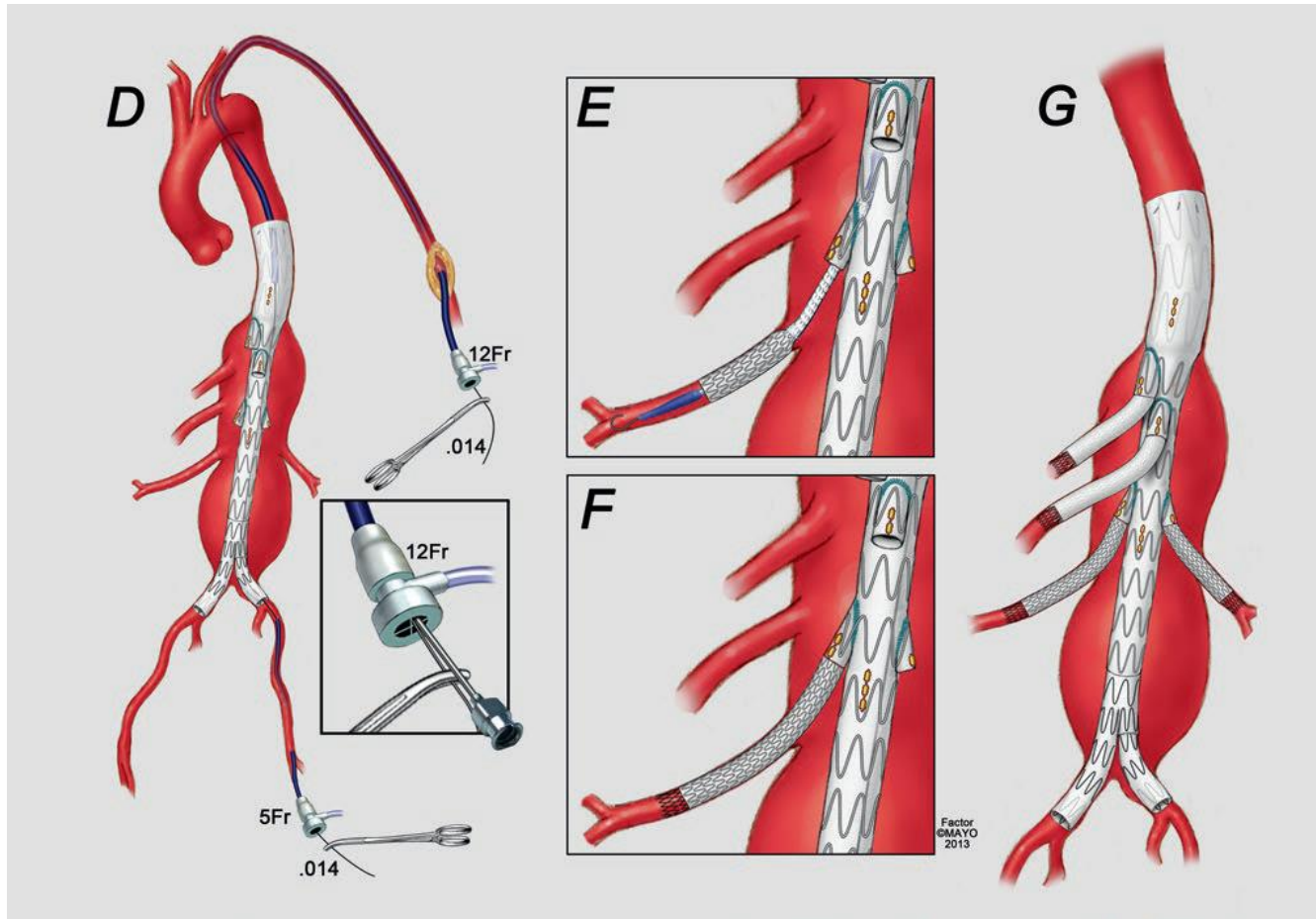
THE 24TH INTERNATIONAL EXPERTS SYMPOSIUM
CRITICAL ISSUES
IN AORTIC ENDOGRAFTING

DECEMBER 17 & 18 2021
PULLMAN CENTRE PARIS BERCY - PARIS FRANCE

Disclosures

None

Brachial approach by B-EVAR



Stroke Risk

Right brachial access is safe for branched endovascular aneurysm repair in complex aortic disease



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ABSTRACT

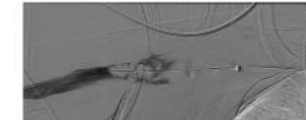
Background: The risk of perioperative cerebrovascular events in endovascular repair of thoracic and thoracoabdominal aneurysms is reported from 2% to 15%. **The unavoidable use of an upper extremity access during branched endovascular aneurysm repair (b-EVAR) may play a role in embolic brain injuries.** For this reason, some advocate the use of a left-sided upper access to avoid crossing the origin of supra-aortic vessels. However, the assumption that right brachial access has a higher risk for stroke during b-EVAR has not been confirmed in the literature.

Conclusions: The postoperative stroke rate in b-EVAR with the use of a right brachial access in our experience was in line with the literature for treatment of thoracic and thoracoabdominal aortic aneurysms. **We conclude that the right brachial access with the use of a stabilizing through-and-through wire is a safe approach during b-EVAR.** (J Vasc Surg 2017;56:360-6.)

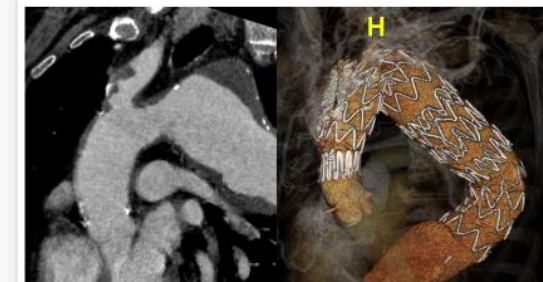


Upper Extremity Access Complications

- Hematoma
- Nerve damage
- Plexus damage
- Stroke
- Rupture
- Ischemia
- Prolonged operating time
- Radiation exposure



Anatomical exclusion criteria



- Occlusion/stenosis
- Thrombotic/shaggy
- AV-fistula
- LIMA Bypass
- Antegrade branches after arch-repair

Technical Note

Use of a Steerable Sheath for Retrograde Access to Antegrade Branches in Branched Stent-Graft Repair of Complex Aortic Aneurysms

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Fiona Rohlfes, MD¹ , Konstantinos Spanos, MD¹ ,
E. Sebastian Debus, MD, PhD¹, and Tilo Kölbel, MD, PhD¹

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Journal of Endovascular Therapy

1-5

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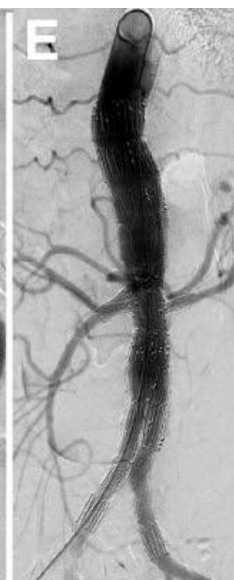
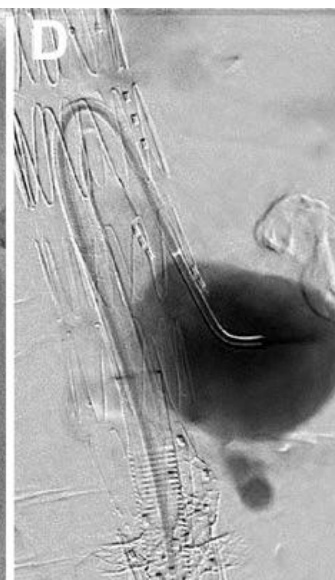
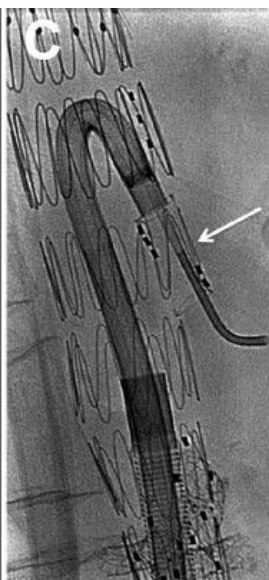
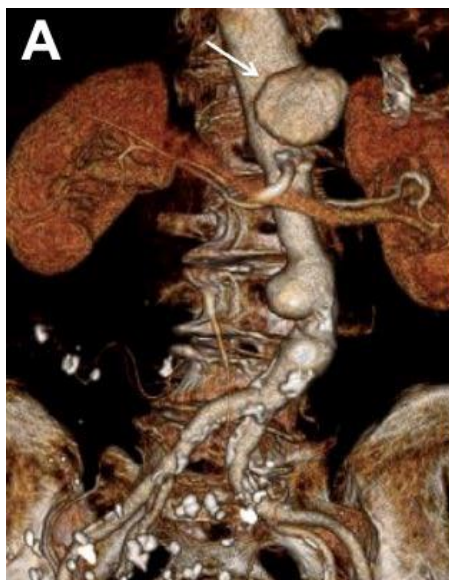
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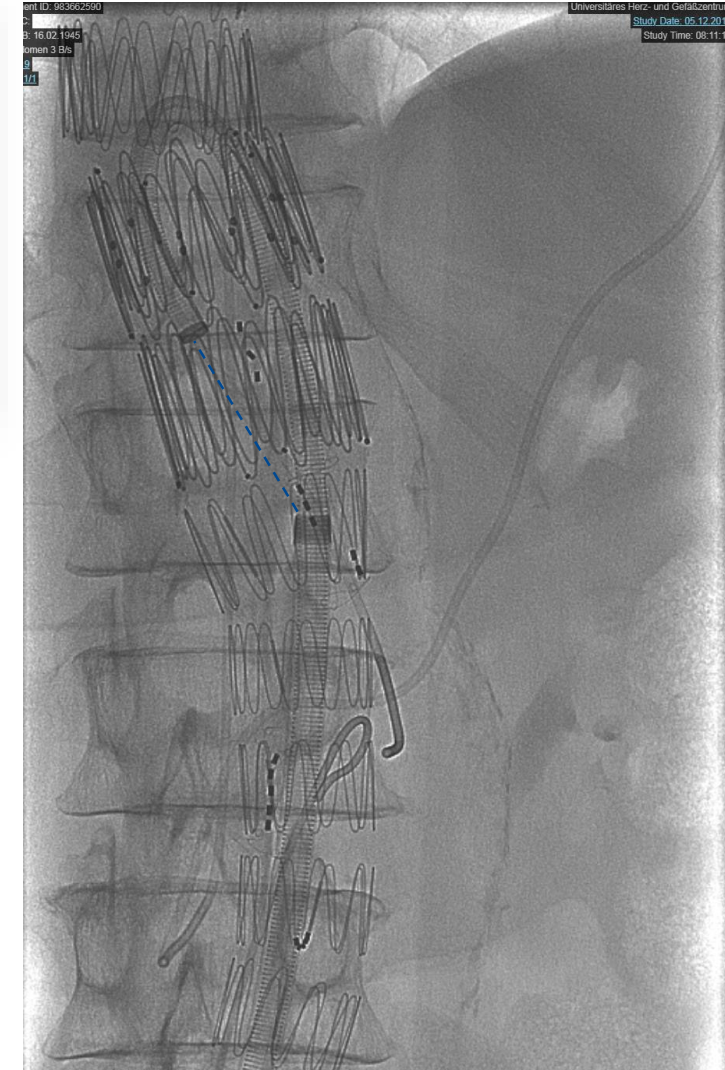
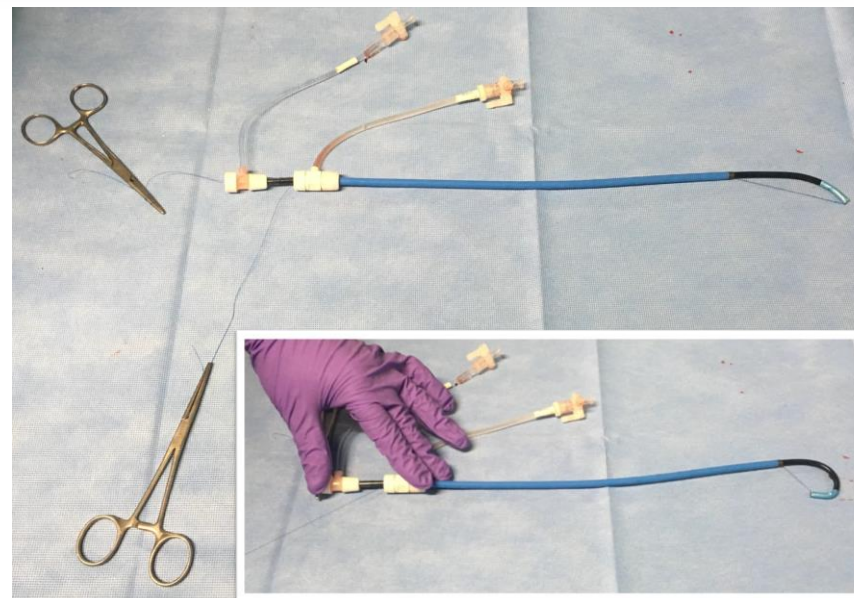
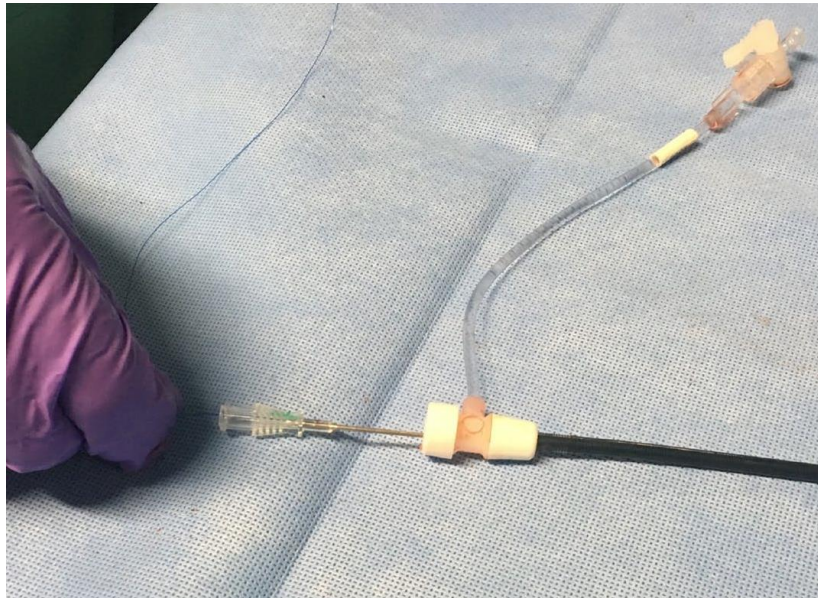
 SAGE



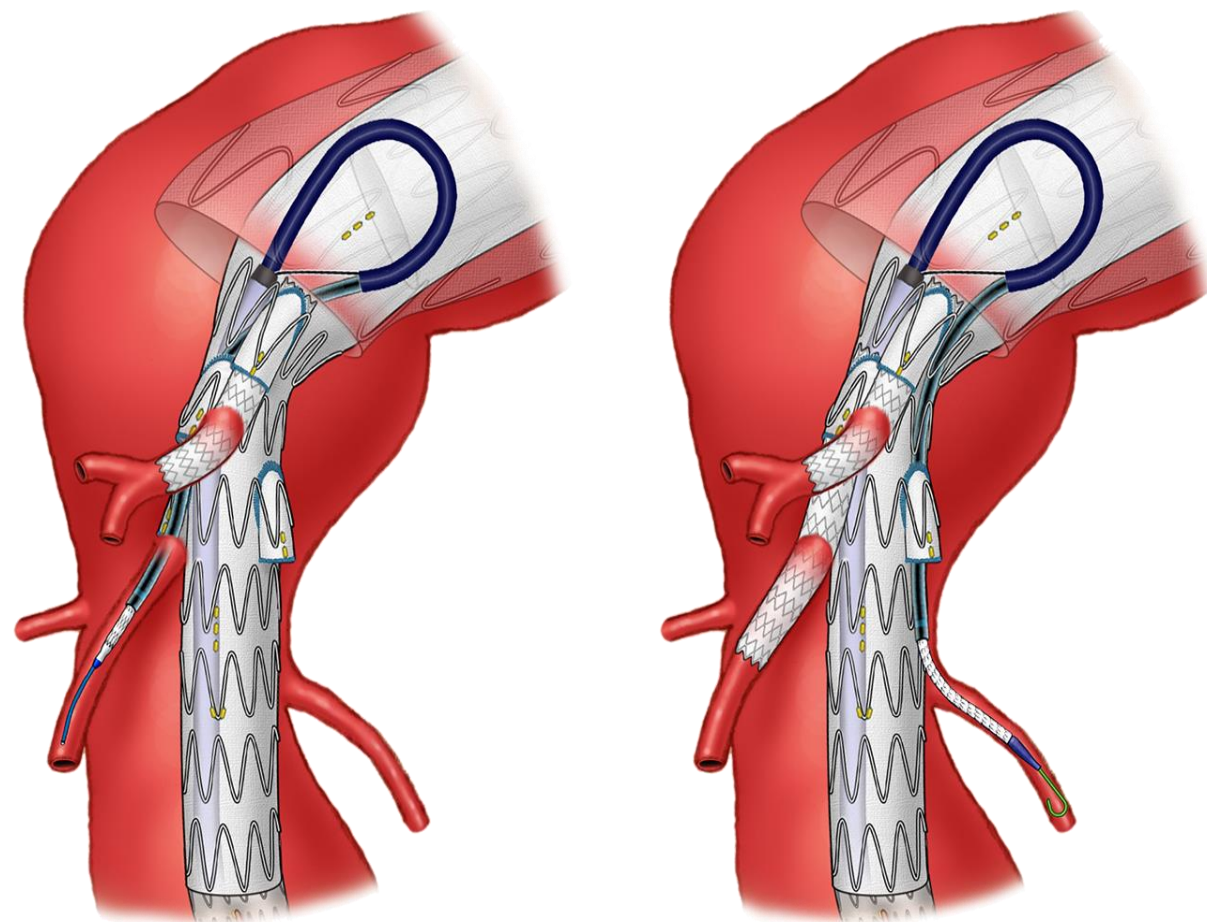
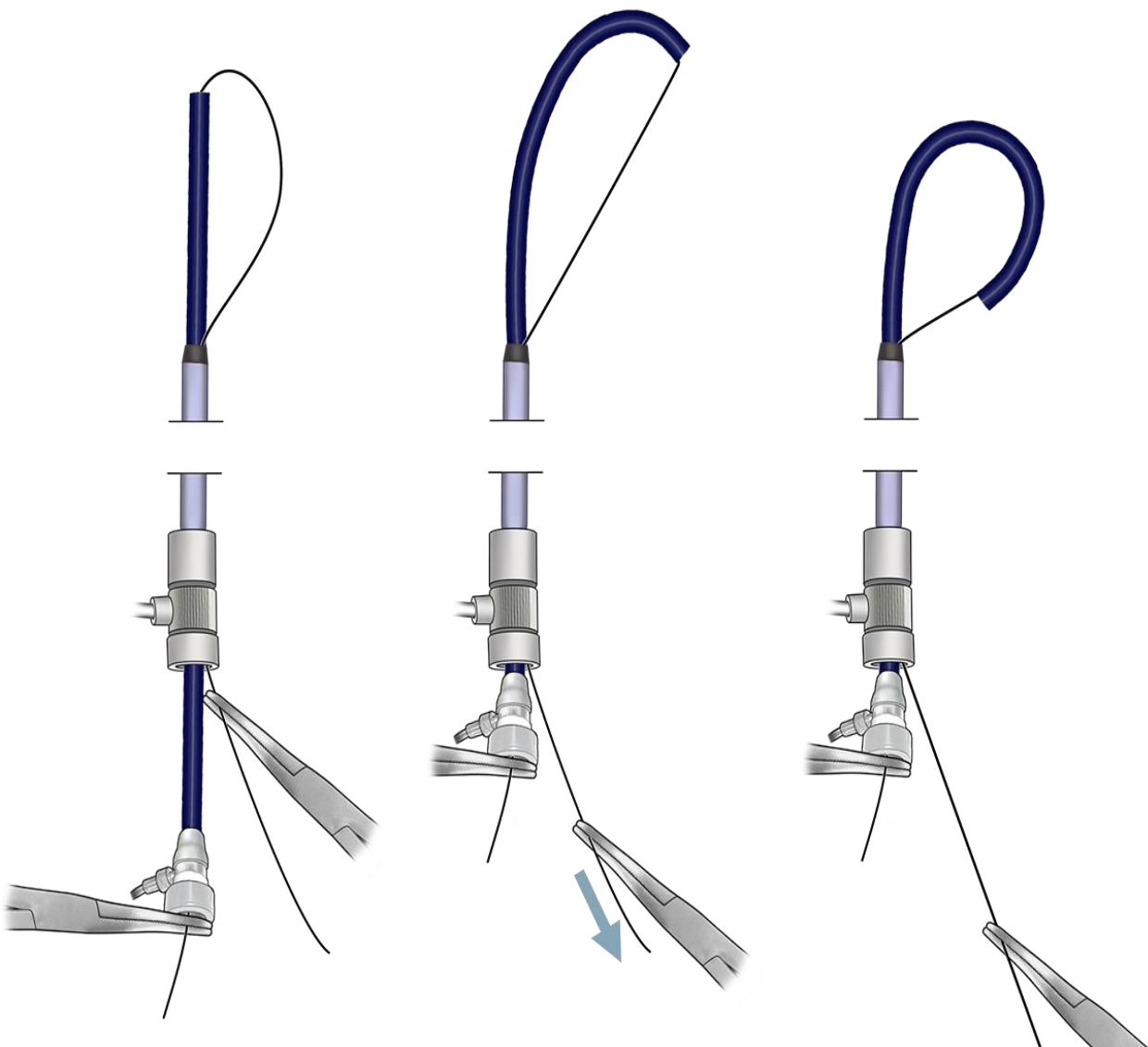
Through-and-Through Suture Technique to Stabilize a Sheath in Branched Endovascular Aortic Repair

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T&T Suture Technique



Courtesy of Gustavo Oderich



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Volume 73, Issue 5, May 2021, Pages 1498-1503

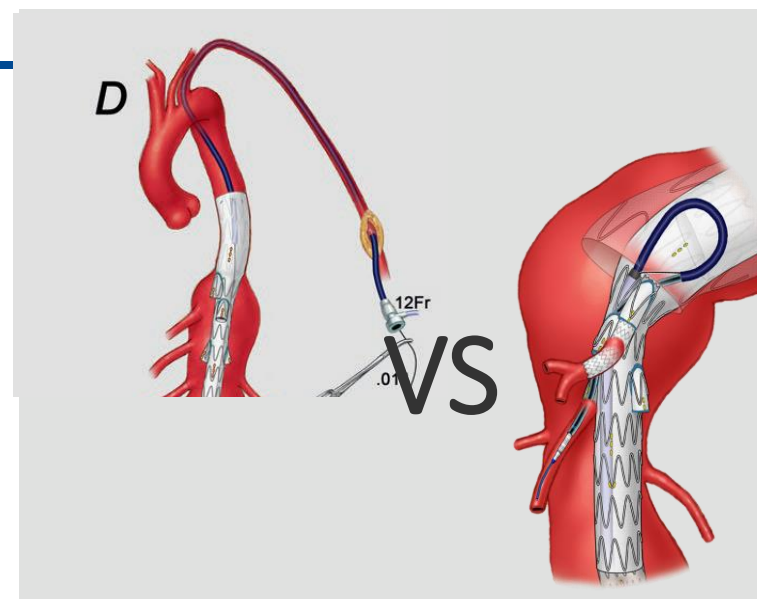


Clinical research study

Thoracoabdominal and complex aortic aneurysms

Comparison of transfemoral versus upper extremity access to antegrade branches in branched endovascular aortic repair

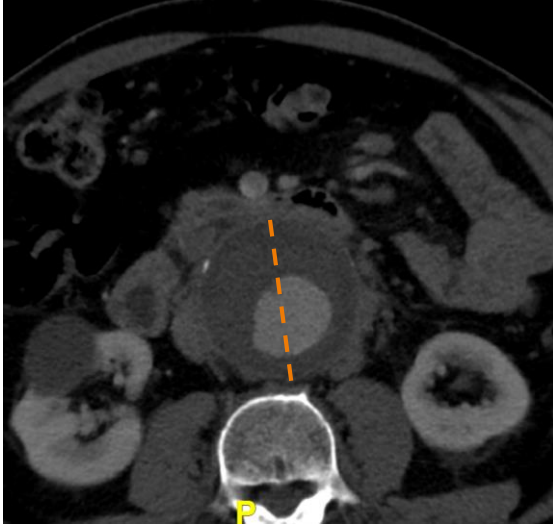
Wolf Eilenberg MD, PhD ^a, Tilo Kölbel PhD ^a, Fiona Rohlfes MD ^a, Gustavo Oderich MD ^b, Ahmed Eleshra MD ^a, Nikolaos Tsilimparis PhD ^a, Sebastian Debus PhD ^a, Giuseppe Panuccio MD ^a



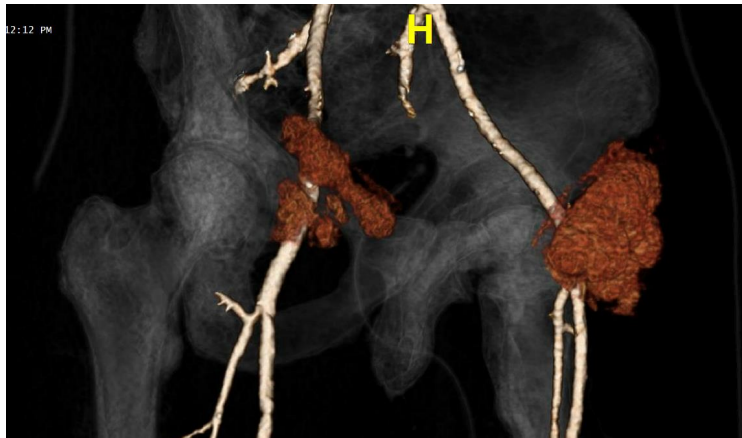
Total patients N=152	TFA n=60	UEA n=92
DAP (Gy/cm ²)	221 (138-406)	255 (148-425) *
Contrast Agent (ml, IQR)	141 (123-165)	130 (101-157)
Operating time (min, IQR)	300 (240-356)	364 (290-475) *
Stroke (%)	0	3 (2%)*
Paraplegia	7 (12%)	15 (16%)
UEA complication	0	4(4%)*

68 yo Male

7cm Suprarenal AAA



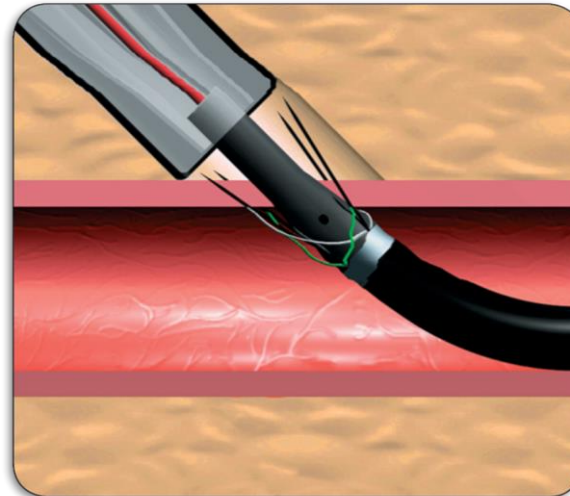
lymphoma



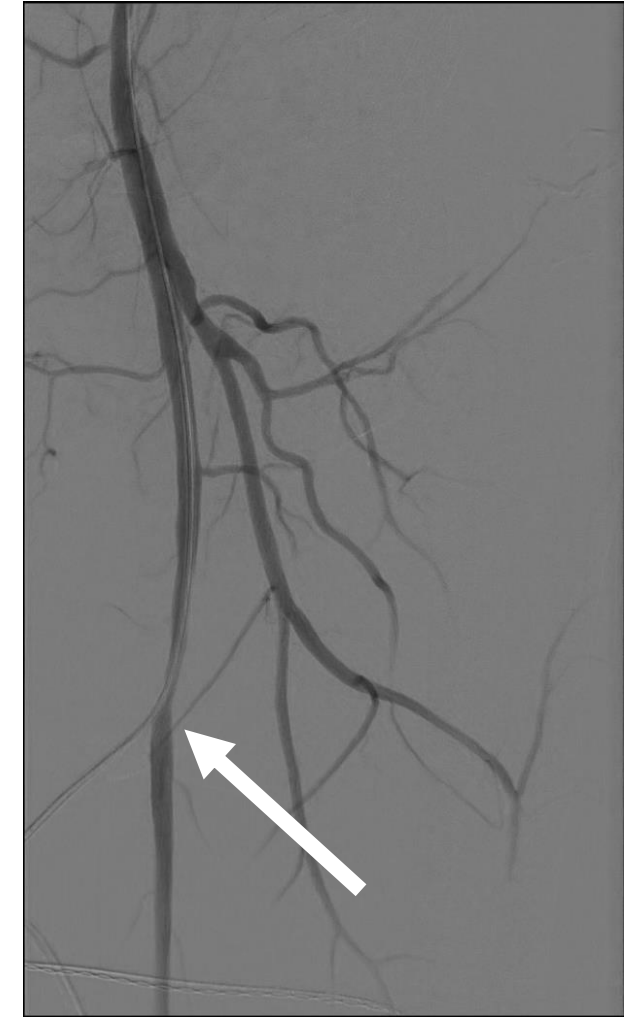
20Fr sheath: distal SFA



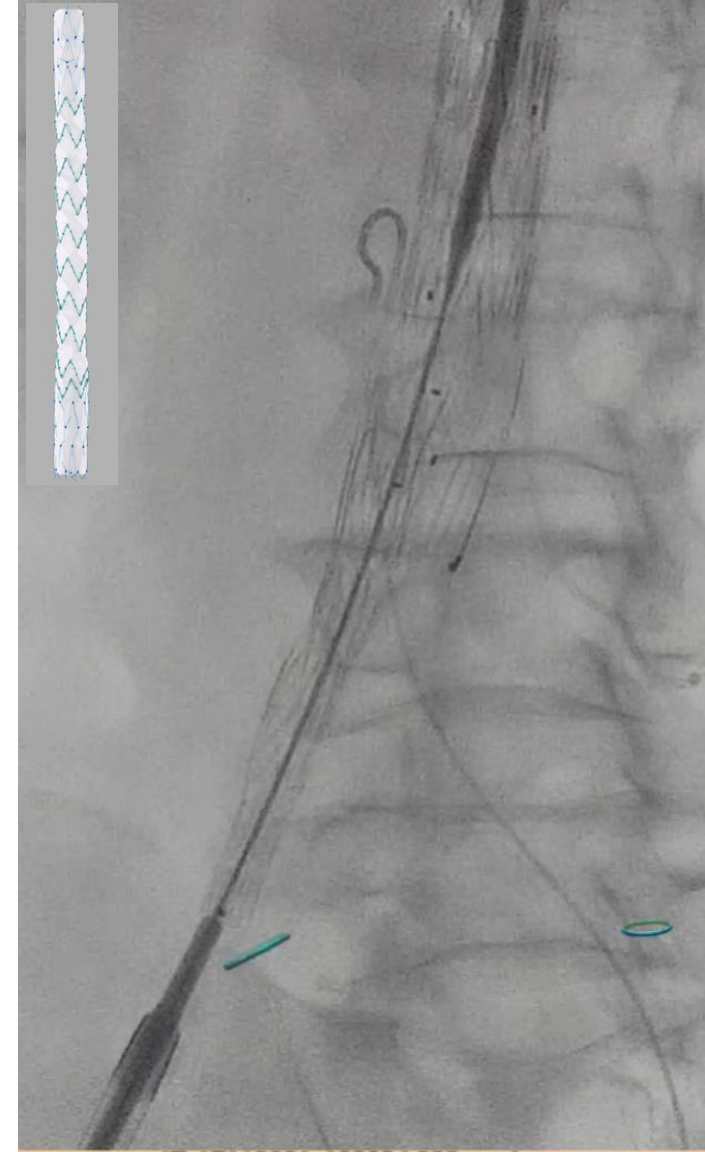
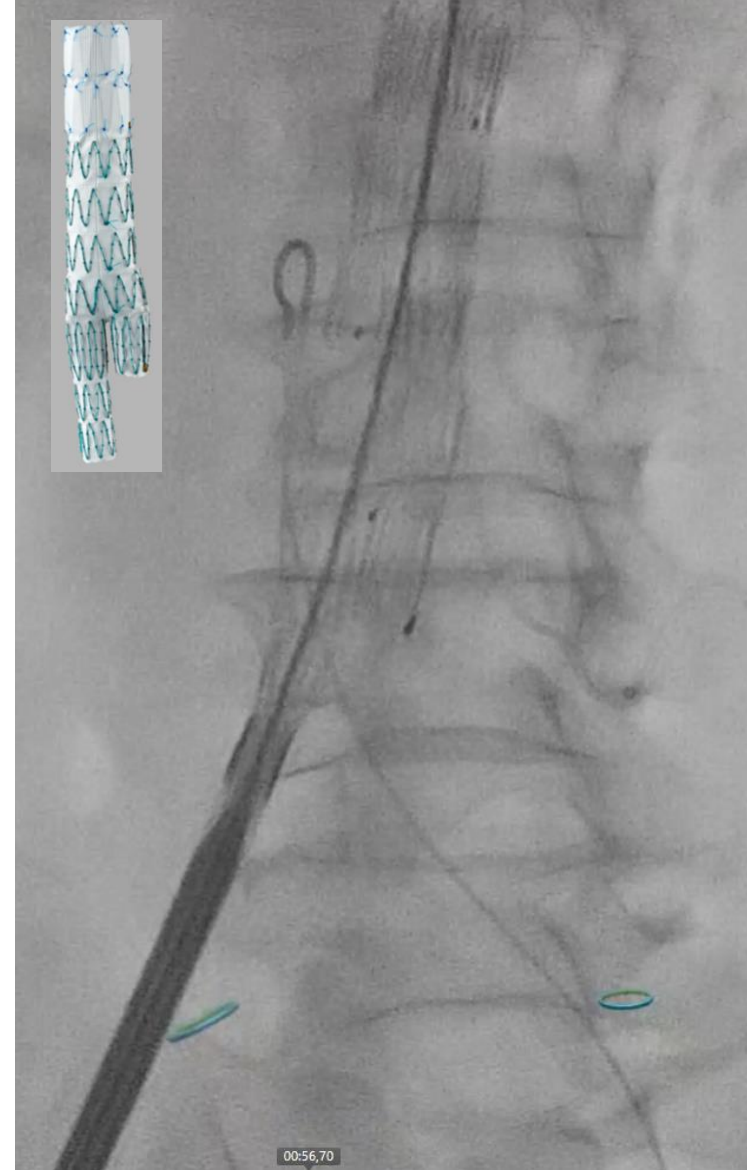
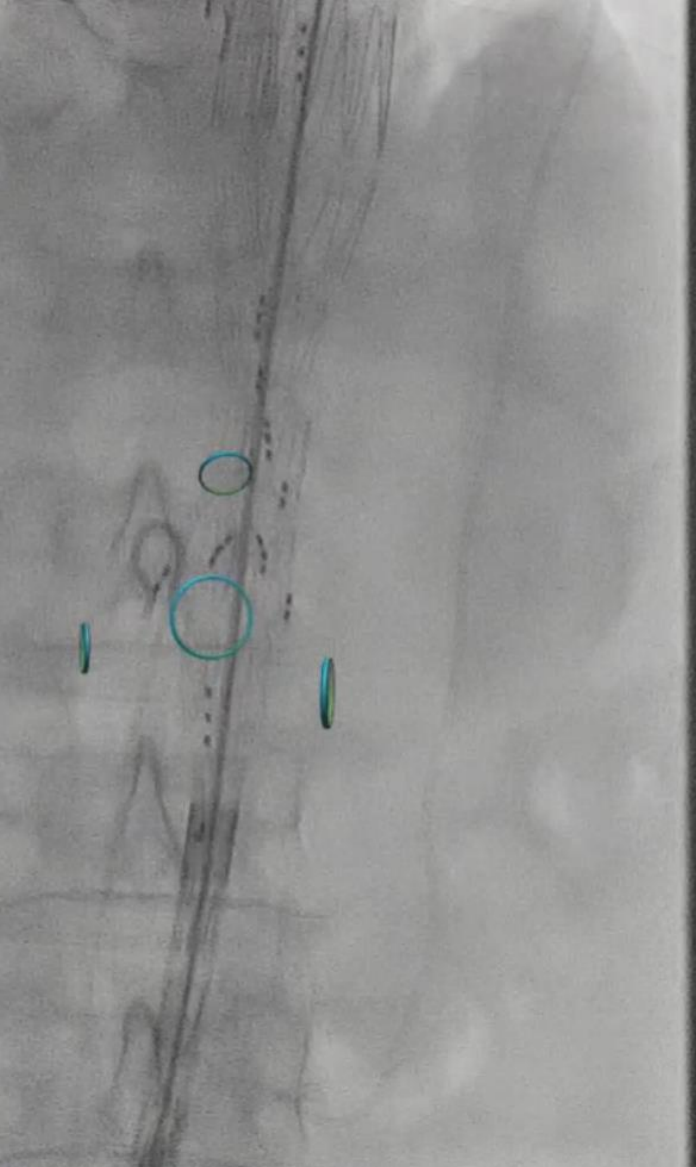
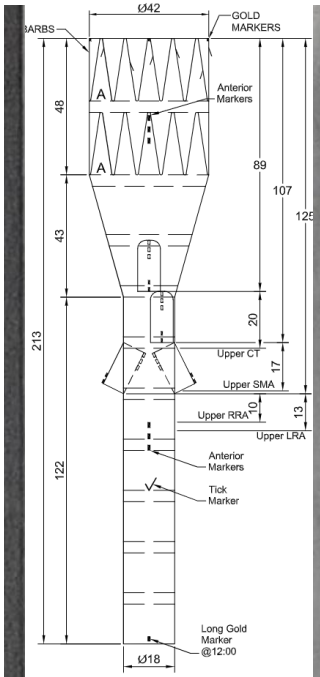
Prostar™ XL
Percutaneous
Vascular Surgical



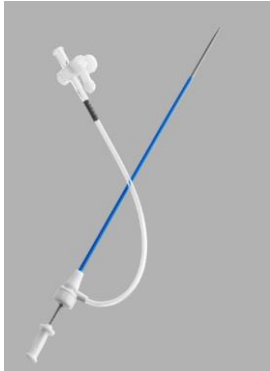
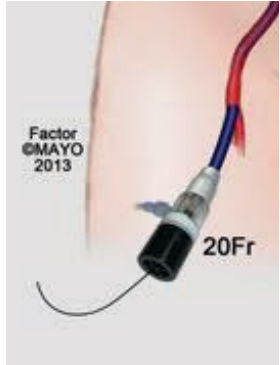
6Fr sheath: distal SFA



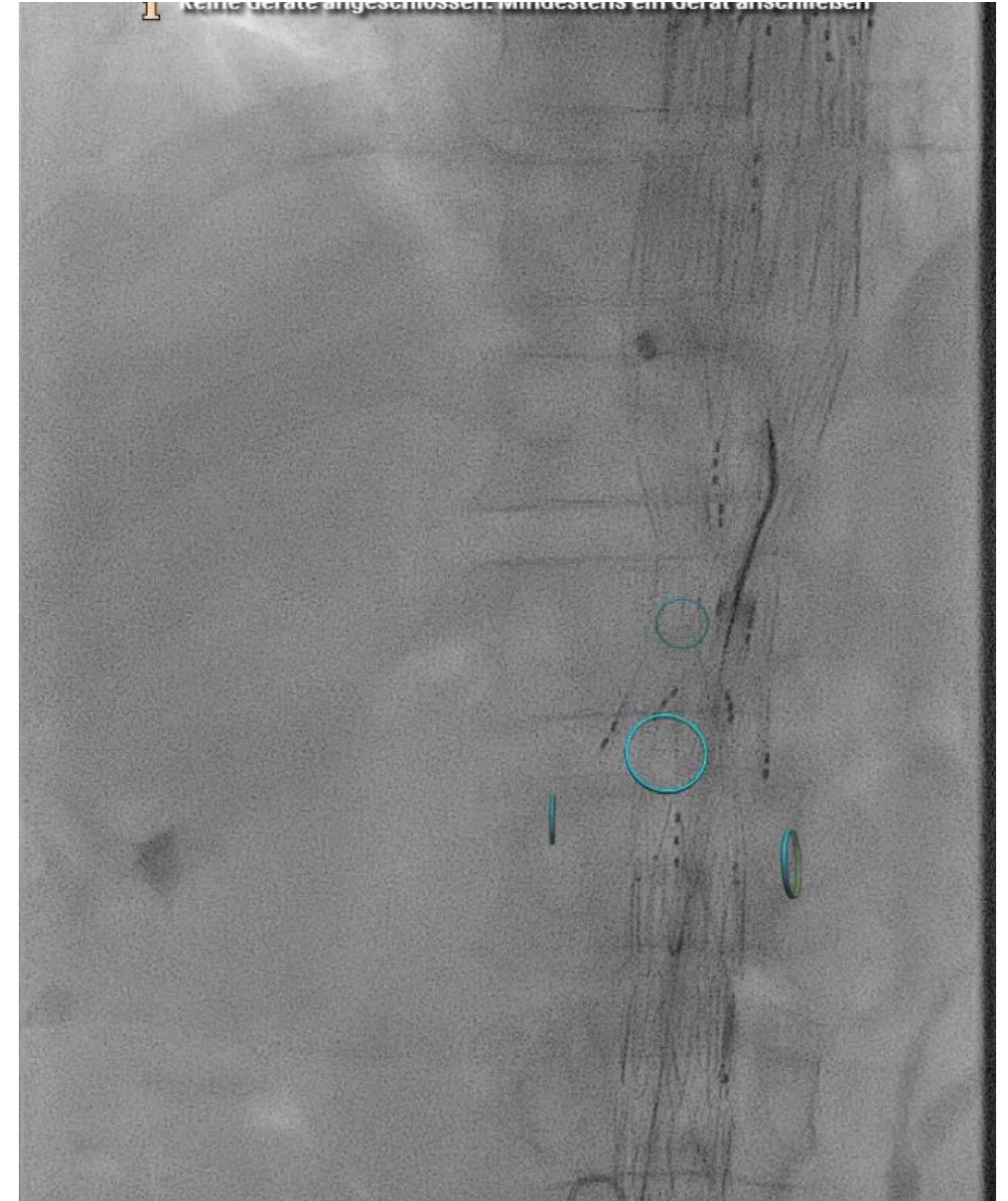
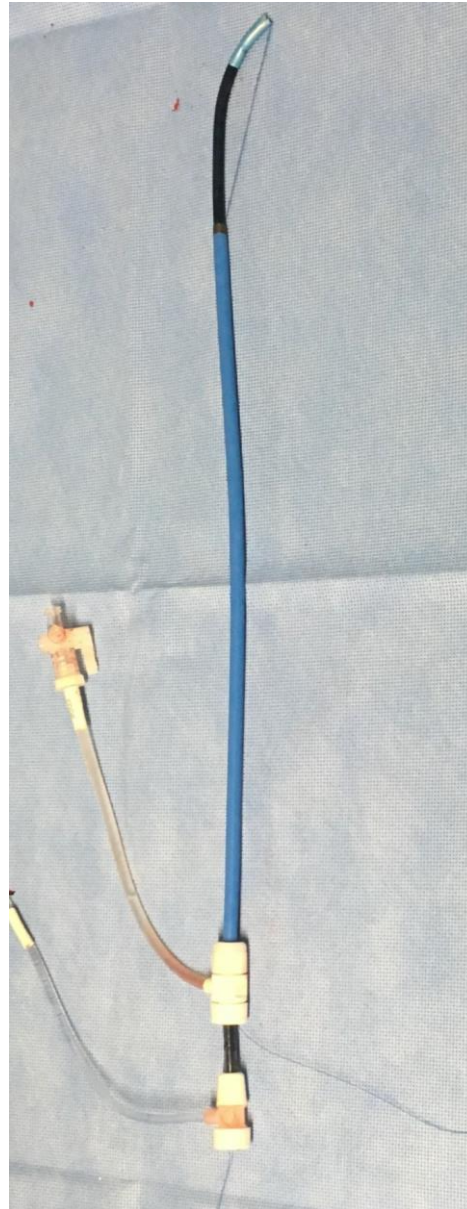
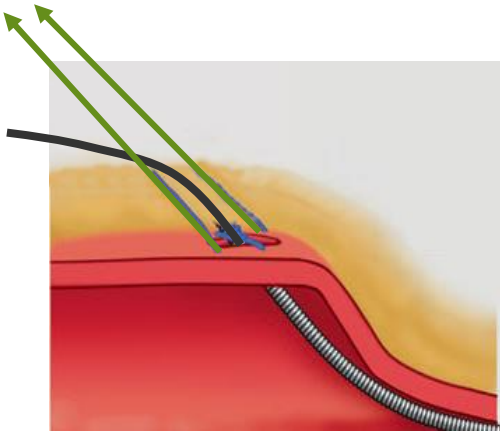
Main Body Deployment



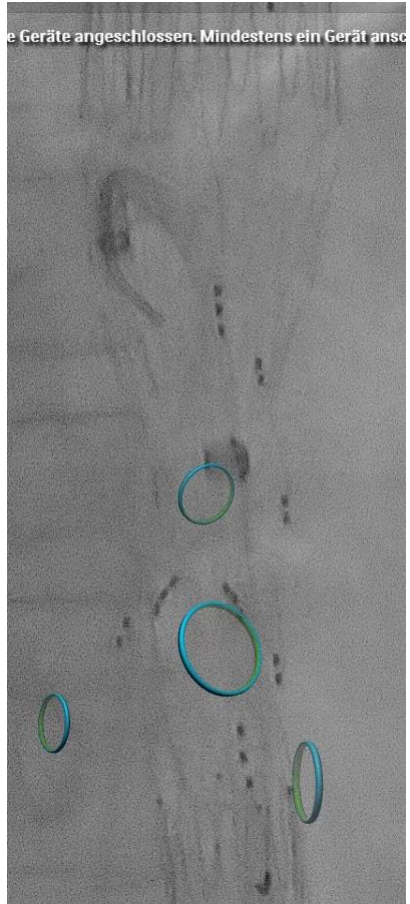
Steerable Sheath Placement



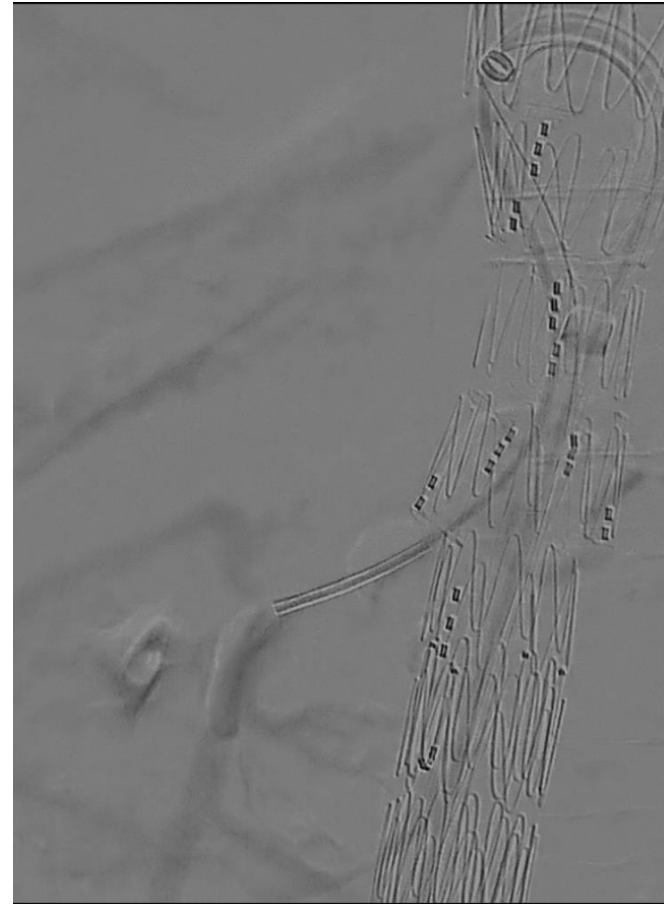
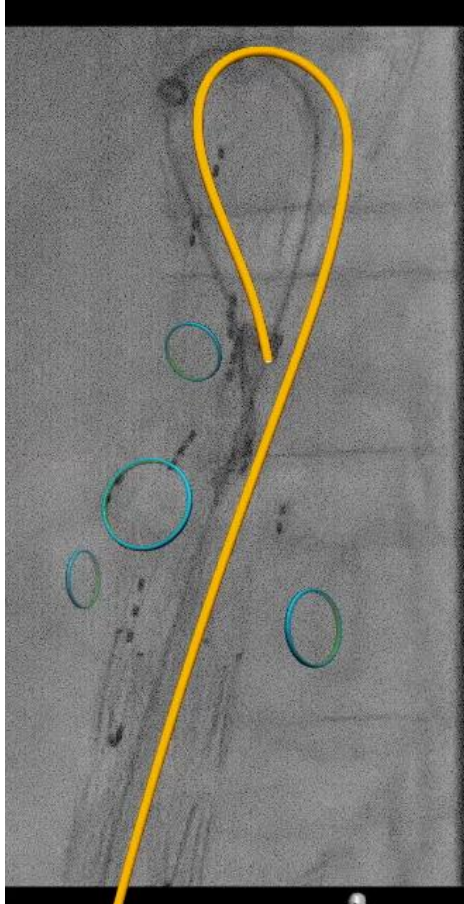
Downsizing from 20 to 14 Fr



Branch Catheterization



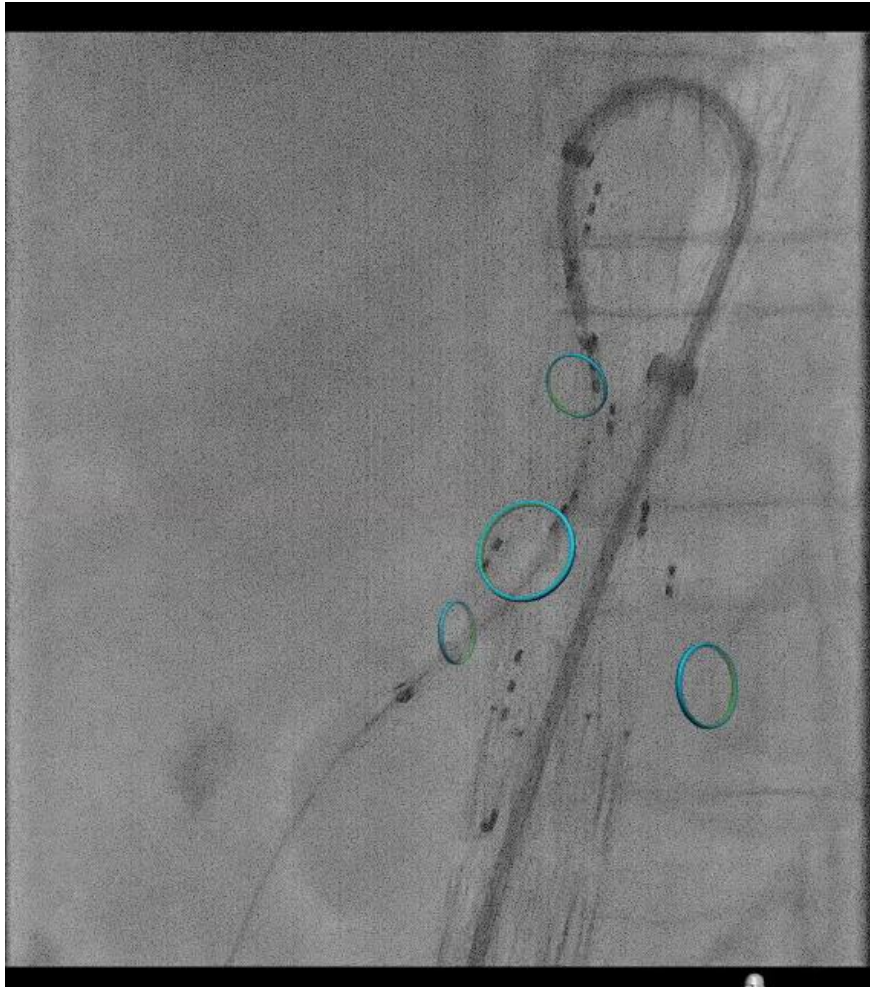
Vessel Catheterization FORS assisted



BSG Delivery



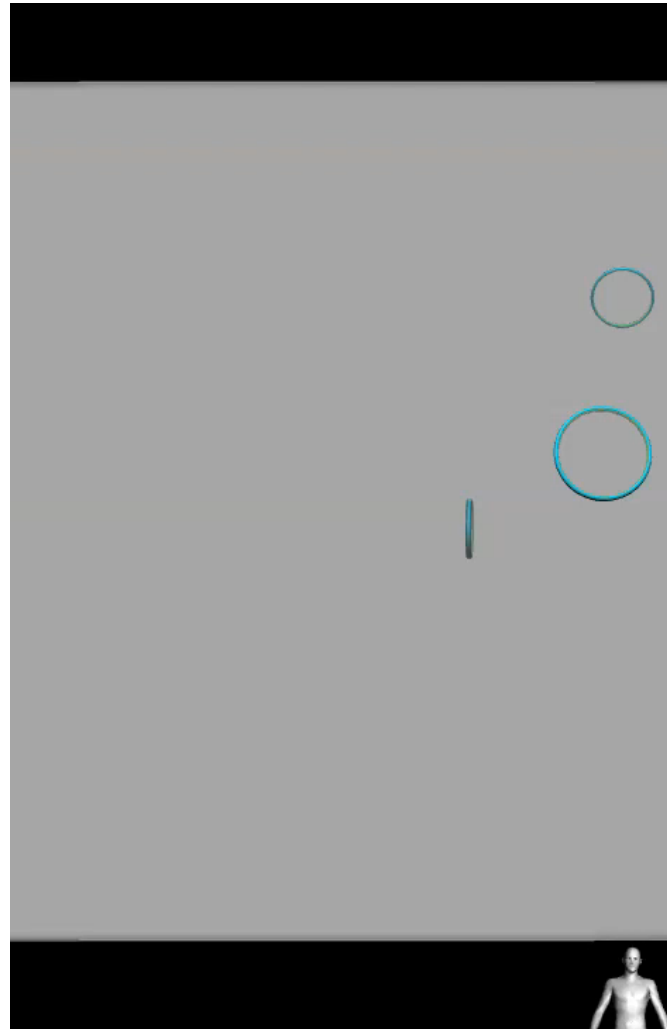
BSG Deployment



DSA



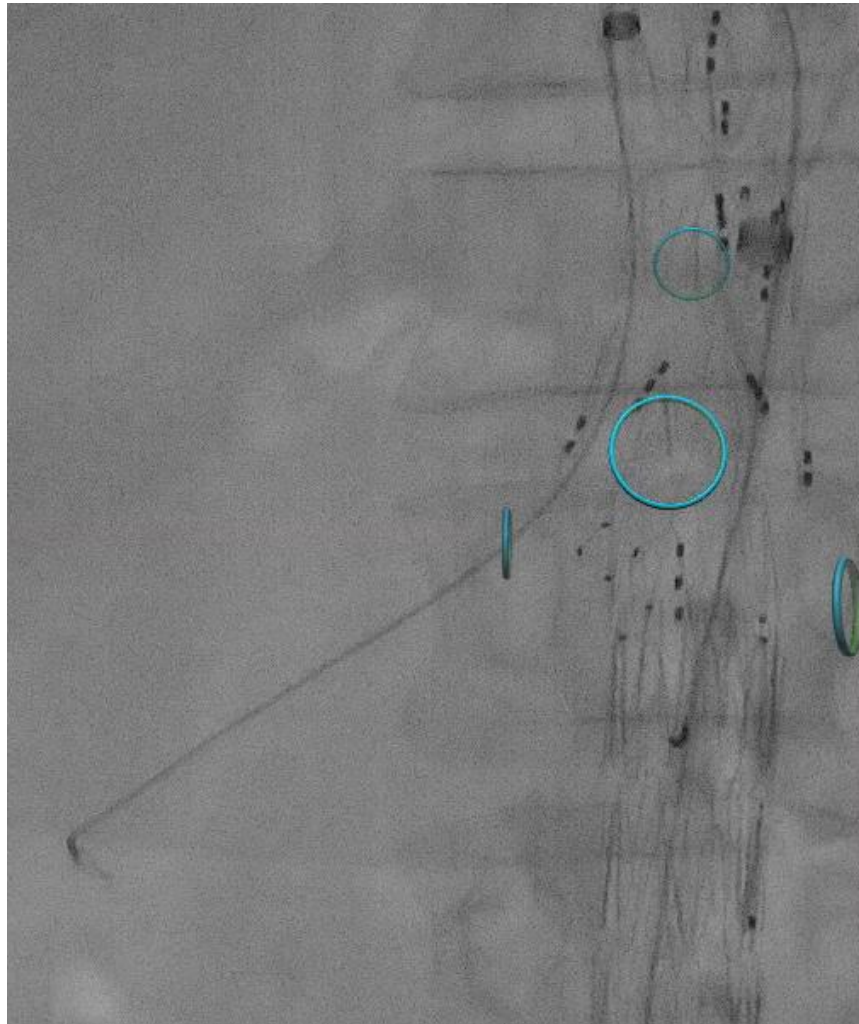
Branch Catheterization

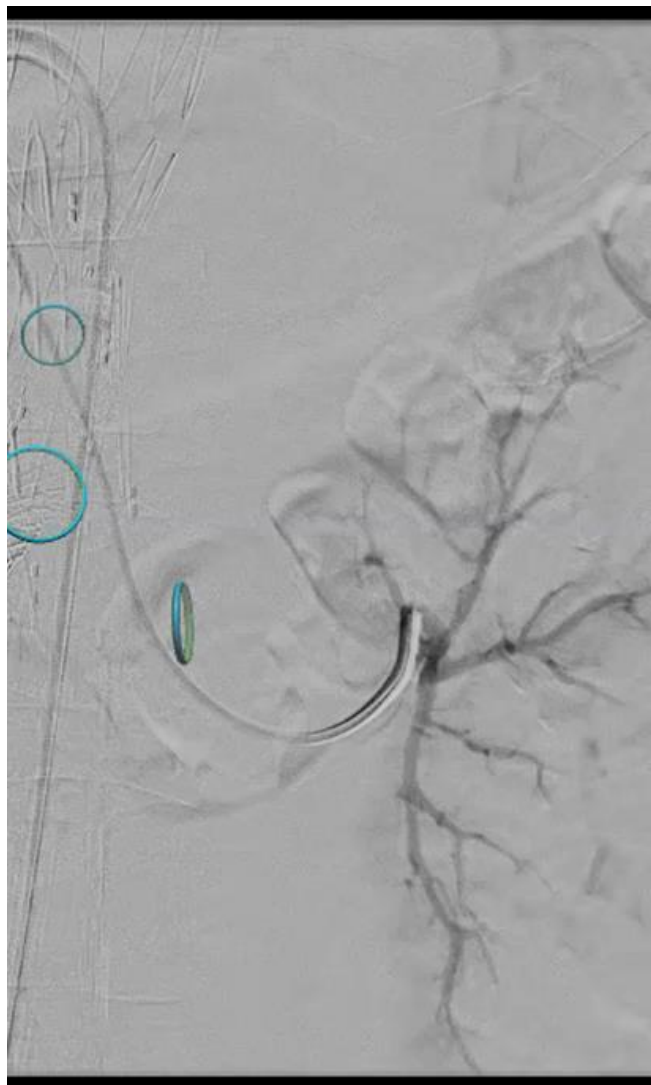
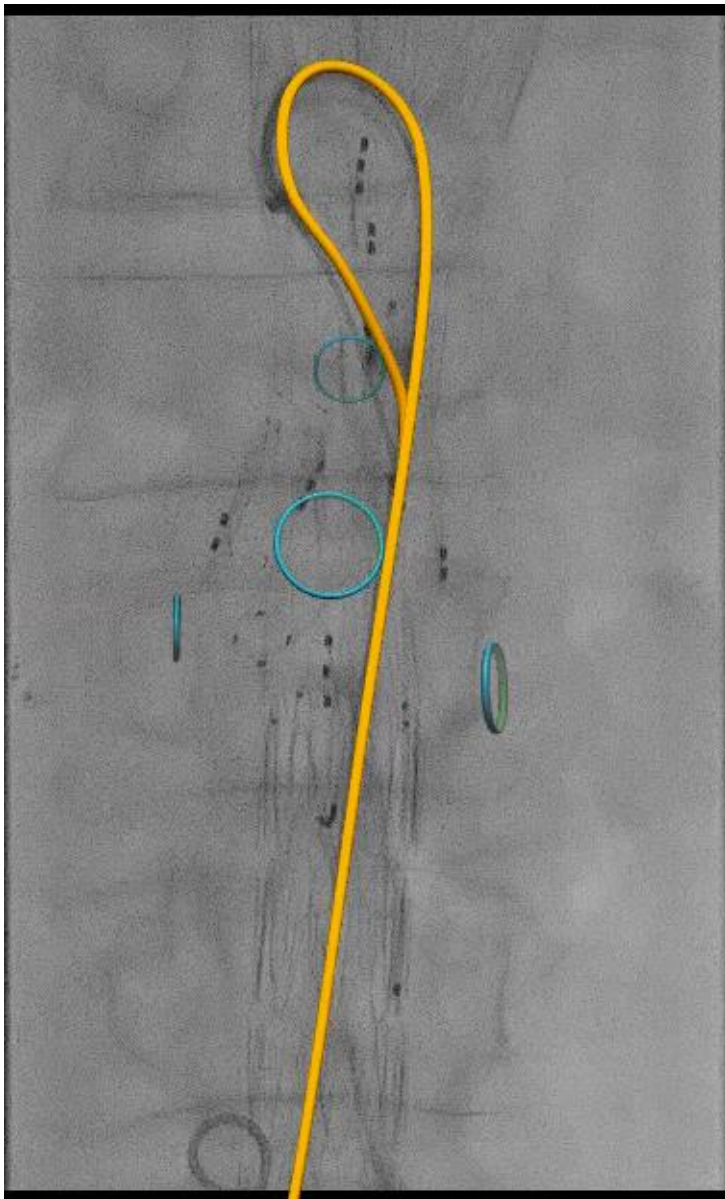


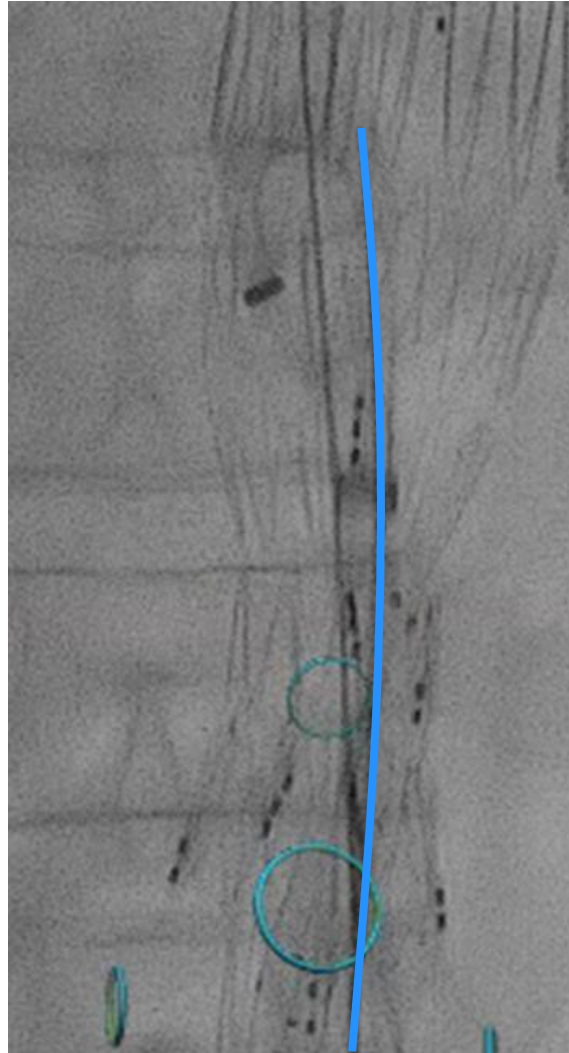
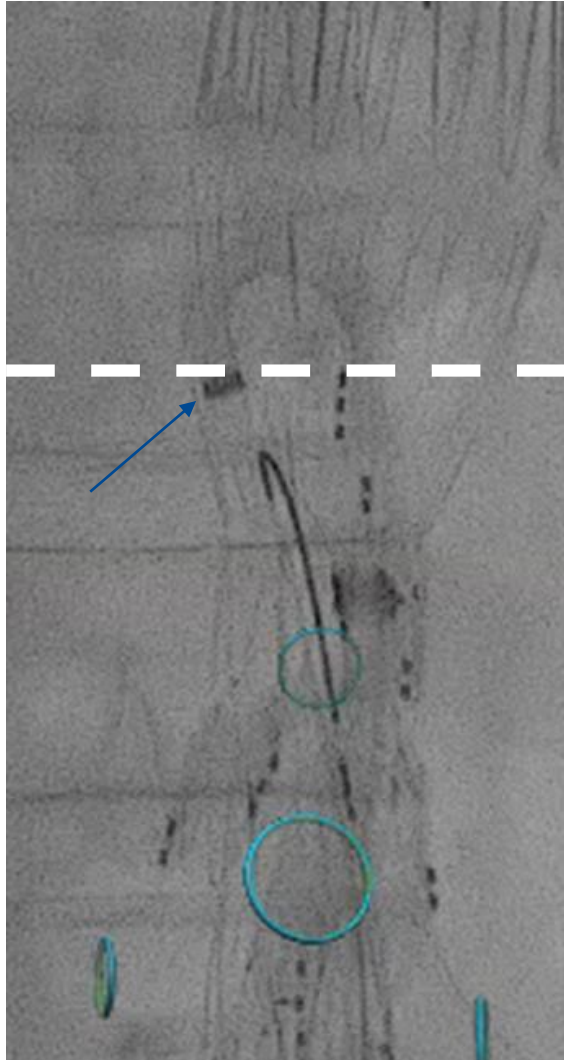
Vessel Catheterization



BSG Delivery

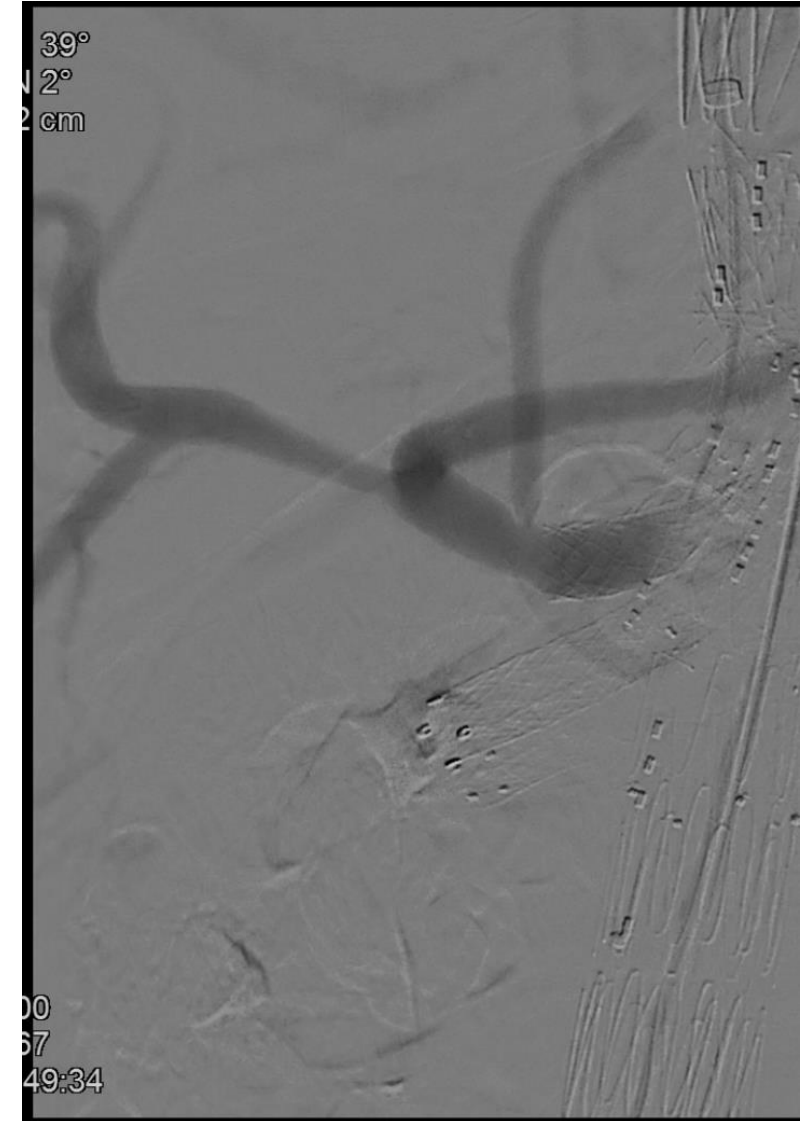
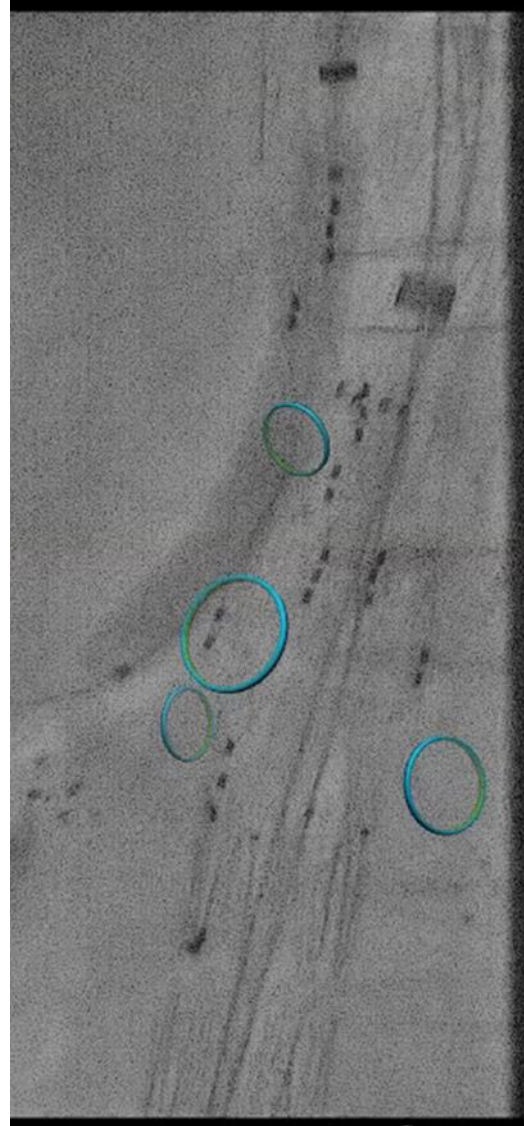




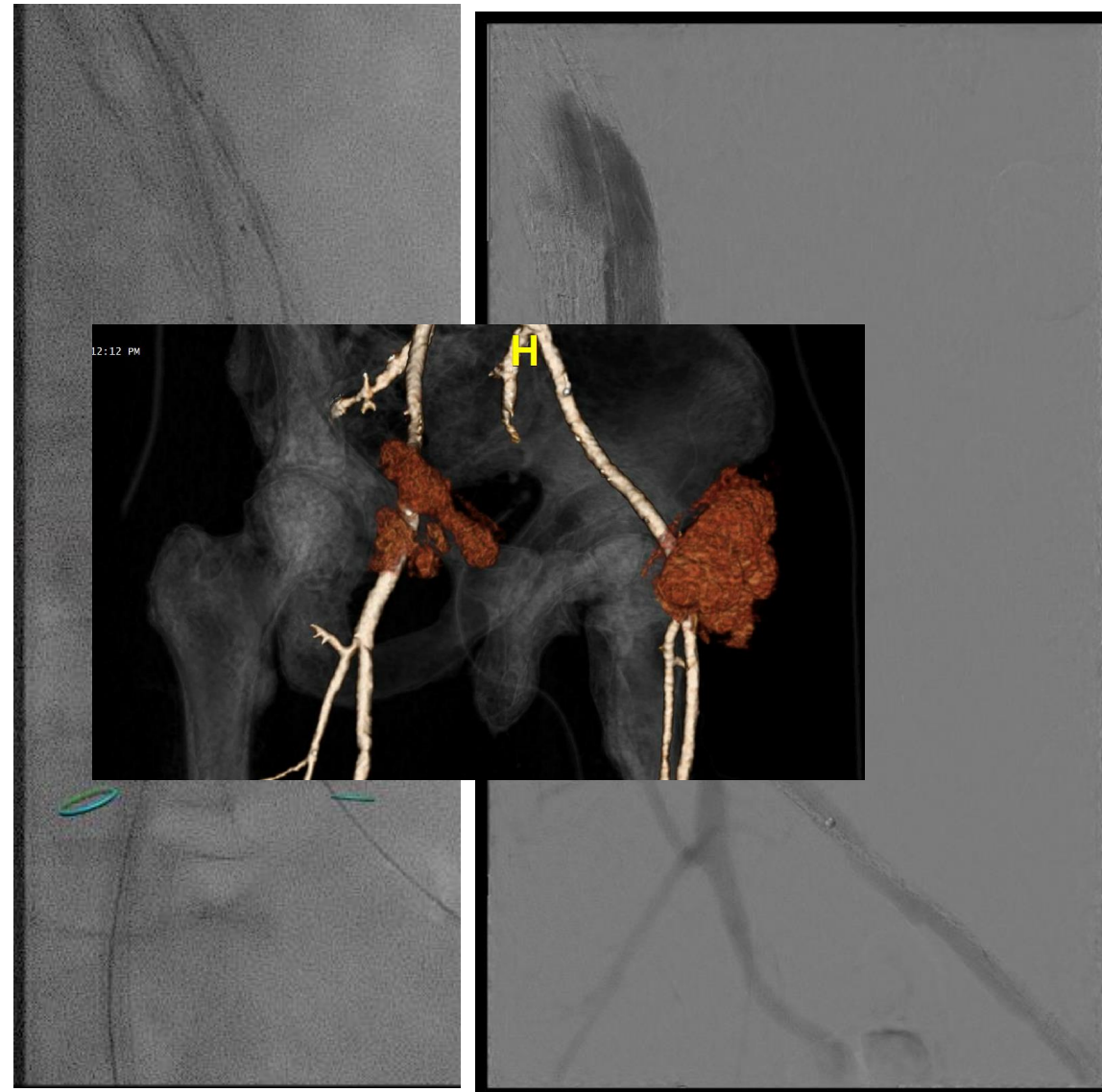


Additional reversed Lunderquistwire
to increase the stiffness of the system and gain some cm

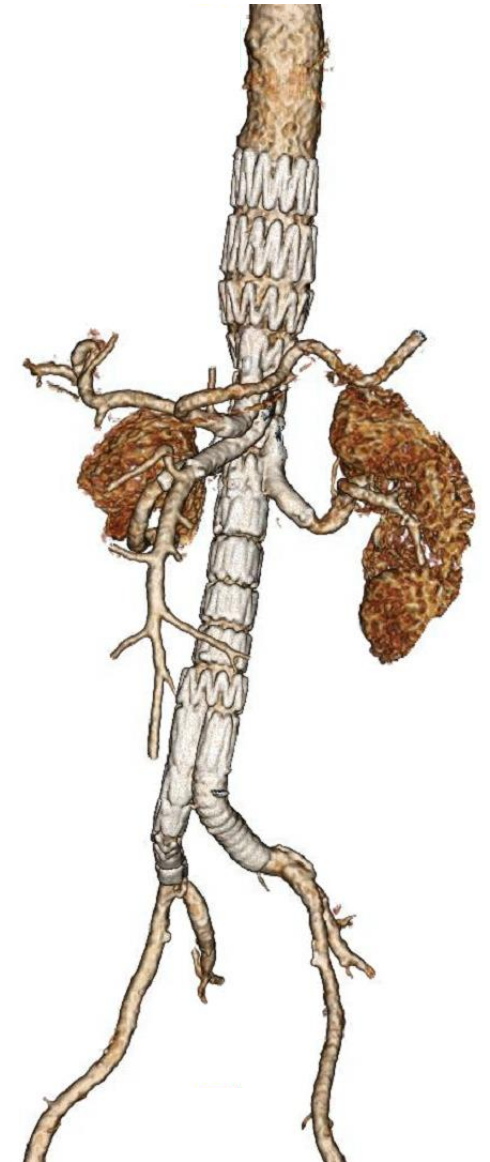
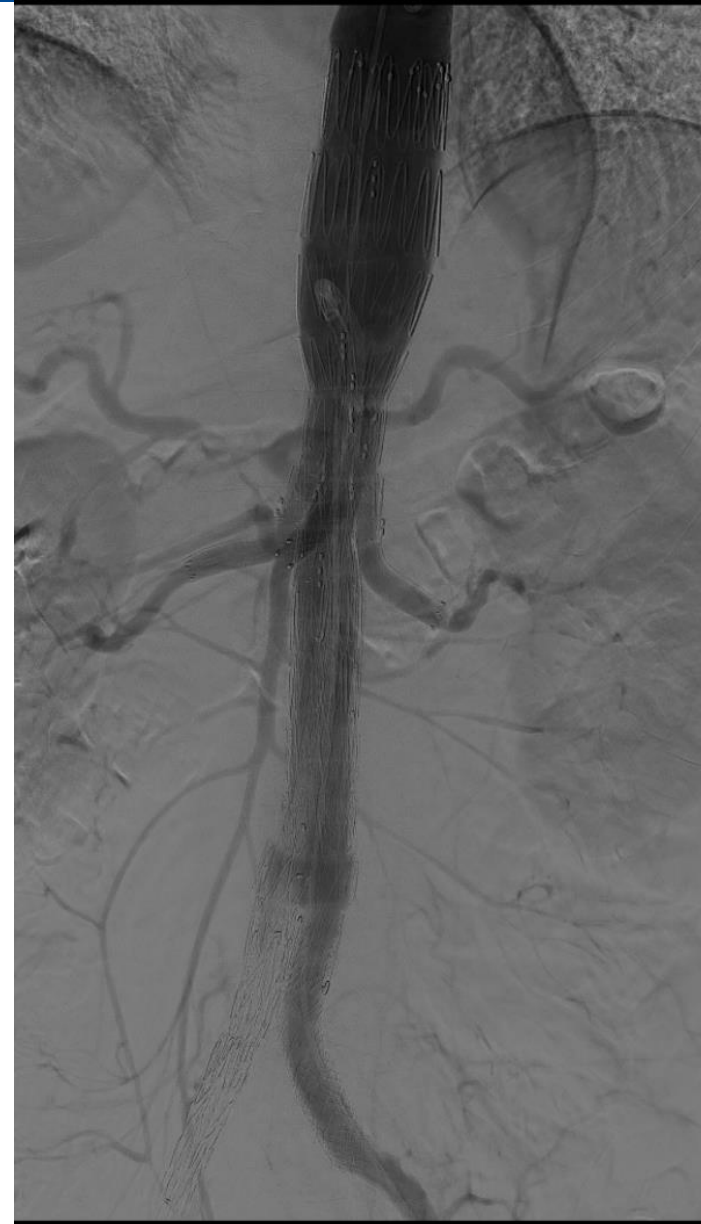
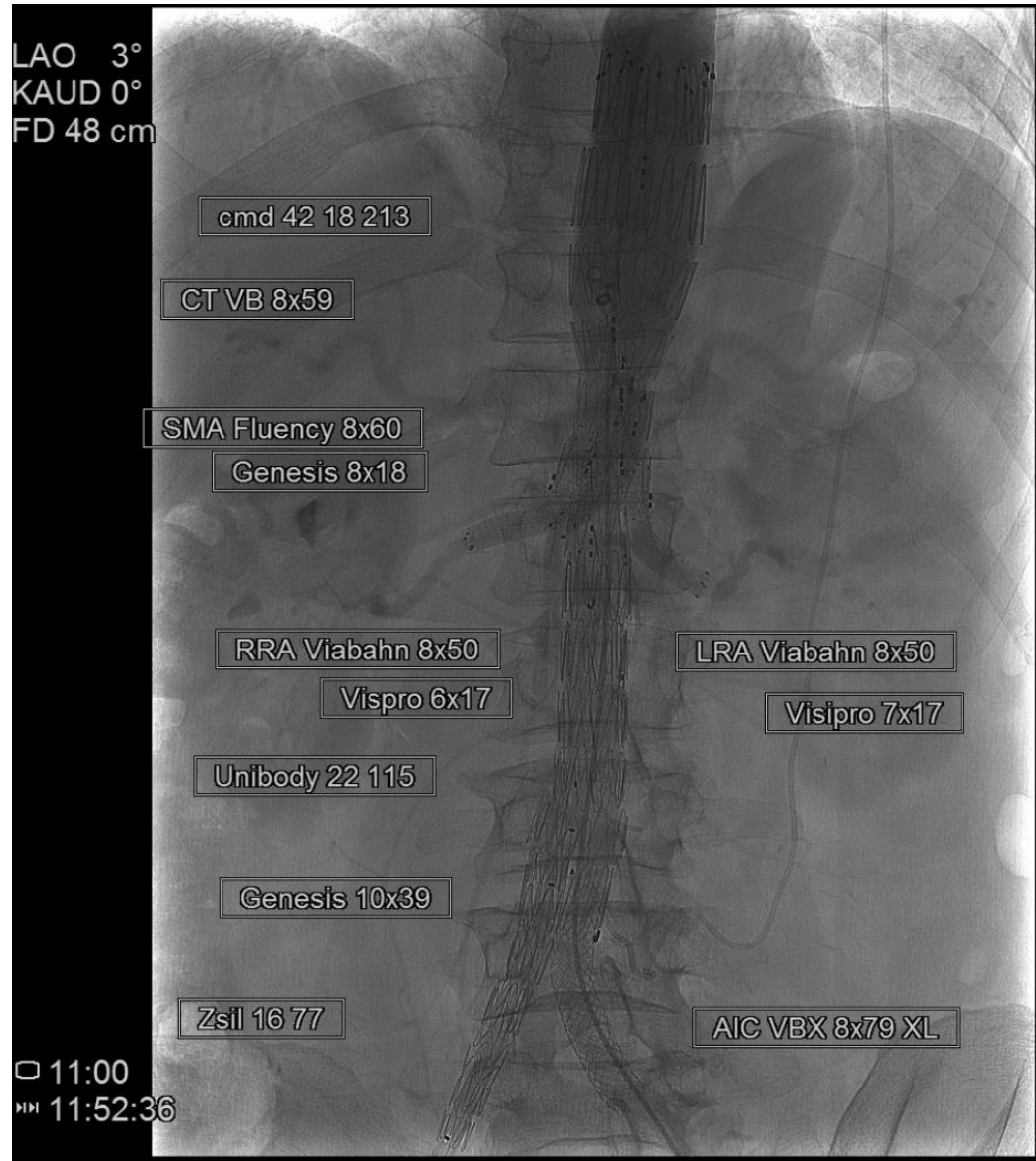




Contralateral Limb

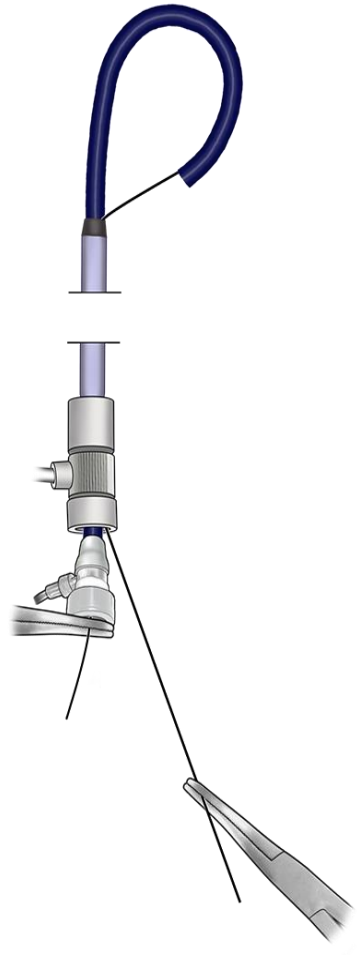


Final Result

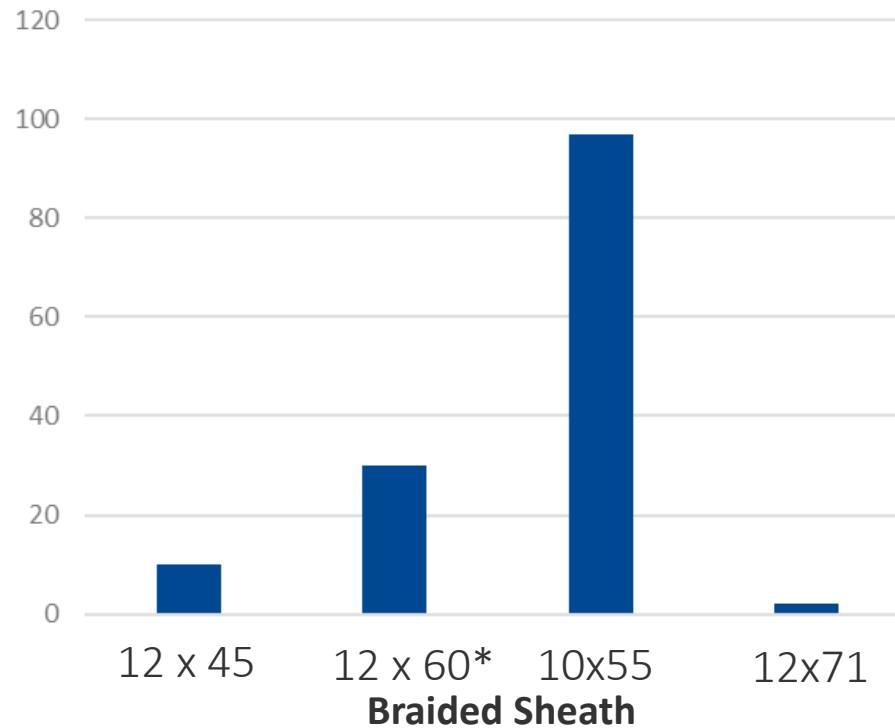


Conclusions

A transfemoral approach with steerable sheath & stabilization wire is routinely used in our center



N=140 Procedures



*modified by shortening a 80 cm sheath

N=442 BSGs

