



Acute type B dissection

When do we intervene - 14 days? 3 months?

E. Gallitto MD, PhD, FEBVS

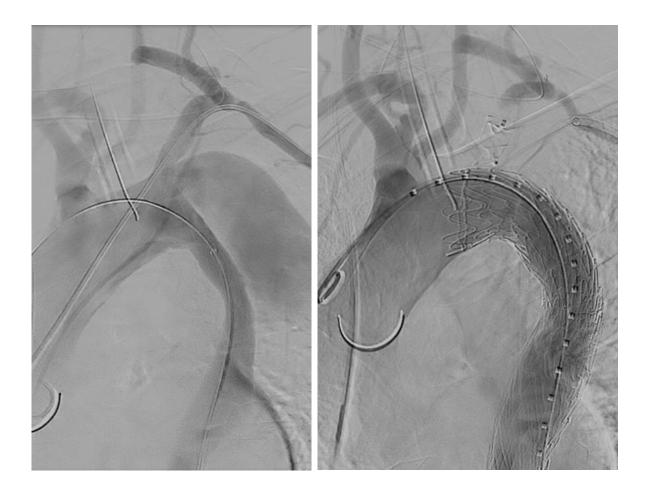


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The rational of Intervention for acute TBAD

- 1. Cover the proximal entry tear
- 2. Redirect aortic flow toward the True L

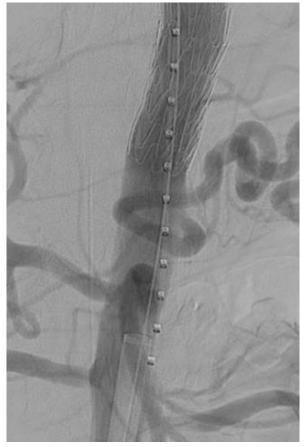


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The rational of Intervention for acute TBAD

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- 3. Reduce blood pressure / perfusion within the False L



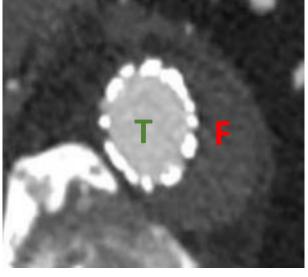


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The rational of Intervention for acute TBAD

- 1. Cover the proximal entry tear
- 2. Redirect aortic flow toward the True L
- 3. Reduce blood pressure / perfusion within the False L
- 4. False L thrombosis, aortic remodeling, aortic wall stabilization





Clinical presentation - implication for pts management & outcomes

√ Complicated

Rupture, malperfusion, stroke/SCI, rapid enlargement

✓ Uncomplicated

No evidence of rupture or end-organ malperfusion

Clinical presentation - implication for pts management & outcomes

- ✓ @ High-risk of subsequent complications
- 1. Refractory pain or hypertension (> 12 h) / readmission
- 2. Aortic diameter > 40 mm
- 3. Primary entry tear > 1 cm
- 4. Entry tear location in the inner curve (vs outer curve)
- 5. False lumen diameter > 22 mm
- 6. Certain radiographic findings of bloody effusion
- 7. Radiographic but not clinically apparent malperfusion





Chronicity classification - implication for pts management & outcomes

	Time from onset of symptoms
Hyperacute	< 24 hours
Acute	1 - 14 days
Subacute	15 - 90 days
Chronic	> 90 days

When do we intervene?





0 days 14 days 3 months

International guidelines / reporting standard

✓ ESVS 2017 Riambau et al, EJVS 2017

✓ SVS / STS 2020 Lombardi et al, JVS 2020

✓ ESC / EIPA / EACTS 2020 Czerny et al, EJCTS 2020







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When do we intervene?



Complicated TBAD

Class I - Level C

Symptoms onset

Uncomplicated TBAD - selectively considered to prevent aortic complication Class I - Level C



14 days



3 months



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Editor's Choice — Management of Descending Thoracic Aorta Diseases

Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS)



Recommendation 16	Class	Level of evidence
In patients with complicated acute type B aortic dissection, endovascular repair with thoracic endografting should be the first line intervention	I	С
Recommendation 17		
In complicated acute type B aortic dissection, endovascular fenestration should be considered to treat malperfusion	lla	С
Recommendation 18		
To prevent aortic complications in uncomplicated acute type B aortic dissection, early thoracic endografting may be considered selectively	IIb	В





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Surgical Decision Making in Uncomplicated Type B Aortic Dissection: A Survey of Australian/New Zealand and European Surgeons

Bijit Munshi a,b,f,*, Barry J. Doyle a,c,d,e, Jens C. Ritter f, Shirley Jansen b,g,h,i, Louis P. Parker a,c, Vincent Riambau j, Colin Bicknell k,l, Paul E. Norman a,b,f, Anders Wanhainen m

- ✓ Online Survey 2018
- ✓ Pre-emptive TEVAR in UTBAD

43% of Surgeons



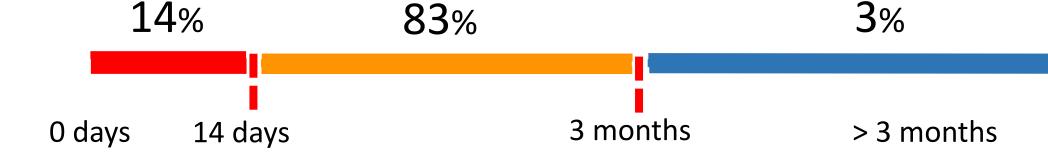
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CRITICAL ISSUES

IN AORTIC ENDOGRAFTING



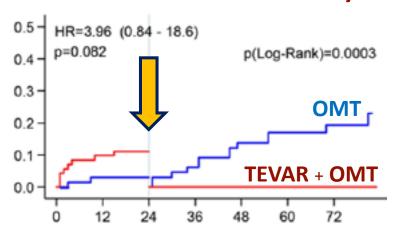
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Endovascular Repair of Type B Aortic Dissection Long-term Results of the Randomized Investigation of Stent Grafts in Aortic Dissection Trial

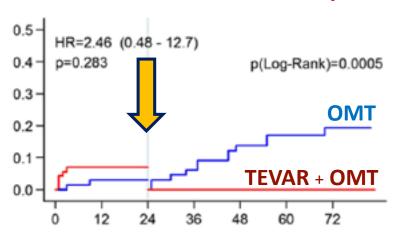
Christoph A. Nienaber, MD, PhD; Stephan Kische, MD; Hervé Rousseau, MD, PhD; Holger Eggebrecht, MD; Tim C. Rehders, MD; Guenther Kundt, MD, PhD; Aenne Glass, MA; Dierk Scheinert, MD, PhD; Martin Czerny, MD, PhD; Tilo Kleinfeldt, MD; Burkhart Zipfel, MD; Louis Labrousse, MD; Rossella Fattori, MD, PhD; Hüseyin Ince, MD, PhD; for the INSTEAD-XL trial

TEVAR for uncomplicated TBAD

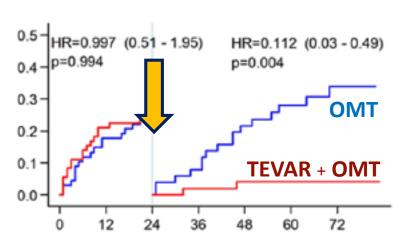
Overall mortality



Aortic mortality



Adverse events

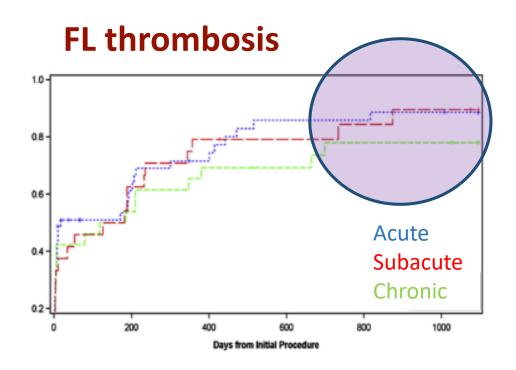


In stable type B dissection with suitable anatomy
Pre-emptive TEVAR should be considered to improve late outcomes

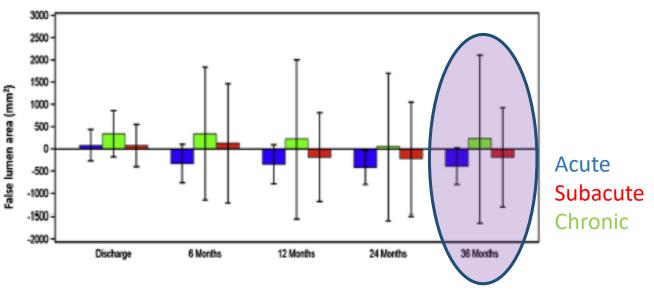
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Mid-term Outcomes and Aortic Remodelling After Thoracic Endovascular Repair for Acute, Subacute, and Chronic Aortic Dissection: The VIRTUE Registry

The VIRTUE Registry Investigators *



Change in FL area



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Mid-term Outcomes and Aortic Remodelling After Thoracic Endovascular Repair for Acute, Subacute, and Chronic Aortic Dissection: The VIRTUE Registry

The VIRTUE Registry Investigators *

✓ Subacute TBAD similar aortic remodeling to patients with acute TBAD



✓ Lower risk of damage to the acutely vulnerable/fragile/inflamed aorta by stentgraft Acute Subacute Chronic



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TEVAR complications in TBAD

	Acute TBAD %	Non acute TBAD %
Retrograde type A dissection	0.5 - 1.6	0 - 1.5
Stroke	0.5 - 6.0	0 - 1.5
SCI	0 - 3.4	2.9 - 4.5
30-day mortality	0.5 - 7.1	0 - 4.5





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EDITORIAL

Looking for the Holy Grail in Acute/Subacute Type B Dissection

To prevent further aortic complications (50% of cases)

√ '(Over)treatment' of these patients by TEVAR
may only mean operative risk without later benefit





THE 24TH INTERNATIONAL EXPERTS SYMPOSIUM IN AORTIC ENDOGRAFTING

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2021

Eur J Vasc Endovasc Surg (2021) 61, 788-797

Timing and Outcome of Endovascular Repair for Uncomplicated Type B **Aortic Dissection**

Enmin Xie 🚧, Fan Yang V, Yuan Liu Y, Ling Xue Y, Ruisin Fan Y, Nianjin Xie Y, Lyufan Chen Y, Jitao Liu Y, Janfang Luo "A"

Department of Controling Variation Codes, Guargining Continues late Institute, Gaugeting Provided Rey Literatury of Control yields Classificate (Institute Codes), See Section 1997 (Institute Codes), Codes (Institute Codes), Cod

267 cases

Thoracic endous scular aertic repair (TEVAR) can be used in uncomplicated type B aertic dissection (uTBAD) to improve long term outcomes, but the impact of intervention timing remains unclear. The present study found no significant difference in early or its outcomes between acute (1–14 days) and subsecute (15–90 days) groups. Although not statistically significant, 30 day mortality in the acute group was five times higher, and acrtic rupture, retrograde type A dissection, and disabiling stroke were observed only in the acute group. These results suggest caution in endowscular repair for utility Department of the acute phase.

endovascular aortic repair (TEVAR), on early and late outcomes in high risk patien B portic dissection (uTBAD).

Methods: The study retrospectively evaluated 257 uTBAD patients with high risk underwent pre-emptive TEVAR during the acute and subacute periods. Demogra operative imaging features, peri-procedural details, and follow up outcomes were as Results: Among the 267 pre-emptive TEVARs for high risk utRAO, 130 were performed skeys; and 137 in the subsource phase (15–90 days), from initial presentation. The years and 222 (83.1%) were men. The 30 day mortality rate in the acute group v that in the subacute group (3.8% vs. 0.7%), although without statistically signistatistically significant difference in 30 day outcomes (aortic rupture, retrograde immediate type la endoleak, stroke, spinal cord ischaemia, and re-intervention) wa Of note, aortic rupture, RTAD, and disabling stroke were observed only in the logistic analyses showed that intervention timing was not associated with 30 d clinical follow up was 482 \pm 25.9 months (range 1 - 306 months). There were rall cause mortality, dissection related death, late intervention, or acritic related cohorts (p > .05 for each). Furthermore, portic remodelling, by analysing the flo and evaluation of aortic diameters, either at the thoracic aorta level or the abdo

Conclusion: The present study indicates that TEVAR for high risk uTBAD in the acute

Keywords: Endowascular treatment, Outcome, Timing, Uncomplicated type B acrtic dissocion Article history: Residved 6 Janes 2009, Amepord 19 February 2021, Available calines 10 April 2022 C 2021 Encomes Society of Variaties Coursey, Published by Elevier EV, All circles reserved.

*Bonsh Xe and Be Yang contributed equalty to bits work.

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Goungston, Goungston, Goungston, Clayson Park 18 product of China.

Thoracic endous

esvs Vascular & Endovascular Surgery (cTBAD).1,2 For uncomplicated type B acrtic dissection

Timing of endovascular repair impacts long-term outcomes of uncomplicated acute type B aortic dissection

Dongqiao Xiang, MD,^{Ab} Felhong Wu, MD,^{Ab} Lei Chen, MD,^{Ab} Hulmin Liang, PhD,^{Ab} Bin Xiong, PhD,^{Ab} Bin Liang, PhD, Ab Fan Yang, PhD, Ab and Chuarsheng Zheng, PhD, Ab Wuhen, Chine

Objective: To compare the 5-year outcomes of acute versus subacute thoracic endovacular acrtic repa patients with uncomplicated acute type B sortic dissection (ATBAD) Methods: Between March 2008 and September 2018, 258 consecutive patients with uncon

EVAR in the acute or subscute phase and were analyzed retrospectively. The primary end points were all In the action of subsections probe error were anneyed incorporately, the primary and ports were any and audio-cellulad death. The secondary and ports were all composed of the outcomes of death from any calculation, new disastion, netrograde type A sortic disastiction, end death and allow an intervention. Invaries probability treatment weighting were used to belience beautiful characteristics. Weighting death and exist in the secondary and weighting the secondary of the secondary and weighting the secondary of the secondary and weighting the secondary of the sec

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significant interaction between treatment effect and time ($P_{\rm totalion} = .00$), v composite outcomes in the acute TEVAR group compared with the subscute Ci, 0.080.79; P = .02], and a companion rate between 1 and 5 years (HR, 125 Condusions: At the 5-year followup, no significant differences exist in the between acute and subscute TEVAN. However, acute TEVAR is associated cations within 1 year, which suggests that performing TEVAR in the subscu option. (2 Vacc Surg 2021a; 3-30.)

Acute type B aortic dissection (ATBAD) is a potentially life-threatening condition, but the advent of thorado endowscular acrtic repair (TEVAR) has provided a novel tony, with a treatment strategy? Currently, the first-line therapoutic option in patients with complicated ATBAD is TEVAR,344 whereas uncomplicated ATBAD is best medical

From the Department of Radiology, Union Hospital, Tongli Medical College, Huarhong University of Science and Technology⁴, and the Hubel Pitwince Key Laboratory of Molecular Imaging.^b BY and CZ contributed equally acco-corresponding authors.

Additional material for this article may be found online at www.juescaurg.org. Correspondence. Fan Yang, PhD, Chuansheng Zheng, PhD, Department of Radiology Union Hospital, Tongil Medical College, Husehong University of Science and Technology, Wuhan 400.2, China je-mali fyang@hust.edu.cr

JVS Vascular Surgery New Society for Vescular Surgery Reporting sion at 4 ye Nonetheles the treatme of Stent Cra

238 cases

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From the Society for Vascular Surgery

Timing of thoracic endovascular aortic repair for uncomplicated acute type B agrtic dissection and the association with complications

Daniel J. Torrent, M.D., MPH, Graeme E. McFarland, M.D., Grace Wang, M.D., MSCE, Mahmoud Malas, MD, MHS, Benjamin J. Pearce, MD, Victoria Aucoin, MD, Dan Neai, MS, Emily L. Spangier, MD, Zdenek Novak, MD, PhD, Salvatore T. Scali, MD, and Adam W. Beck, MD, PhD, Salvatore T. Scali, MD, and Adam W. Beck, MD, Salvatore T. Scali, MD, and Adam W. Beck, MD, Salvatore T. Scali, MD, and Adam W. Beck, MD, Salvatore T. Scali, MD, and Adam W. Beck, MD, Salvatore T. Scali, MD, Scali, Birminghern Ale Philadelphia, Pe Sen Diego Calif, and Gainesville File

687 cases

SVS Street Service

Objective Devices replications have dearly established a consistion between timing of thoseic and a Objective Previous publications have clearly existable of consistent between timing of thoresic enclosescular sortic respect (TRAPA) and complications share therefore of complicated actual type is bant classication (ATRAPA) between the temporal association of TBAPA with morbidity when uncomplicated presentations is poorly understood and has not predicately been examined using neal-world national data. Therefore, the objective of this analysis was to determine whether TBAPA driving of uncomplicated ATRAPA (INTBAPA) is associated with past operation complications.

Methods: The Neutring is incompanion critical, potential, stated and make the place companion of Methods the Neutrin Qualify Initials INITIAR and compile endouscular annual maps in gisty was analyzed from 2000 to 2008. Procedure performed for non-disection-related disease as well as for ATRAD with malperfusion or repair was excluded. Sease of Inherent of Mercus between thirting cohorts, properly score matching was performed to ensure like companions. University and multivariable analysis after matching was used to determine differences between timing groups (symptom onset to TBVAR acute, 1-14 days, sub hospital complications, and reintervention.

Results: A total of 685 cases meeting inclusion orteria were identified. day and 15- to 90-day treatment groups, there were no statistically signanslysis, the 1- to 14-day treatment group had a higher proportion of or compared with UATBAD patients undergoing TEVAR within 15 to 90 o 007) at 1 year, with 33.8% of the 1- to 14-d ay UATBAD patients undergo to 90-day group. There were no statistically significant differen complications, or long-term reintervention. There was a twind tows having 23 times the odds of requiring an In-hospital reintervention Conclusions: Timing of TEVAR for UATBAD does not appear to on ever, there is a strong association between repair within 1 to 14 days a related to the 1- to 14 day group's representing an inherently higher a

Thoracic endovescular acrtic repair (TEVAR) of complicated acute type B aortic dissection (ATBAD) is well medic accepted; however, its role in patients with an uncompil- aorta-r cated presentation remains controversial. The most domin

From the Division of Vaccular Surgery and Endovercular Therapy, University of Alabama as ill minigham, ill minigham^{*}, the Division of Vaccular Surgery and Endovaccular Therapy, Hospital of the University of Pennsylvania, Philadelphiaⁿ) the DM sion of Vaccular and Endowacular Surgery, Univently of Cal-Ib mis San Diego, San Diego^a, and the Division of Vaccular Surgery and

JVS Vascular Surgery New Society for Vescular Surgery Reporting be entirely accounted for with propersity analysis. The role of optima future study design of TEVAR trials for UATBAD. () Vasc Surg 2021/75 Keywords: Acrtic; Dissection; Timing: Type B; Endowsculer, Uncor frequently cited rationale for TEVAR during the early ation,

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	@ 30-day	Acute TBAD %	Subacute TBAD %	р
\checkmark	Death	3.8	0.7	.11
\checkmark	Aortic rupture	1.5	0	.24
\checkmark	Retrograde type A dissection	0.8	0	.49
\checkmark	Disabling stroke	0.8	0	.49
	Minor stroke	1.5	0.7	.61
	SCI	0.8	2.2	.62
	Reinterventions	0.8	0.7	1.0



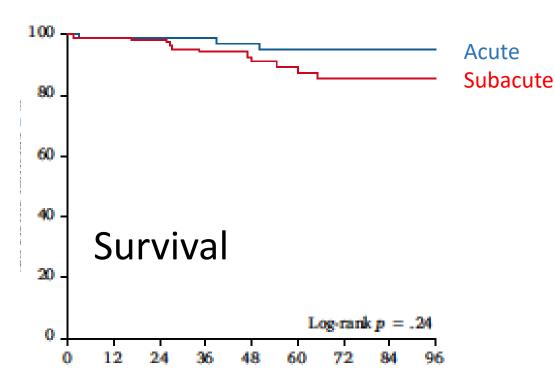
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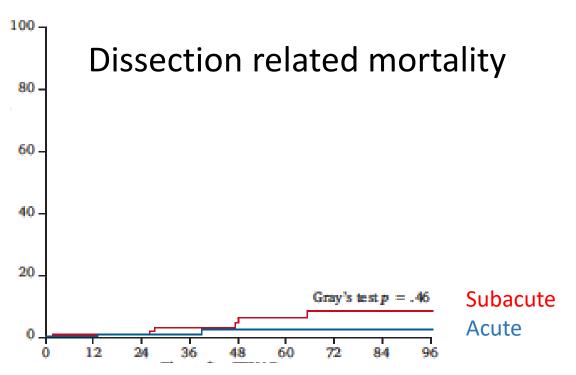
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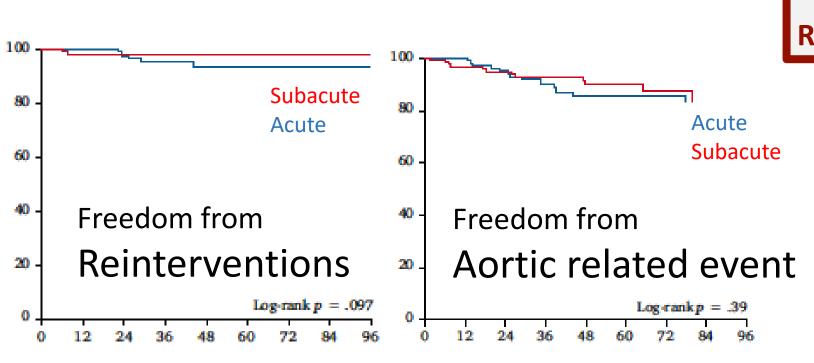
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Aartic Re

Aortic	Acute	Subacute	P
modeling	intervention $(n = 120)$	intervention $(n = 133)$	value
Thoracic aorta			
Maximum diameter	36.4 ± 8.6	37.8 ± 8.0	.31
of aorta — mm			
False lumen status			.79
Partially	10 (9.3)	12 (10.4)	
thrombosed			
Completely	97 (90.7)	103 (89.6)	
thrombosed			
Abdominal aorta			
Maximum aortic	32.7 ± 8.3	34.1 ± 7.9	.19
diameter – mm			
False lumen status			.61
Patent	22 (20.6)	21 (18.3)	
Partially	35 (32.7)	47 (40.9)	
thrombosed			
Completely	30 (28.0)	26 (22.6)	
thrombosed			
Normal	20 (18.7)	21 (18.3)	

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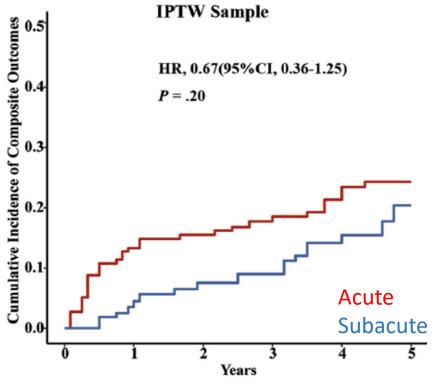
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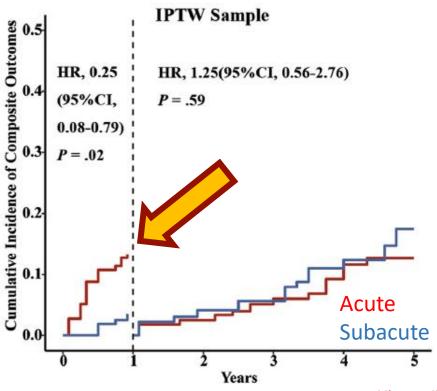
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@ 1-year Composite Endpoints

- ✓ Death
- ✓ Rupture
- ✓ RTA dissection
- ✓ New dissection
- ✓ Endoleak
- ✓ Late reinterventions







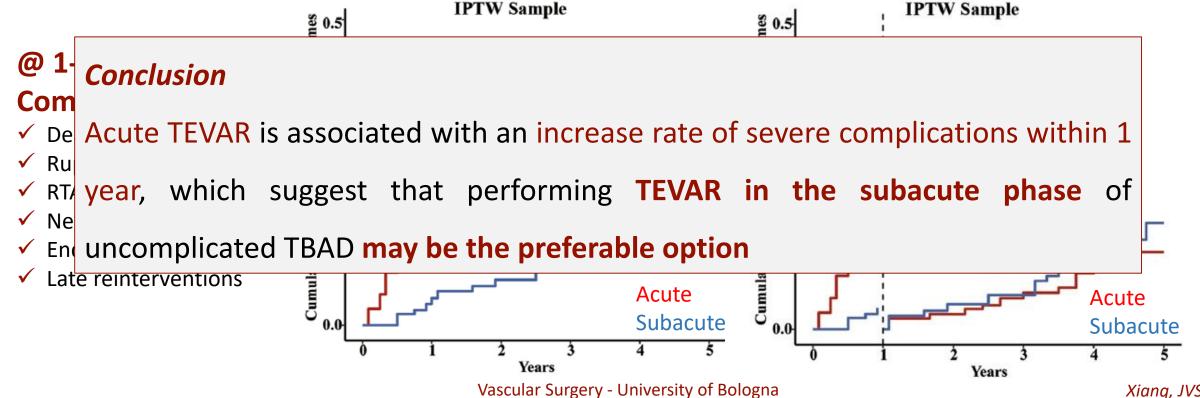
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VQI TEVAR Registry



	Acute TBAD %	Subacute TBAD %	р
Mortality @ 30-day	5.4	3.5	.40
Reinterventions @ 30-day	15.3	5.2	.02
Mortality @ 1-year	12.4	9.9	.50
Reinterventions@ 1-year	33.8	14.5	.007
Any complication	24.1	17.6	.10

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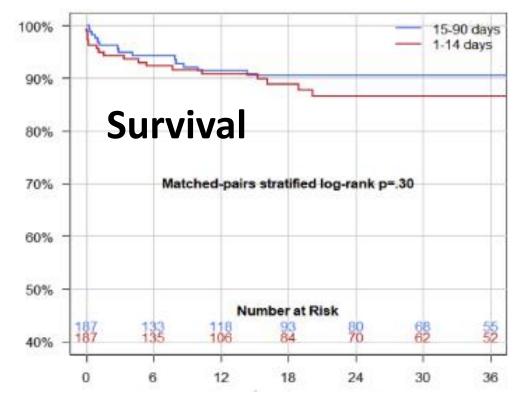
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VQI TEVAR Registry





Outcome	OR or HR (95% CI)	P value	
Long-term survival	HR = 1.4 (0.780-2.34)	.282	
Any complication	OR = 1.5 (0.882-2.44)	.140	
In-hospital reintervention	OR = 2.3 (0.909-5.71)	.080	
Long-term reintervention	HR = 1.5 (0.915-2.51)	.106	
CI, Confidence interval; HR, hazard ratio; OR, odds ratio.			

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ESVS 2021

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Randomized Trials



to evaluate the role of optimal TEVAR timing



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CRITICAL ISSUES

POSITION STATEMENT

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DECEMBER 17ε 18 2021

IN AORTIC ENDOGRAFTING

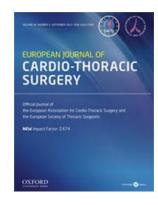
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Current options and recommendations for the use of thoracic endovascular aortic repair in acute and chronic thoracic aortic disease: an expert consensus document of the European Society for Cardiology (ESC) Working Group of Cardiovascular Surgery, the ESC Working Group on Aorta and Peripheral Vascular Diseases, the European Association of Percutaneous Cardiovascular Interventions (EAPCI) of the ESC and the European Association for Cardio-Thoracic Surgery (EACTS)

POSITION STATEMENT



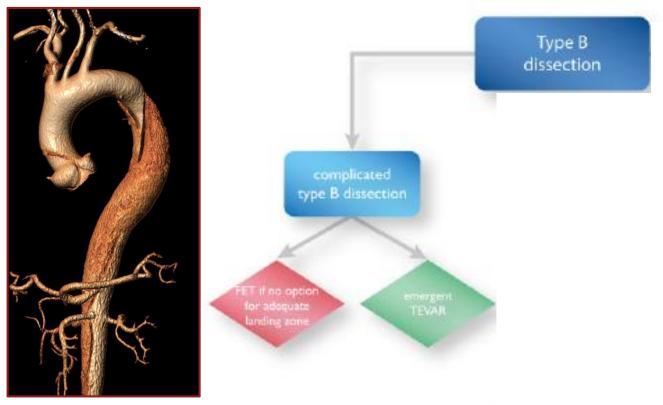
- ✓ TEVAR in acute complicated type B dissection
- ✓ TEVAR in high risk uncomplicated type B dissection

Primary entry tear at inner curvature

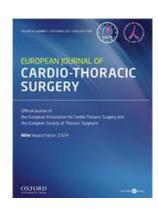
Primary entry tear > 10 mm

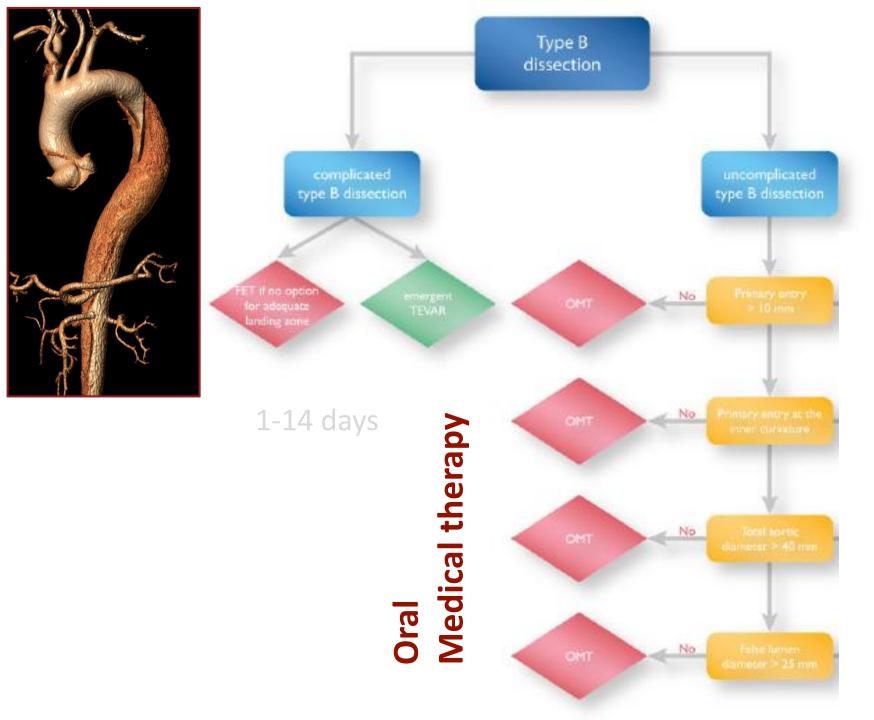
False lumen diameter > 25 mm

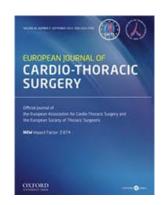
Aortic diameter > 40 mm

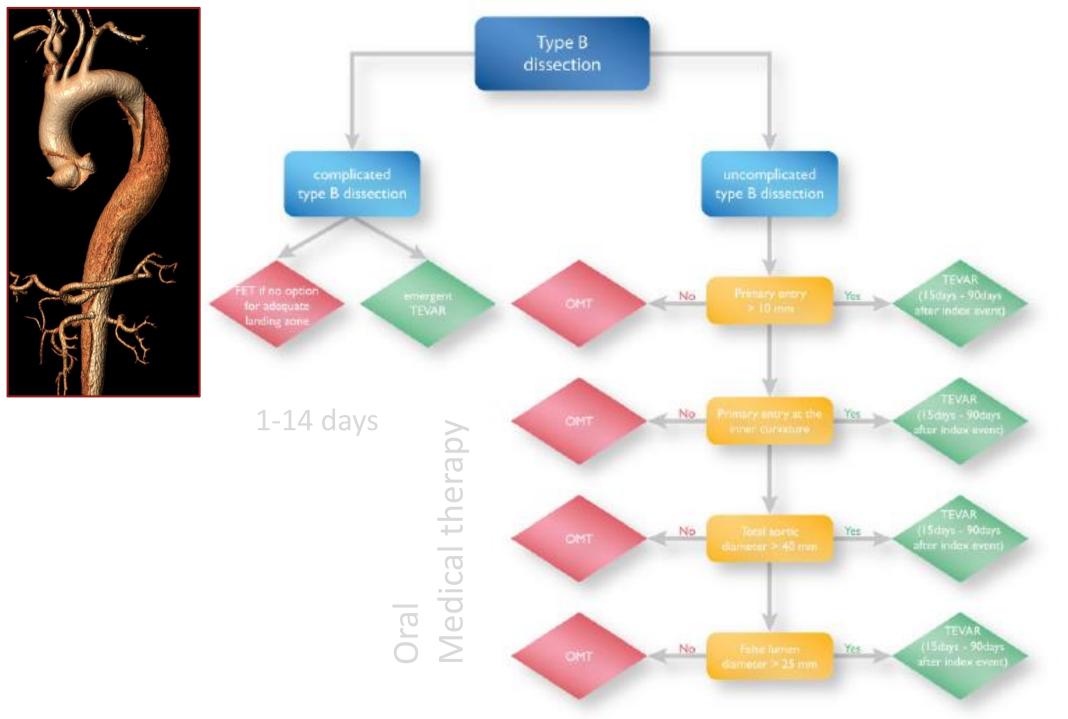


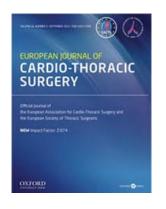
1-14 days











TEVAR 15 days - 3 months



When do we intervene?

Complicated TBAD

- Rupture
- Malperfusion
- Refractory pain / HPT
- Rapid enlargement

Uncomplicated TBAD

- High risk radiological features
- Symptoms recrudescence
- Readmission

if anatomically feasibility

0 days

14 days

3 months

Conclusion - When do intervene?

- 1. Conservative medical therapy for uncomplicated cases arterial pression and pain control
- 2. Urgent / Emergent TEVAR for complicated cases < 14 days + endovascular fenestrations, TVVs spot stenting, adjunctive advanced procedure
- 3. TEVAR between 15 90 days for acute uncomplicated type B aortic dissection at high risk





Conclusion - When do intervene?

4. TEVAR for UTBAD in presence of anatomical feasibility

proximal sealing zone \geq 25 mm (healthy aorta)

oversize 10 %

dedicated device

LSA revascularization

CSF-drainage if extensive coverage