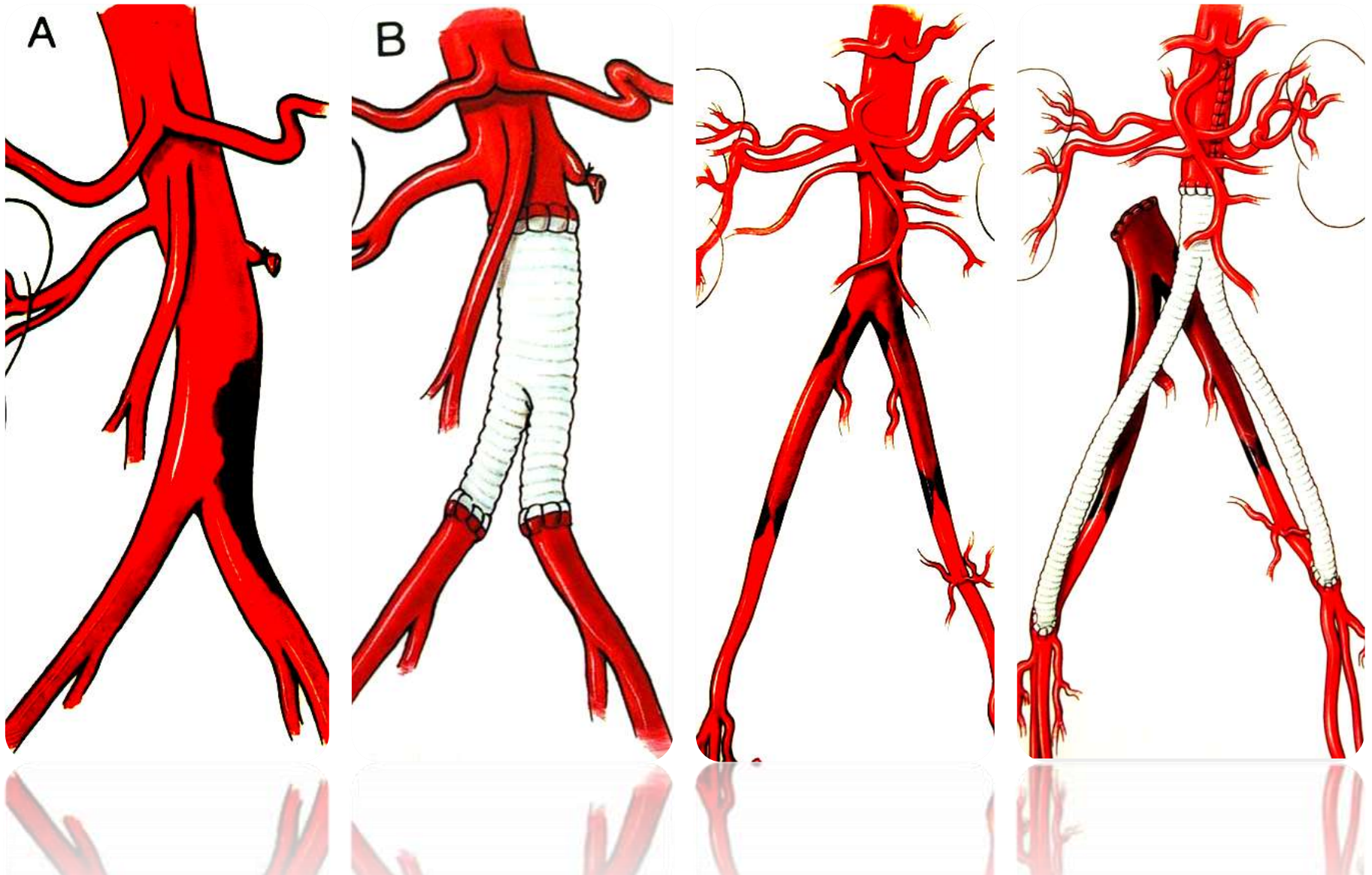
Tratamiento Endovascular de la Oclusión Aortica

Dr. Martín Rabellino
Jefe del Servicio de Diagnóstico por Imágenes
Hospital Italiano de Buenos Aires

Opciones Quirúrgicas



Eur J Vasc Endovasc Surg. 2010 Apr;39(4):460-71. doi: 10.1016/j.ejvs.2009.12.014. Epub 2010 Mar 20.

Review of direct anatomical open surgical management of atherosclerotic aorto-iliac occlusive disease.

Chiu KW, Davies RS, Nightingale PG, Bradbury AW, Adam DJ.

University of Birmingham, Department of Vascular Surgery, Heart of England NHS Foundation Trust, Netherwood House, Solihull Hospital, Birmingham, UK.

29 estudios 5738 pacientes

	Mort	Morbi	Per 5 a
•By pass aorto-femoral	4.1%	16%	86.5%
•By pass ilio-femoral	2.7%	18.9%	85.3%
•Endarterectomia aortoiliaca	2.7%	12.7%	88.3%

Eur J Vasc Endovasc Surg (2024) 67, 9–96

EJVES Open Access

CLINICAL PRACTICE GUIDELINE DOCUMENT

Editor's Choice – European Society for Vascular Surgery (ESVS) 2024 Clinical Practice Guidelines on the Management of Asymptomatic Lower Limb Peripheral Arterial Disease and Intermittent Claudication☆

Joakim Nordanstig [*,a], Christian-Alexander Behrendt [a], Iris Baumgartner [a], Jill Belch [a], Maria Bäck [a], Robert Fitridge [a], Robert Hinchliffe [a], Anne Lejay [a], Joseph L. Mills [a], Ulrich Rother [a], Birgitta Sigvant [a], Konstantinos Spanos [a], Zoltán Szeberin [a], Willemien van de Water [a]

ESVS Guidelines Committee [b], George A. Antoniou, Martin Björck, Frederico Bastos Gonçalves, Raphael Coscas, Nuno V. Dias, Isabelle Van Herzeele, Sandro Lepidi, Barend M.E. Mees, Timothy A. Resch, Jean-Baptiste Ricco, Santi Trimarchi, Christopher P. Twine, Riikka Tulamo, Anders Wanhainen

Document Reviewers [c], Jonathan R. Boyle, Marianne Brodmann, Alan Dardik, Florian Dick, Yann Goëffic, Andrew Holden, Stavros K. Kakkos, Phillipe Kolh, Mary M. McDermott

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☆ For full list of authors' affiliations, please refer to Appendix B.

[a] **Writing Committee:** Joakim Nordanstig (Chair; Gothenburg, Sweden), Christian-Alexander Behrendt (Co-chair; Hamburg, Germany), Iris Baumgartner (Bern, Switzerland), Jill J. F. Belch (Dundee, UK), Maria Bäck (Gothenburg and Linköping, Sweden), Robert Fitridge (Adelaide, Australia), Robert J. Hinchliffe (Bristol, UK), Anne Lejay (Strasbourg, France), Joseph L. Mills (Houston, TX, USA), Ulrich Rother (Erlangen, Germany), Birgitta Sigvant (Örebro and Uppsala, Sweden), Konstantinos Spanos, (Larissa, Greece), Zoltán Szeberin (Budapest, Hungary), Willemien van de Water (Maastricht, The Netherlands).

[b] **ESVS Guideline Committee:** George A. Antoniou (Manchester, UK), Martin Björck (Uppsala, Sweden), Frederico Bastos Gonçalves (Review Coordinator; Lisbon, Portugal), Raphael Coscas (Boulogne-Billancourt and Gif-sur-Yvette, France), Nuno V. Dias (Malmö, Sweden), Isabelle Van Herzeele (Ghent, Belgium), Sandro Lepidi (Trieste, Italy), Barend M. E. Mees (Maastricht, The Netherlands), Timothy A. Resch (Copenhagen, Denmark), Jean-Baptiste Ricco (Poitiers, France), Santi Trimarchi (Milan, Italy), Christopher P. Twine (Bristol, UK), Riikka Tulamo (Helsinki, Finland), Anders Wanhainen (Uppsala, Sweden).

[c] **Document Reviewers:** Jonathan R. Boyle (Cambridge, UK), Marianne Brodmann (Graz, Austria), Alan Dardik (New Haven, CT, USA), Florian Dick (St. Gallen and Bern, Switzerland), Yann Goëffic (Paris, France), Andrew Holden (Auckland, New Zealand), Stavros K. Kakkos (Patras, Greece), Phillipe Kolh (Liège, Belgium), Mary M. McDermott (Chicago, IL, USA).

* Corresponding author
E-mail address: joakim.nordanstig@vgregion.se (Joakim Nordanstig).

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https://doi.org/10.1016/j.ejvs.2023.08.067

Recommendation 58

For patients with disabling intermittent claudication undergoing revascularisation who are considered as low risk with long life expectancy, open surgery may be considered for Trans-Atlantic Inter-Society Consensus Document II C/D lesions that include the iliac arteries as well as the aorta up to the renal arteries, due to favourable primary and secondary patency rates compared with endovascular approaches.

Class	Level	References	ToE
IIb	B	Salem *et al.* (2021)[536] Premaratne *et al.* (2020)[537] Indes *et al.* (2013)[538] Starodubtsev *et al.* (2022)[539]	

Permeabilidad

	Per 5 a
•By pass aorto-femoral	86%
•By pass ilio-femoral	85%
•Endarterectomia aortoiliaca	88%
•CERAB	77/88/95% 85/94/97%

J Endovasc Ther. 2023 Apr 28:15266028231166539. doi: 10.1177/15266028231166539. Online ahead of print.

Long-Term Outcomes of the Covered Endovascular Reconstruction of the Aortic Bifurcation (CERAB) Technique in Patients With Aorto-Iliac Occlusive Disease

Kaj B Rouwenhorst [1], Omar M A Abdelbaqy [1,2], Daphne van der Veen [1], Rianne E van Rijswijk [1,3], Suzanne Holewijn [1], Michel M P J Reijnen [1,3]

Affiliations + expand

PMID: 37114939 DOI: 10.1177/15266028231166539

Abstract

Background: The Covered Endovascular Reconstruction of the Aortic Bifurcation (CERAB) reconstruction is an endovascular technique, developed to reconstruct the aortic bifurcation in the most optimal anatomical and physiological manner. Short-term data were promising, but long-term data are still lacking. The objective was to report the long-term outcomes of CERAB for extensive aorto-iliac occlusive disease and to identify predictors for loss of primary patency.

Methods: Consecutive electively treated patients with CERAB for aorto-iliac occlusive disease in a single hospital were identified and analyzed. Baseline and procedural data and follow-up were collected at 6-weeks, 6 months, 12 months, and annually thereafter. Technical success, procedural, and 30-day complications were evaluated, as well as overall survival. Patency and freedom from target lesion revascularization rates were analyzed using Kaplan Meier curves. Uni- and multivariate analysis were performed to identify possible predictors of failure.

Results: One hundred and sixty patients were included (79 male). Indication for treatment was intermittent claudication for 121 patients (75.6%) and 133 patients (83.1%) had a TASC-II D lesion. Technical success was obtained in 95.6% of patients and the 30-day mortality rate was 1.3%. The 5-year primary, primary-assisted, and secondary patency rates were 77.5%, 88.1%, and 95.0%, respectively, with a freedom-from clinically driven target lesion revascularization (CD-TLR) rate of 84.4%. The strongest predictor of loss of primary patency of CERAB was a previous aorto-iliac intervention (odds ratio [OR]=5.36 (95% confidence interval [CI]: 1.30; 22.07), p=0.020). In patients not previously treated in the aorto-iliac tract, 5-year primary, primary assisted, and secondary patency rates were 85.1%, 94.4%, and 96.9%, respectively. At 5-year follow-up, an improved Rutherford was found in 97.9% of patients and the freedom from major amputation rate was 100%.

Conclusion: The CERAB technique is related to good long-term outcomes, particularly in primary cases. In patients that had prior treatment for aorto-iliac occlusive disease, there were more reinterventions and therefore surveillance should likely be more intense.

Clinical impact: The Covered Endovascular Reconstruction of the Aortic Bifurcation (CERAB) reconstruction was designed to improve outcomes of endovascular treatment of extensive aorto-iliac occlusive disease. At 5-year follow-up clinical improvement was found in 97.9% of patients without major amputations. The 5-year overall primary, primary-assisted, and secondary patency rates were 77.5%, 88.1%, and 95.0%, respectively, with a freedom-from clinically driven target lesion revascularization rate of 84.4%. Significantly better patency rates were observed for patients that were never treated before in the target area. The data implicate that CERAB are a valid treatment option for patients with extensive aorto-iliac occlusive disease. For patients previously treated in the target area, other treatment options might be considered, or more intensive follow-up surveillance is warranted.

160 p

83% TASC D

Éxito técnico 95.6%

Mortalidad a 30 días 1.3%

5y FU: 77/88/95%

Primer tto 85/94/97%

98% libres de amputación

J Vasc Surg. 2024 Mar 31:S0741-5214(24)00924-8. doi: 10.1016/j.jvs.2024.03.437.
Online ahead of print.

Aorto-bifemoral bypass versus covered endovascular reconstruction of aortic bifurcation

Dana B Semaan [1], Salim G Habib [1], Othman M Abdul-Malak [2], Jeffrey J Siracuse [3], Michael C Madigan [2], Karim M Salem [2], Rabih A Chaer [2], Mohammad H Eslami [4]

Affiliations + expand

PMID: 38565344 DOI: 10.1016/j.jvs.2024.03.437

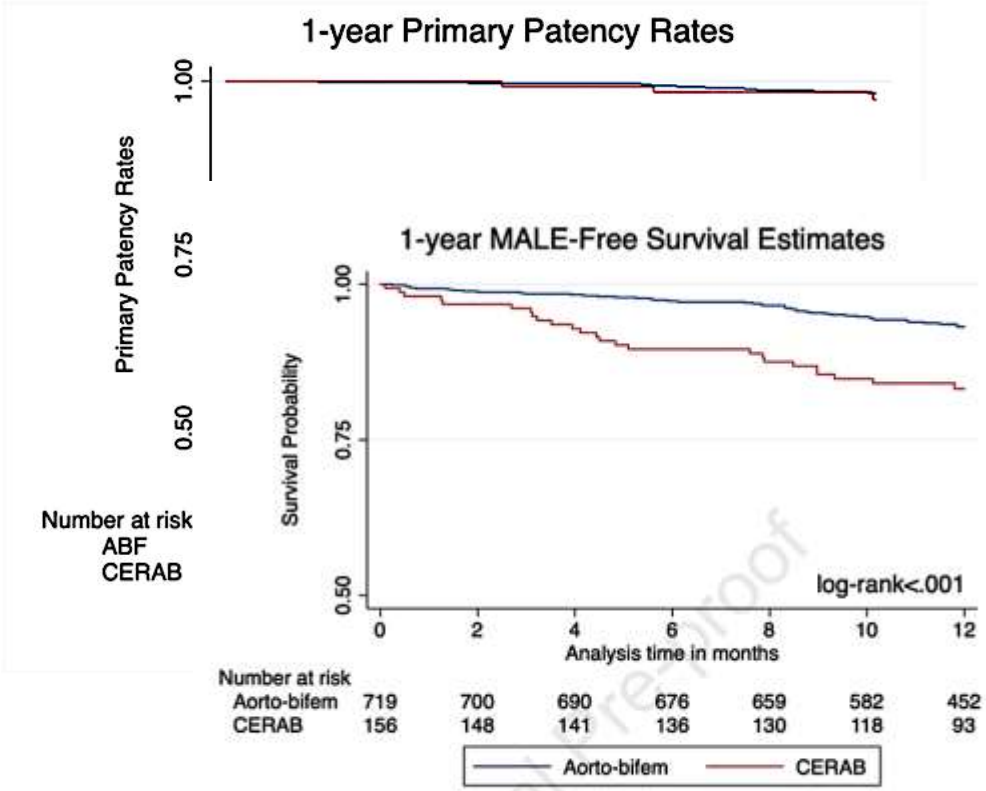
Abstract

Background: Covered endovascular reconstruction of aortic bifurcation (CERAB) is increasingly utilized as a first line treatment in patients with aorto-iliac occlusive disease (AIOD). We sought to compare the outcomes of patients undergoing CERAB compared to the gold standard of aorto-bifemoral bypass (ABF).

Methods: The Vascular Quality Initiative was queried for patients undergoing ABF or CERAB from 2009-2021. Propensity scores were generated using demographics, comorbidities, Rutherford class, and urgency. The two groups were matched using 5-to-1 nearest neighbor match. Our primary outcomes were 1-year estimates of primary patency, major adverse limb events (MALE), MALE-free survival, reintervention-free survival, and amputation-free survival. Standard statistical methods were utilized.

Results: 3,944 ABF and 281 CERAB cases in total were identified. Of all patients with AIOD, the proportion of CERAB increased from 0% to 17.9% between 2009-2021. Compared to ABF, patients undergoing CERAB were more likely to be older (64.7 vs. 60.2; p<.001) and more often had diabetes (40.9% vs. 24.1%; p<.001) and end-stage renal disease (1.1% vs. 0.3%; P=.03). In the matched analysis (229 CERAB vs. 929 ABF), ABF patients had improved MALE-free survival (93.2% [±0.9%] vs. 83.2% [±3%]; p<.001) and lower rates of MALE (5.2% [±0.9%] vs. 14.1% [±3%]; p<.
primary patency rates (98.3% [±0.3%] vs. 96.6% [±1%]; p=.6) and amputatio
[±0.3%] vs. 99.4% [±0.6%]; p=.9). Patients in the CERAB group had significa
free survival (62.5% ± [6%] vs. 92.9% ± [0.9%]; p<.001). Matched analysis al
vs. 7 days; p<.001), as well as lower pulmonary (1.2% vs. 6.6%; p=.01), renal
and cardiac (1.6% vs. 12.8%; p<.001) complications among CERAB patients.

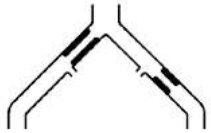
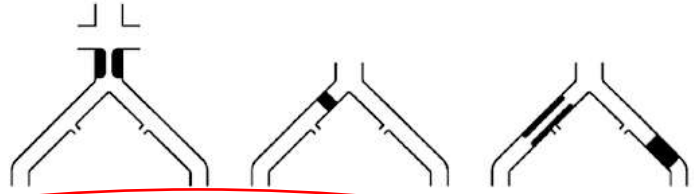
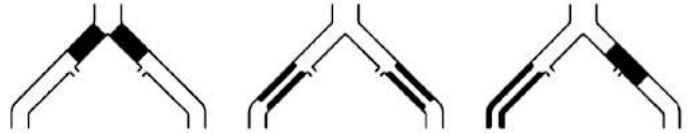
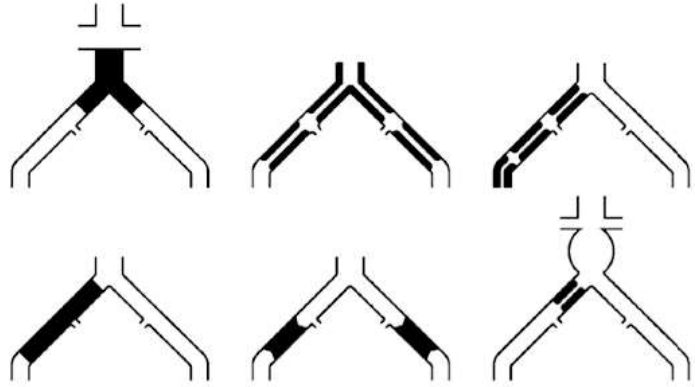
Conclusion: CERAB had lower perioperative morbidity compared to ABF wi
patency 1-year estimates. However, patients undergoing CERAB experience
events and reinterventions. Although CERAB is an effective treatment of pat
studies are needed to determine the long-term outcomes of CERAB compared to the established
durability of ABF and further define the role of CEARB in treatment of AIOD.



Conclusion: CERAB had lower perioperative morbidity compared to ABF with a similar primary patency 1-year estimates. However, patients undergoing CERAB experienced more major adverse limb events and reinterventions. Although CERAB is an effective treatment of patients with AIOD, further studies are needed to determine the long-term outcomes of CERAB compared to the established durability of ABF and further define the role of CEARB in treatment of AIOD.

Permeabilidad

	Per 5 a
•By pass aorto-femoral	86%
•By pass ilio-femoral	85%
•Endarterectomia aortoiliaca	88%
•CERAB	77/88/95% 85/94/97%
•Iliac Registry	92/98% (36 m)

TASC A lesions • Unilateral or bilateral CIA stenoses • Unilateral or bilateral single short (≤3 cm) EIA stenosis	
TASC B lesions • Short (≤3 cm) stenosis of the infrarenal aorta • Unilateral CIA occlusion • Single or multiple stenosis totaling 3 to 10 cm involving the EIA not extending into the CFA • Unilateral EIA occlusion not involving the origins of the internal iliac or CFA	
TASC C lesions • Bilateral CIA occlusions • Bilateral EIA stenoses 3 to 10 cm long not extending into the CFA • Unilateral EIA stenosis extending into the CFA • Unilateral EIA occlusion involving the origins of the internal iliac and/or CFA • Heavily calcified unilateral EIA occlusion with or without involvement of the origins of the internal iliac and/or CFA	
TASC D lesions • Infrarenal aortoiliac occlusion • Diffuse disease involving the aorta and both iliac arteries • Diffuse multiple stenoses involving the unilateral CIA, EIA, and CFA • Unilateral occlusions of both CIA and EIA • Bilateral EIA occlusions • Iliac stenoses in patients with AAA not amenable to endograft placement	

Caso clínico

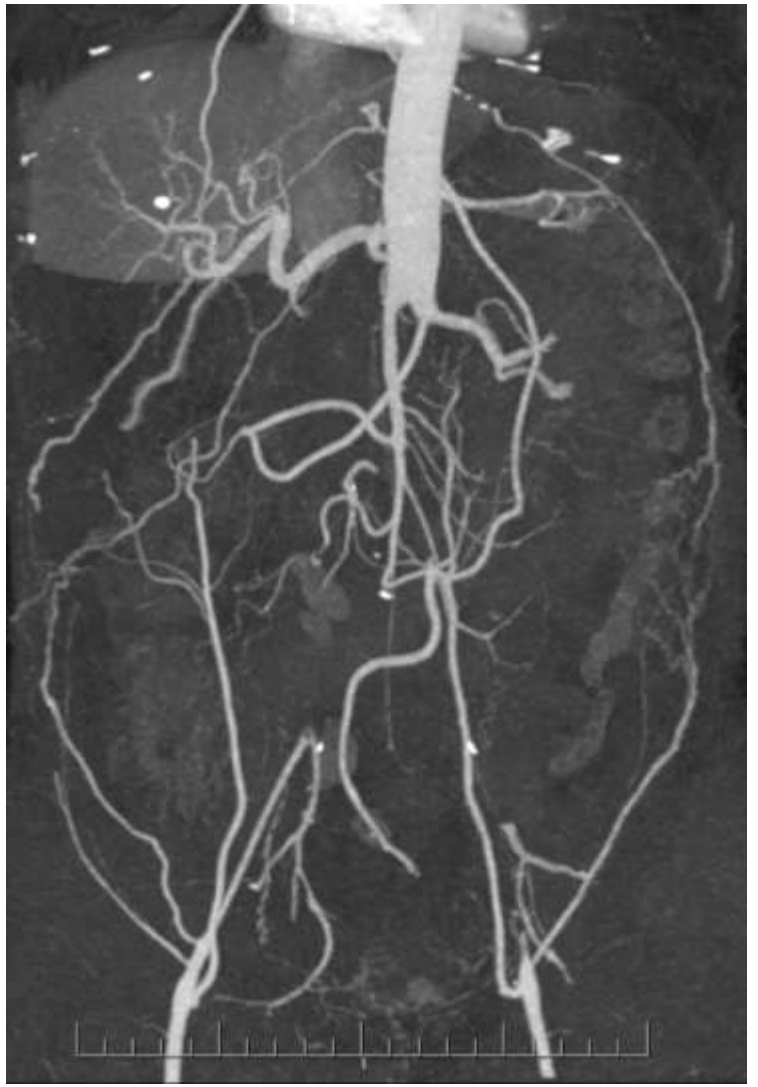
F 52 a
Ingresa por síndrome de
MMII.

Antecedentes:
Tabaquista. Tres meses d

Examen físico:
MMII con ausencia de pu

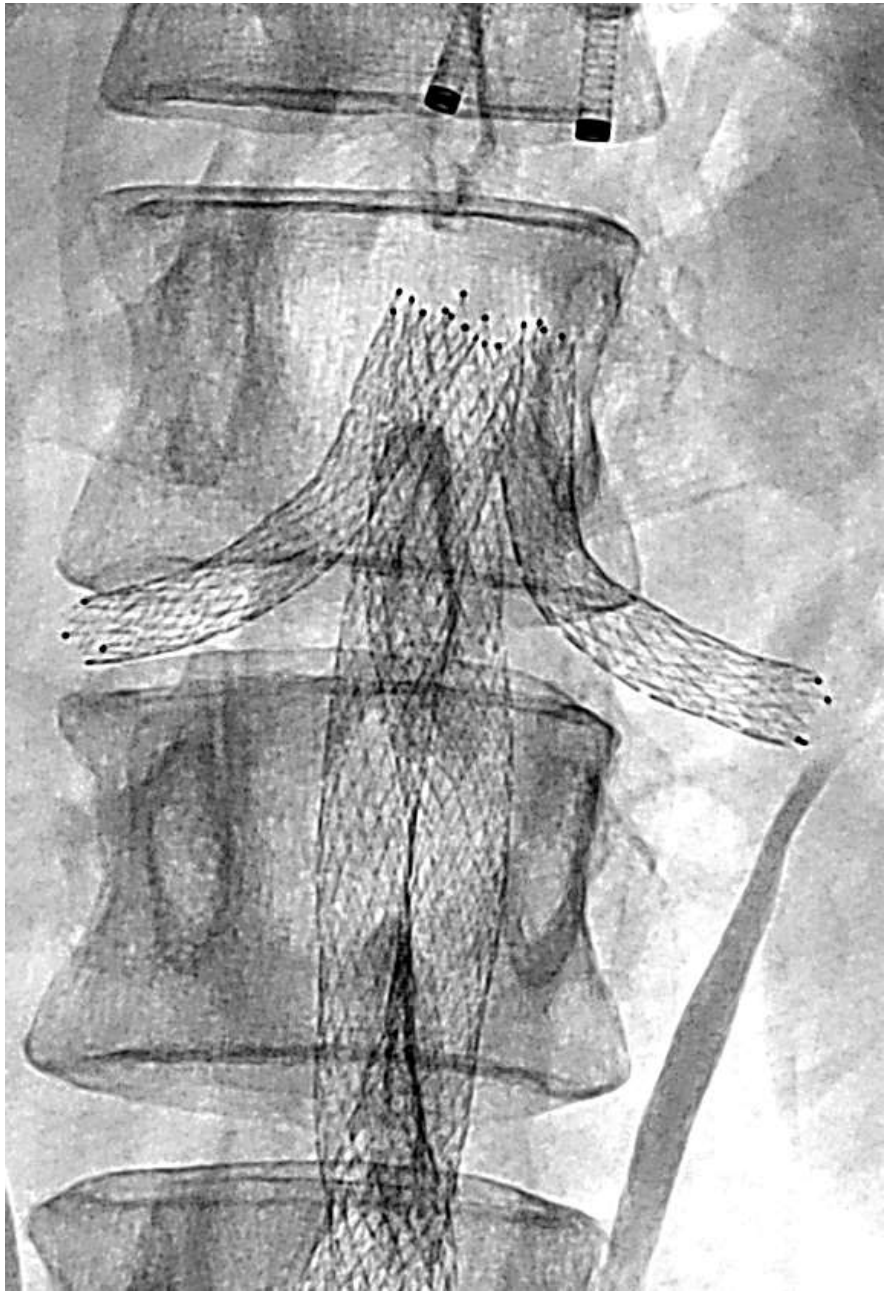
AngioTC

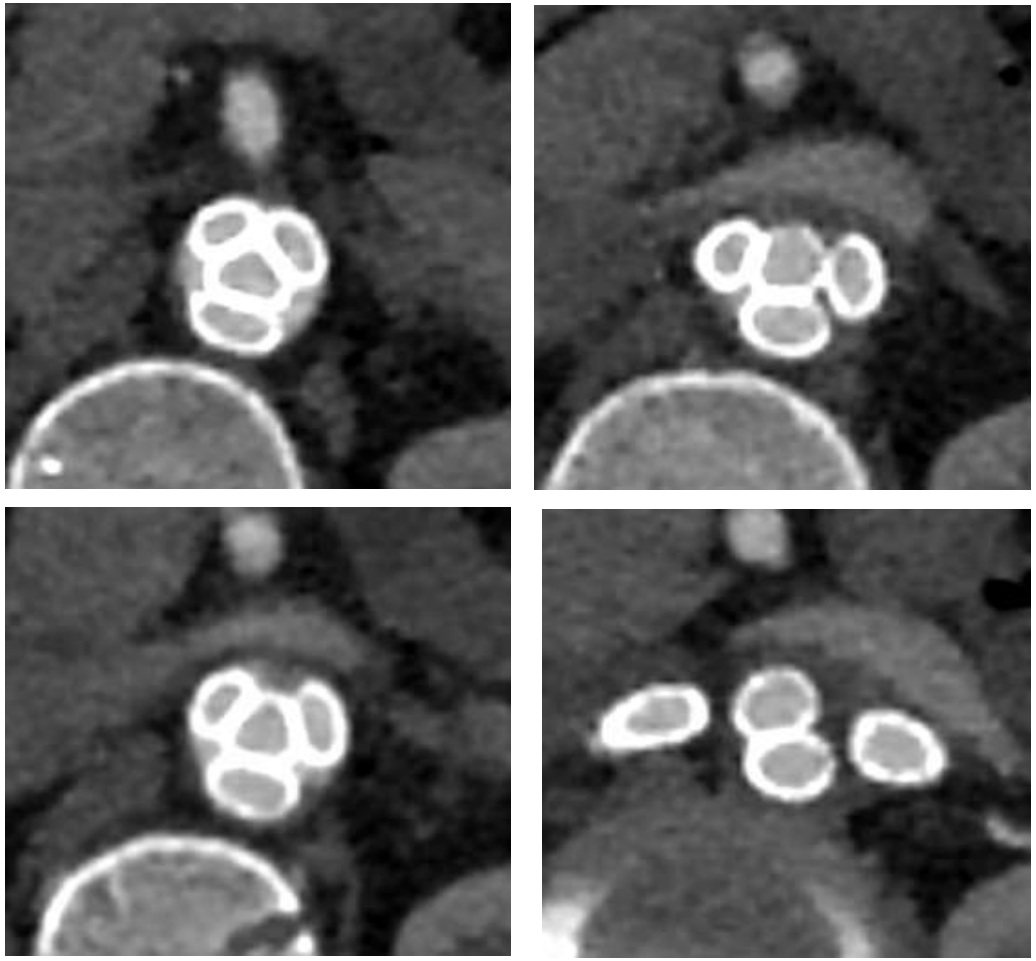

HLP
ARH
MPR
AHL
RHA
RPF
CTA
SANATORIO JUNCAL
Aquilion Lightning
10cm



AngioTC post tratamiento 24 hs

Configuración de los stents





Alta a las 24 hs.
Pulsos palpables, coloración, temperatura y relleno capilar normal.

Clopidogrel, Rivaroxaban y estatinas.

Oclusión o estenosis de aorta infrarenal

¿Cuándo endovascular?

¿Cuándo no endovascular?

Cuándo no:
Poca experiencia
Restricciones de insumos