‘Radiologic Malperfusion’ in the context of TBAD

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Potential C.O.I.
Medtronic: Consulting, Sales Training
Complicated type B (30% of TBAD cases):
TEVAR imperatives

- Rupture
- Malperfusion

[Image of medical study]
Malperfusion = Ischemia

visceral
renal
lower extremities
spinal cord
combinations of above
Subacute type IIIb
Pain and rising creatinine
(3d after contrast CT)
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Pain and rising creatinine
(3d after contrast CT)
Surgeon feels TEVAR should be postponed until creatinine returns back to normal
Mechanisms of aortic branch compromise in AD
STATIC with re-entry (no ischemia)
- SHOULD "RADIOLOGIC" MALPERFUSION BE CONSIDERED FOR EARLY OR EVEN URGENT TEVAR INTERVENTION?
Should we think of it as *silent* if not actual malperfusion??
Factors to balance and weigh in:

The patient
TBAD anatomy and anticipated technical issues
Potential complications
One’s experience and track record
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PETITCOAT: proximal stent-graft + distal bare-metal Sx stent
Cook Dissection Stent

XL Jostent