Banding technique and debranching as treatment of type I endoleak in a mycotic thoracic aortic pseudoaneurysm.

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Disclosure

Speaker name: ..............................................................................................................

I have the following potential conflicts of interest to report:

☐ Consulting
☐ Employment in industry
☐ Stockholder of a healthcare company
☐ Owner of a healthcare company
☐ Other(s)

☐ I do not have any potential conflict of interest
TEVAR Complications

• Postimplantation graft migration occurs with an incidence of 1–2.8%.

• Endoleak: rates ranging from 3.9 to 15%

Medical History

74 years old male

Non Small Cell Lung Cancer

Right upper lobectomy (March/2014)

S. Aureus Bacteremia
Vascular History

Mycotic thoracic pseudoaneurysm
(26mm maximum diameter)
April 2014

Right to left common carotid artery bypass +
Z1 proximal landing zone TEVAR (Valiant Captivia, Medtronic)
3 Years Follow up (2017)

- Aortic dilatation (57 mm)
- Type I endoleak
Initial Arteriography
Ascending Aorta to Inominate Artery Bypass
Endoprosthesis deployment

Ascendent aortic maximum diameter 38mm

- Auricular Fibrillation
- Distal to aortic bypass anastomosis.
- TEVAR (Valiant Captivia, Medtronic) 42x150mm Z0 Landing zone
Control Arteriography
Double banding around aortic landing zone
Final Angiography
Discussion

• An adequate aortic landing zone is determinant for a success TEVAR procedure (1)

• The proximal aortic dilatation can lead to endoleak or endograft migration.

• Banding technique has been described to prepare landing zone prior to endograft deployment.
In this case, we use the banding technique as treatment of a type I endoleak.
Conclusion

Banding could be used as an adjunctive technique in prevention and treatment of selected cases of TEVAR type I endoleak.
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Thank you

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