

# **EVAR for AAA, the solution or the beginning of problems**

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## **Objective:**

Since the introduction EVAR became the first choice for the treatment of AAA. As the early mortality and morbidity is significant lower for endovascular surgery there are new kind of problems like endoleaks. Postoperative is a regular follow up necessary and the reintervention rate is higher but most can be solved endovascular. After the first years the difference in mortality between both methods disappears. With this case report we want to discuss what is definition of success.

## **Methods:**

We present a case of a 54 year old male patient with a 5.5 cm AAA and typical risk factors. He was treated with standard EVAR Jotec E-vita. After postop sac regression the aneurysm started growing 3 years. In the following surveillance over a period of 14 years he developed different endoleaks which were treated with different endovascular procedures before the next problem shows up.

## **Results:**

After EVAR the aneurysm diameter reduces to 43mm until it starts growing, 2013 Type 1b endoleak treated with right ISB device Jotec, 2015 same on the left side. 2017 coiling of lumbar Type 2 endoleak. After sac regression neck dilatation, 2023 Type 1a endoleak, proximal extension with fenestrated Anaconda stent graft. 2023 Type 3 endoleak at the left hypogastric stents, 2024 repair and intraoperative finding of fabric defect (Type 3b endoleak) which was repaired endovascular. Finally intact endovascular aneurysm exclusion.

## **Conclusion:**

Nowadays a AAA which is anatomically suitable will be treated with EVAR. We know the reintervention rate is higher than after open surgery and regular follow up is required. But we believe the advantages outweigh. If patients with ruptured aneurysms after EVAR show up they have Type 1 endoleaks and mostly the last years without follow up.

This case report shows the dynamic evolution of aortic disease which can continue even after EVAR. In the follow up the aneurysm increased from 43 to max 103mm. What does this mean for rupture risk, should we continue endovascular or decide earlier for open conversion.

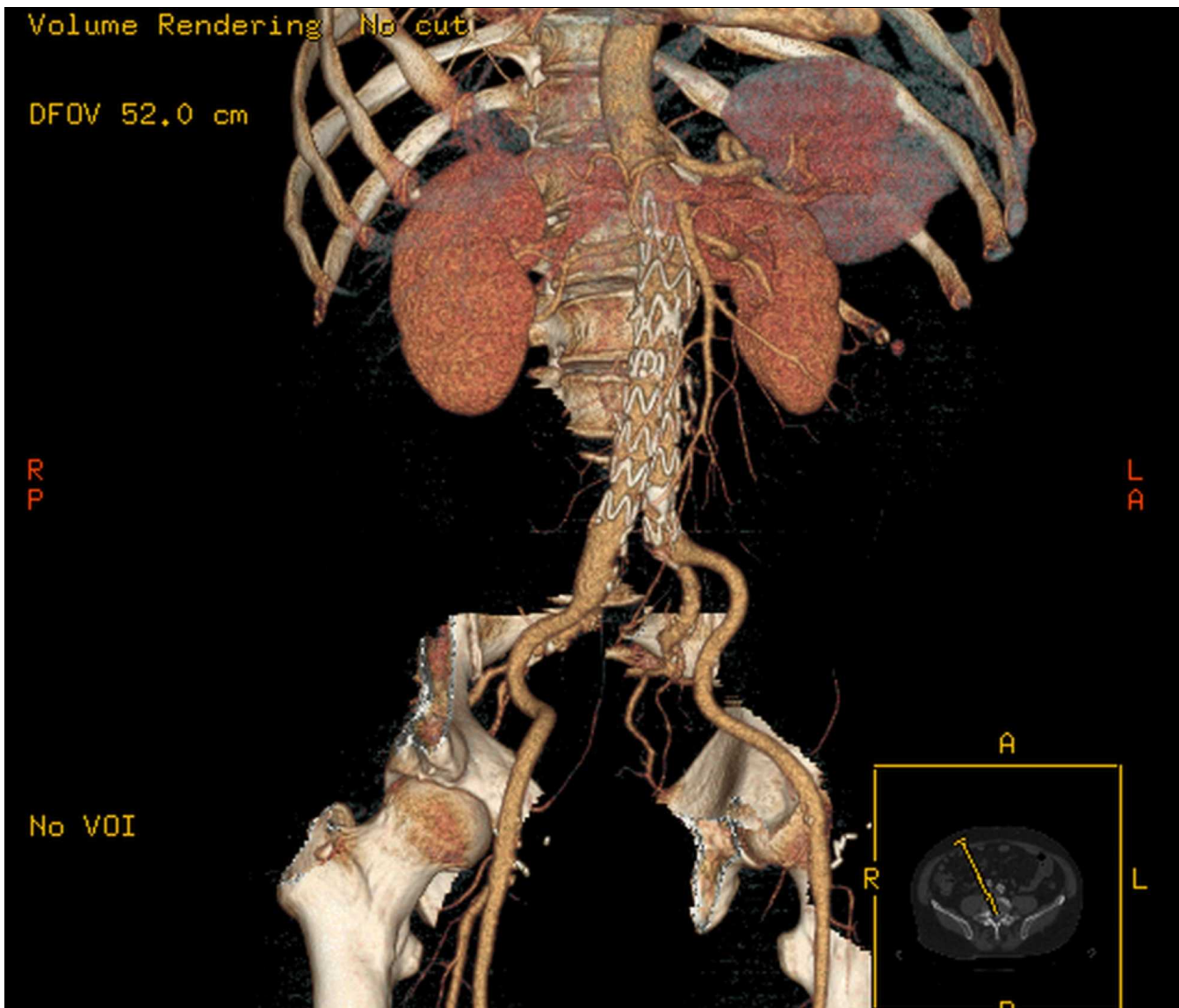


Fig 1 EVAR 2011