Outcomes Of EVAR For Inflammatory AAAs Are Favorable

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Although uncommon, infectious forms, caused by bacteria, fungi, or mycobacteria, may result from hematogenous seeding of the aorta or direct spread from a contiguous infectious source.

The noninfectious forms include a number of entities, the most common of which is atherosclerosis, a disease that primarily affects the aortic intima but has important secondary effects on the media and adventitia that may result in aneurysm formation.

Giant cell arteritis, Takayasu arteritis, granulomatosis with polyangiitis (Wegener granulomatosis), sarcoidosis, and lymphoplasmacytic aortitis.

Importantly, there is increasing recognition that there is a subset of cases of lymphoplasmacytic aortitis perhaps better classified under the spectrum of so-called IgG4-related sclerosing disease, with important clinical and therapeutic ramifications.

In conclusion; treatment of inflammatory abdominal aortic aneurysms with EVAR was effective and reduced aneurysmal sac diameter and the extent of PAF with acceptable morbidity.
Medical treatment:
IgG4 has therapeutic implications to glucocorticoid treatment may prevent progression of disease.

Immunosuppressive agents: azathioprine, methotrexate rituximabs are second-line agents.

Behcet’s Disease

Behcet’s disease is an inflammatory disorder of unknown cause, characterized by recurrent oral aphthous ulcers, genital ulcers, uveitis, and skin lesions. In Behcet’s disease, vasculitides account for much of the pathologic process and can affect veins and arteries of all sizes.

Surgical treatment of inflammatory aortic aneurysms in the setting of Behcet’s disease led to recurrent false aneurysms at the anastomotic site in 30%-50% of cases.

Endovascular repair of inflammatory aortic aneurysms has been used as an alternative to open surgical repair and seems to provoke less of a cytokine release and inflammatory response.

Recurrence of aneurysm after repair is a major problem and is difficult to avoid completely in Behçet disease.

To suppress vasculitis and prevent recurrent aneurysm after stent implantation, immunosuppressive and anti-inflammatory medication should be maintained.
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**Methods:**
Between April 2002 and April 2008, 12 pseudoaneurysms in nine men and one woman with Behçet disease were evaluated. All 10 patients received immunosuppressive therapy after the implant procedure.

**Results:**
All patients underwent successful endovascular therapy without major complications during the 30 days immediately after the procedure. These two were the only patients who did not adhere to taking immunosuppressive medicine after discharge.

**Conclusion:**
Endovascular stent graft placement combined with immunosuppressive treatment for aortic pseudoaneurysms in Behçet disease is a feasible and effective management option. Long-term immunosuppressive therapy after endovascular repair is important to limit pseudoaneurysm recurrence.

**Behçet’s disease**
- Recurrence of pseudoaneurysm at the distal end of the Cover stent: 35 y, F
- AUI-Contralateral occluder Fem-fem by-pass
- FU CTA v CT: No endoleak

**Behçet’s disease**
- In past 3 open surgery, r-AAA (pseudoaneurysm): 45 y, F; treated by tubular endograft

**Takayasu Disease**
Treatment of aneurysms in Takayasu Disease require a different strategy rather than atherosclerotic aneurysms.

The pathology is diffuse, progressive, and relapsing in nature, and young patients have greater longevity.

3 parameters are important:
- the location,
- extent of the aneurysmal lesions,
- degree of the inflammation,

indicate for the timing of conventional or endovascular repair.

Isolated aortic aneurysms are rare; Matsumura et al, described aneurysms in 32% of the patients affected by TA.
Multiple endovascular stent-graft implantations in a patient with aortic thoracic and abdominal aneurysms due Takayasu arteritis

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Aortic aneurysms in systemic lupus erythematosus: a meta-analysis of 35 cases in the literature and two different pathogeneses.


BACKGROUND:
Aortic aneurysms including dissection are uncommon complications of systemic lupus erythematosus, but their incidence has been increasing with an improved prognosis for this disease. However, the mechanisms contributing to aneurysm formation in systemic lupus erythematosus have not been fully clarified.

Kurata et al suggested that aortic aneurysms in patients with SLE may be classified into two principal patterns:

One was the fatal nonatherosclerotic thoracic aneurysm which was associated with cystic medial degeneration and probably due to vasculitis.

The other was atherosclerotic abdominal aneurysm which was associated with long-term steroid treatment and it showed a relatively favorable prognosis.


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THANK YOU