The t-Branch stent-graft, (Cook Medical, Bloomington, IN/USA) now available as an off-the-shelf device for treatment of thoracoabdominal aortic aneurysm (TAAA) evolved from the original multibranched design proposed by Chuter et al in 2001.

It consists of a 202-mm tapered covered stent-graft with a 34-mm-diameter proximal stent and a 18-mm-diameter distal stent. It has 4 clock-oriented downward branches destined for the celiac trunk, superior mesenteric artery (SMA), and both renal arteries.

Any SURGEON can make modifications to expand the indications and also make the procedure safer. Example: Cutting one or two proximal stents to avoid longer distal aortic cover (Less paraplegia??).
Also the distal component can be modified proximally or distally, even to a tubular shape.

Very simple maneuvers, as this one that we call DDBS

Device Driven By the Sheath

That simple maneuver avoid the new graft to grab a previous one, also allows one to rotate easily the device to correct the branches positioning and also facilitates its migration across very unfriendly anatomes.

SNARE-RIDE

TECHNIQUE

This procedure assure one to complete all the branches even those with malrotation of the main graft or those with upward trends.

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Conclusion

- The use of branched stent-grafts in the treatment of TAAAs has proven feasible and safe, and the off-the-shelf multibranched t-Branch can be used in both urgent and elective scenarios.

- Employing adjunctive maneuvers can increase the anatomic suitability of the t-Branch; in our experience, these techniques have increased the applicability to 80% or more of all TAAA cases.

Role Of Branched EVAR (B/EVAR) To Treat Visceral Segment TAAAs With Chronic TBADs: Challenges And How To Overcome Them

Thank you for your kind attention
Thank you Frank for accepting my talk recorded
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