PERSPECTIVES

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AUTHOR:
DR. CRIADO, FRANK J.
miembro del Colegio Estadounidense de Cirujanos, miembro de la Sociedad para la Medicina Vascular

CORRESPONDENCE:
frankjcriado@gmail.com

At the end of another impressive and successful CACVS Symposium in Paris under the steady visionary leadership of Jean-Pierre Becquemin, I thought it might be interesting to encapsulate and tightly summarize some of the key messages I came out with – at least on the arterial side. There was also a robust Venous program I will not comment on.

-*Branched endograft technologies and technical strategies for aortic arch repair and TAAA* are now evolving rapidly. Significant progress continues to be reported, but much of it remains near-experimental and in the early stages. Much more work remains to be done, experience gained, and mid/long-term results achieved and analyzed before any of this becomes anything close to a new standard of care. And of course, these procedures should and tend to be confined to a few centers of excellence with the necessary case volume and resources that constitute a pre-requisite.

-*TEVAR treatment of type B aortic dissection* moves forward and attracts lots of attention. But despite considerable developments in the definition and evidence for high-risk factors underlying indications for intervention in uncomplicated dissection, uncertainties and doubt persist, with some noted experts still entrenched in the historical posture of only offering treatment for classic-complicated type B cases and nothing beyond that… Additionally, there is emerging evidence suggesting that long-term results of TEVAR for aortic dissection may be less than stellar…

Stay tuned.

-Indications for elective treatment of AAA, 5.0cm versus 5.5cm – smaller (4.5-5.0) for female patients. Little progress here despite the available level-1 evidence in favor of 5.5cm. Many surgeons everywhere still cling on to the 5.0cm historical standard.

And by the way, the 5.5cm indication applies to men! Not to female patients.

Striking differences in indication thresholds and AAA repair rates amongst countries around the world, and AAA-related mortality were brought to our attention, and discussed at some length. Most remarkable are the differences between the U.K. and the U.S., with British AAA patients facing a 2-3X higher risk of death from their aneurysm!

-Iliac-branch devices for hypogastric artery revascularization in the setting of EVAR (and treatment of hypogastric aneurysms) have arrived! These technologies (available from at least 3 different manufacturers) are clearly becoming well established and seem to achieve a high degree of success, in exchange for an acceptable-level increase in procedure time and technical complexity.

Coiling and exclusion of the hypogastric arteries is rapidly becoming a thing of the past, with a much diminished role as we move forward.

-Likewise, *Percutaneous EVA*R is here to stay, now adopted by an increasingly larger number of stent-graft operators everywhere. Decreasing device profiles, and advances with percutaneous arterial closure techniques and devices are the 2 permissive factors underpinning such shift. The "classic" surgical cut-down approach to EVAR will be relegated to only a few cases in the future (when P-EVAR proves unfeasible or contraindicated). It will become an infrequent thing to do indeed.

-Access from above or antegrade to the visceral and thoraco-abdominal aorta is being used increasingly for complex endograft repair including Ch-EVAR, F-EVAR, and Branched TAAA procedures. Without claims of consensus, use of a graft conduit sewn to the axillary artery would appear to be emerging as the more popular and perhaps best technique for antegrade introduction of multiple long sheaths.

-Impressive advances with Ch-EVAR and F-EVAR strategies notwithstanding, increasingly voiced is the view that *open surgical repair should still retain an important role in the treatment of juxta-renal and other complex AAAs* on patients who are medically fit for major aortic surgery.

-*type II endoleaks remain controversial*, with one entire segment of a session devoted to discussing whether they should ever be treated – even in the face of an enlarging aneurysm sac! Not that rupture cannot occur, but some experts maintain that such risk is so very low… that any intervention might be more dangerous than the natural history of untreated type IIs.

Stay tuned for this as well.

-Despite considerable advances with F-EVAR repair, *Ch-EVAR techniques* retain their appeal in many circumstances, especially now when we have more robust data and clinical evidence. And the fact that it has received CE Mark approval for use with the Medtronic Endurant stent-graft. So this is now on-label approved therapy for complex AAA disease.

-As to the carotid arteries: evidence continues to pile showing the *extraordinarily low risk of stroke with asymptomatic stenosis* – even with hemodynamically critical stenosis. More and more surgeons would seem to be shifting to the view that – with few exceptions – symptomatic disease "only" should be treated with an intervention.

In terms of carotid stenting: *mesh-covered stents* represent a significant technological advance and will become the new standard. But the *real game changer may well be cervical access with flow reversal (Silk Road Neuroprotection System)*, a concept that surgeons are rapidly embracing at this time.

-Switching gears to the aorto-iliac and lower extremity vasculature, there is no longer doubt that *severe aortic bifurcation and bilateral common iliac artery disease is best treated with covered stents*. The available evidence is solid and it is real.

Paclitaxel-based devices are emerging as the undisputed champions in the infrainguinal arteries, especially the SFA. DCB angioplasty has become a game changer of sorts, although DES stents also play an important role – particularly

for complex extensive SFA occlusions where many experts feel DES stenting should be used, not DCB.

Advances with atherectomy were examined as well. Many still favor atherectomy over other options, including its use in combination with DCB for some complex lesions (such as ISR). The recent addition of OCT image-guided directional atherectomy (by Avinger) was mentioned as an example of a most interesting new technology to pay attention to in the near future.

And that's a wrap! ■