

Darf die linke Arteria subclavia überstentet werden?

CONTRA

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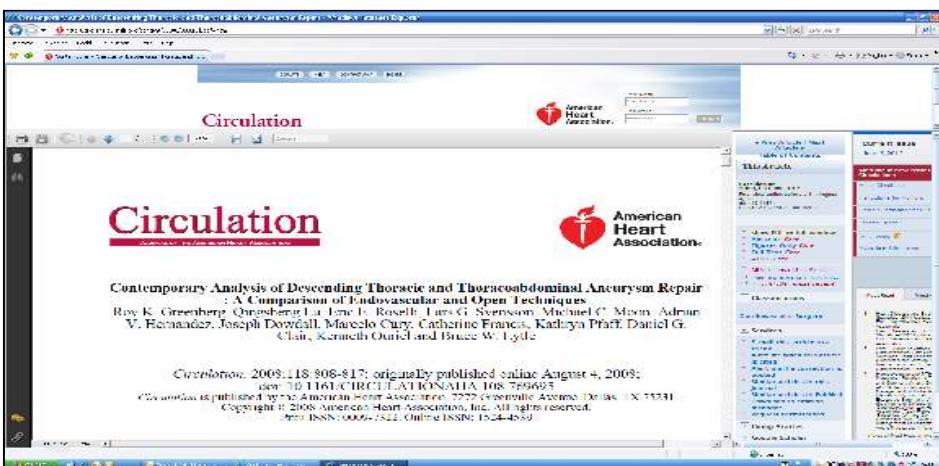
Andreas Greiner
bearbeiten
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Problem TEVAR

- Überstentung der linken A. subclavia (LSA): 50%
- Komplikationen: Cerebraler Insult und Paraplegie
- Keine objektive Methode der Risikoabschätzung verfügbar
- Indikation zur LSA Revaskularisation: Vermutungen
- Die Qualität der verfügbaren Literatur ist niedrig

Formatvorlage des Untertitels im abarbeiten

- Cheng D, Martin J, Shennib H, Dunning J, Muneretto C, Schueler S et al. J Am Coll Cardiol 2010
- Feezor RJ, Lee WA. Semin Vasc Surg 2009
- Peterson BG, Eskandari MK, Gleason TG, Morasch MD. J Vasc Surg 2006
- Riesenman PJ, Farber MA, Mendes RR, Marston WA, Fulton JJ, Keagy BA. J Vasc Surg 2007
- Cina CS, Safar HA, Lagana A, Arena G, Clase CM. J Vasc Surg 2002
- Geisbusch P, Kotelis D, Muller-Eschner M, Hylik-Durr A, Bockler D. J Vasc Surg 2011



Problem TEVAR

Contemporary Mortality of Thoracic and Thoracoabdominal Aneurysm Repair - Circulation Internet Explorer

AMERICAN HEART ASSOCIATION

Circulation

American Heart Association

SAS version 9.1 (SAS Inc, Cary, NC) and S-Plus 6.1 (Insightful Corp, Seattle, Wash).

phrenic aorta (types O and IV), whereas open repair was more frequently used to treat type II and III thoracoabdominal

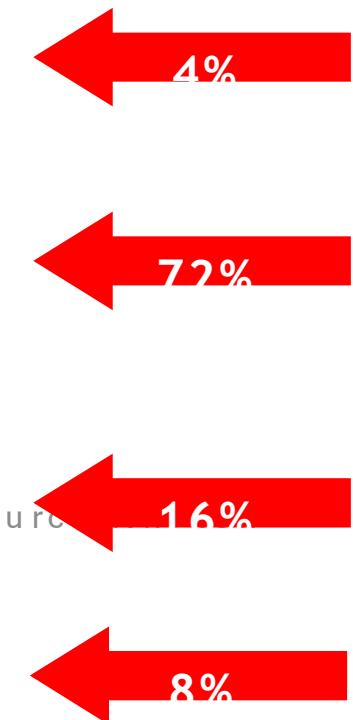
Table 4. Mortality and SCI Classified by Extent of Aneurysmal Disease

Extent	Repair Technique	Mortality at 30 d			Mortality at 1 y			SCI		
		n	n	%*	Rate†	n	n	%*	Rate†	n
None	ER	183	8	5	0.62	20	12	0.14	1	1
	SR	136	8	4	0.73	15	11	0.13	1	1
I	ER	82	6	7	0.94	15	19‡	0.25	8	10
	SR	51	1	2	0.24	2	4	0.04	7	14
II	ER	18	1	6	0.80	5	36	0.45	3	10
	SR	59	10	17	2.36	13	22	0.30	13	22
III	ER	22	2	9	1.10	7	34	0.52	1	5
	SR	82	8	12	1.88	13	21	0.27	6	10
IV	ER	69	3	4	0.55	8	12	0.18	2	3
	SR	84	4	6	0.80	15	22	0.30	1	2
All	ER	352	20	6	0.72	55	16	0.21	15	4
	SR	372	31	7	1.07	59	15	0.19	28	8

*Kaplan-Meier estimate.
†Incidence rates are defined as deaths per person-year.
‡Statistically significant difference between ER and SR with log-rank test.

Downloaded from <http://circ.ahajournals.org/> at UNIVERSITEIT MAASTRICHT on June 8, 2012

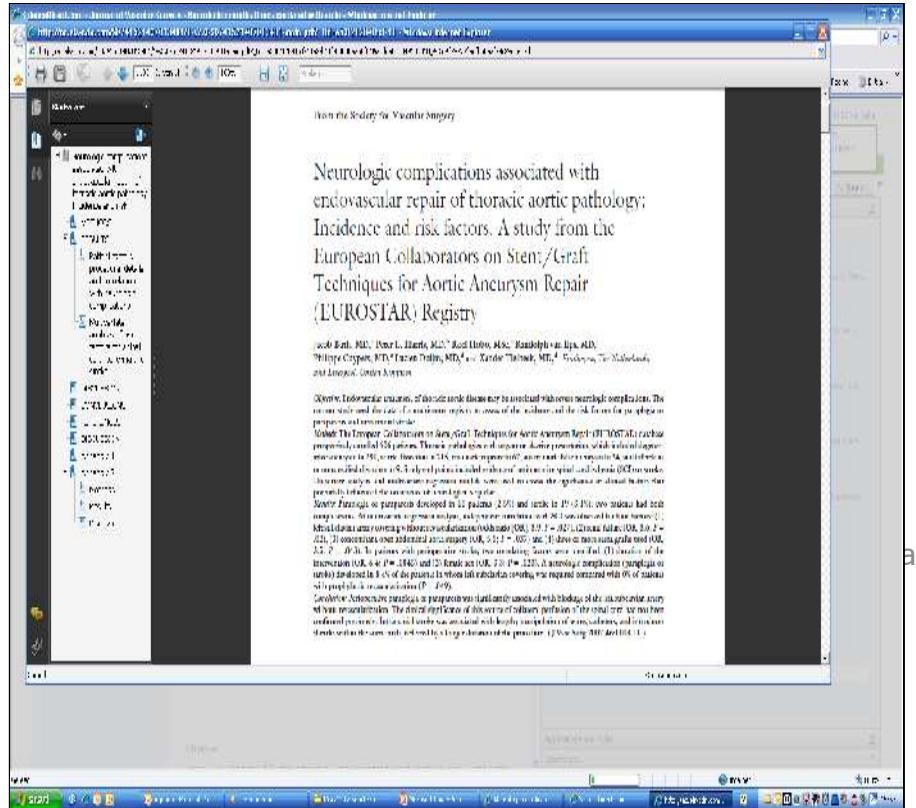
Form a
bearbe





Direkte signifikante Korrelation zwischen spinaler Ischämie und Überstentung von zwei unabhängigen Versorgungsterritorien.

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Journal of Vascular Surgery®

Unabhängige Korrelation zwischen Paraplegie und Überstentung der LSA: OR 3.9

Konkomitante offene AAA Operationen sind signifikante unabhängige Risikofaktoren für spinale Ischämie bei TEVAR.

Während Sie durch Klicken

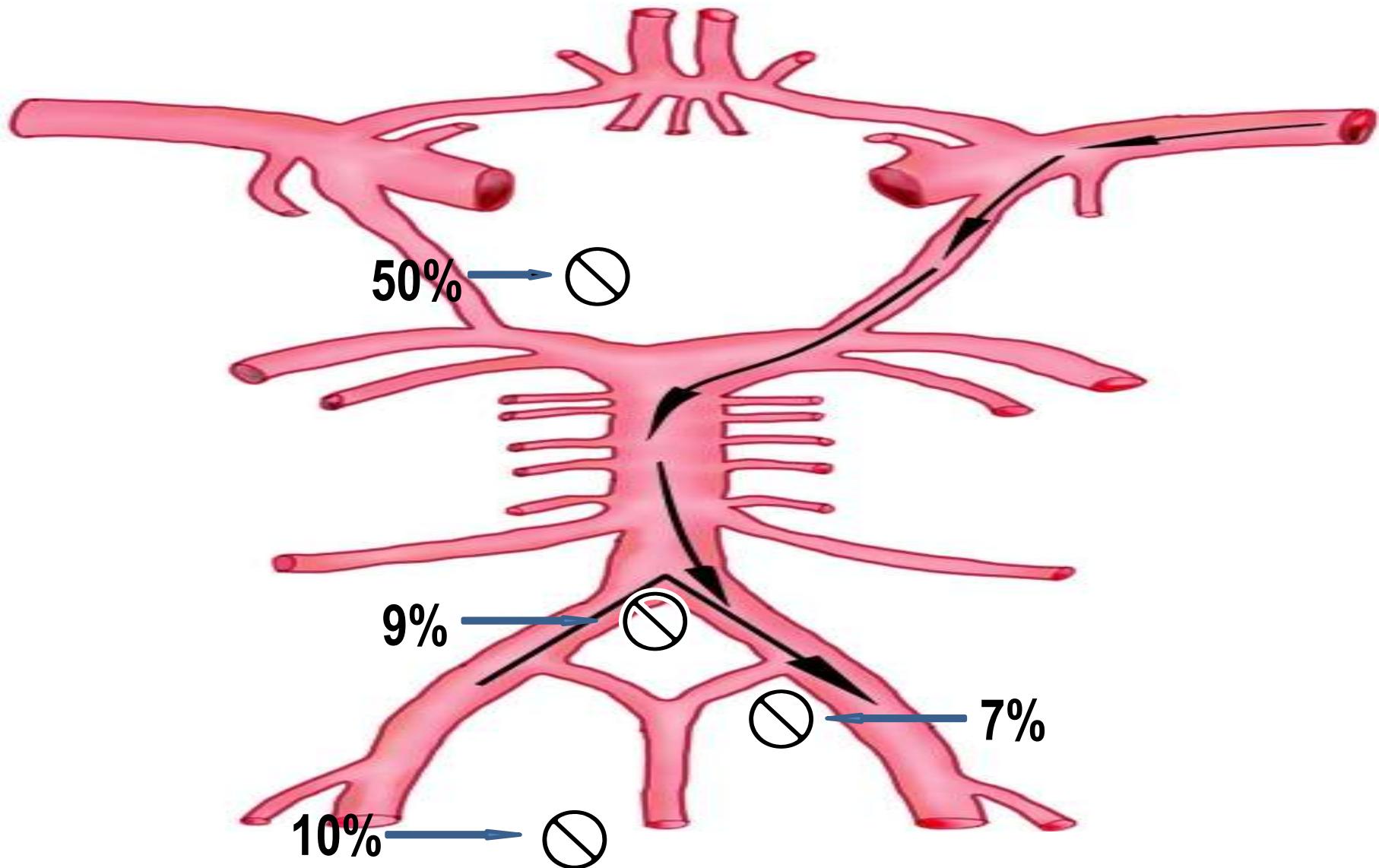
Number needed to treat (NNT)

Paraplegie mit Überstentung der LSA 4 %
ohne Revaskularisation

Paraplegie mit Überstentung der LSA 1 %
mit Revaskularisation

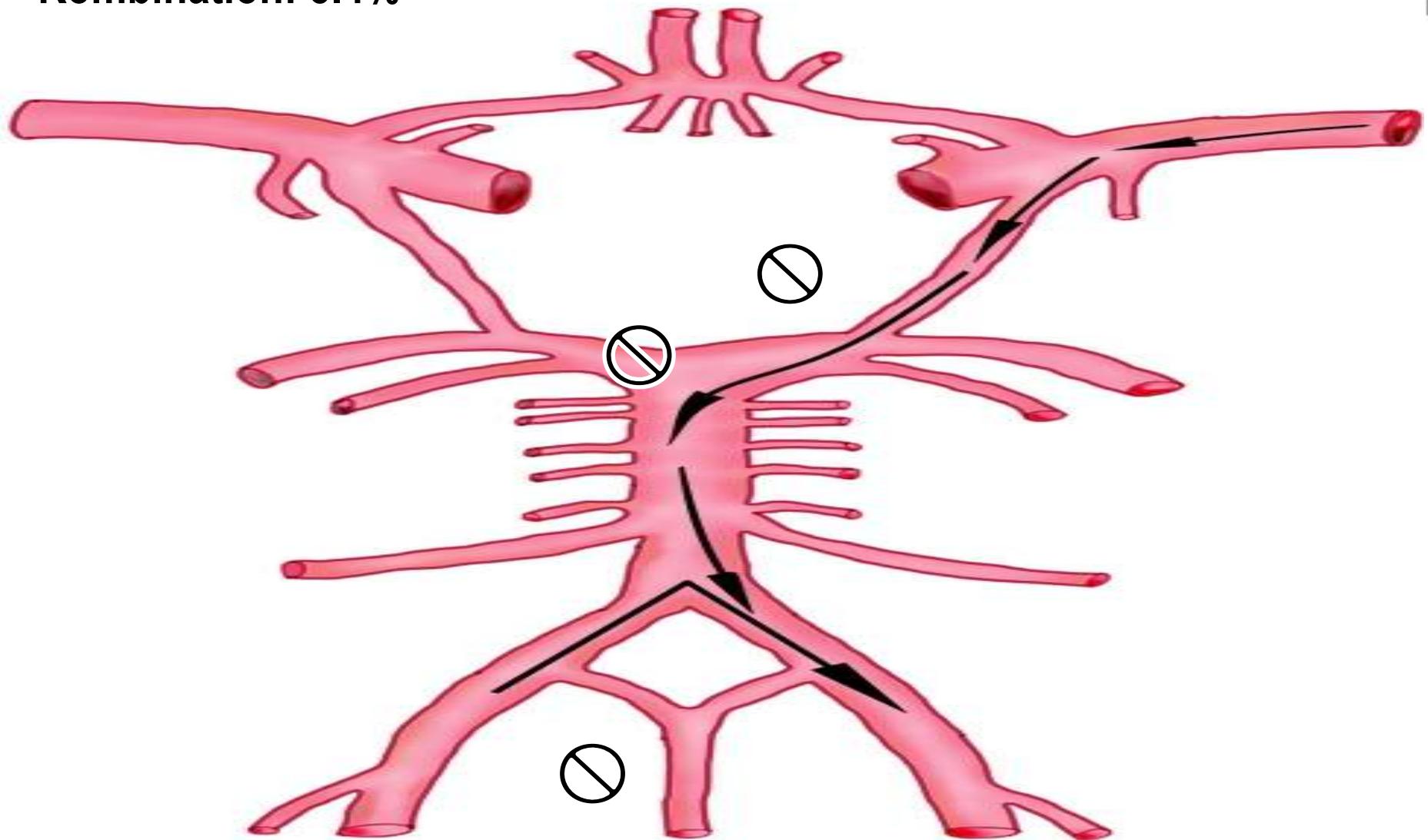
NNT 100:3=33

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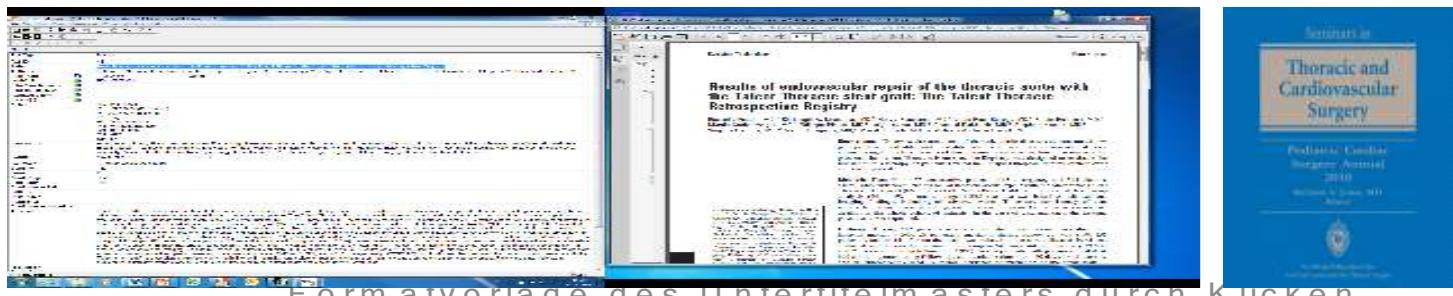


- Jeng JS, Yip PK. Ultrasound Med Biol 2004
- Touboul PJ, Bousser MG, Laplane D, Castaigne P. Stroke 1986
- Manninen H, Tulla H, Vanninen R, Ronkainen A. Ann Thorac Surg 2008

Kombination: 5.4%

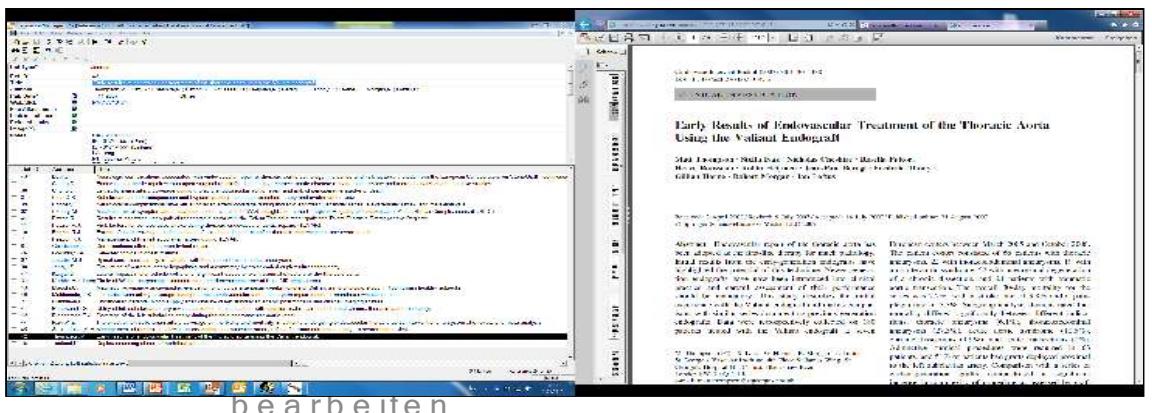


- Jeng JS, Yip PK. Ultrasound Med Biol 2004
- Touboul PJ, Bousser MG, Laplane D, Castaigne P. Stroke 1986
- Manninen H, Tulla H, Vanninen R, Ronkainen A. Ann Thorac Surg 2008



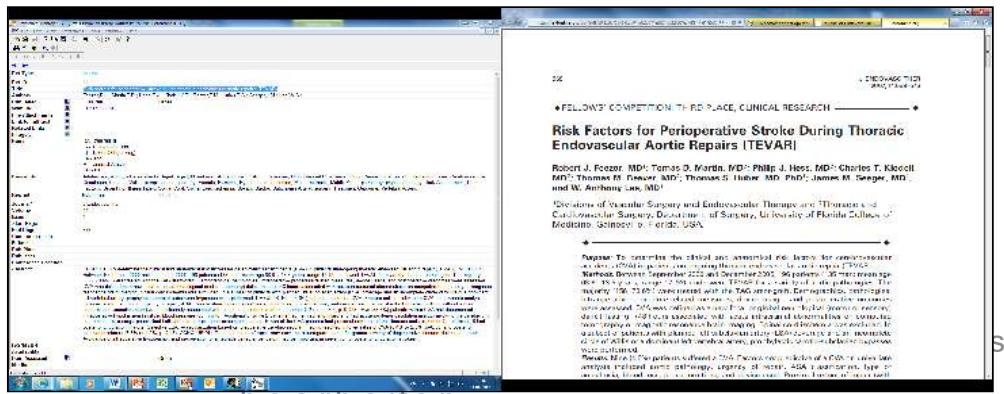
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**Schlaganfälle sind
signifikant mit LSA
Okklusion ohne
Revaskularisation
assoziiert**



Schlaganfallrate 9% vs. 0.8%
(ohne Revaskularisation vs.
mit Revaskularisation)





Selektive Strategie, Schlaganfallsrate im hinteren Kreislauf: 5.5% vs. 1.2%



Risikofaktoren

- Langstreckige Stentung (mindestens zwei Territorien)
- Frühere AAA Chirurgie
- Verschlossene A. Iliaca interna
- Concomitante infrarenale Aortenpathologie
- Renale Insuffizienz
- Hypoplastische RVA in Kombination mit einem inkompletten posterioren Circulus arteriosus cerebri
- Offener IMA-Bypass
- Dialysefistel am linken Arm

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ABER

Patienten ohne Risikofaktoren haben dennoch ein Risiko für neurologische Komplikationen wenn man die LSA ungeschützt überstentet.



**Empfehlung:
LSA
Revaskularisat
ion!**

SVS PRACTICE GUIDELINES

The Society for Vascular Surgery Practice Guidelines: Management of the left subclavian artery with thoracic endovascular aortic repair

Jon S. Matsumura, MD,^a W. Anthony Lee, MD,^b R. Scott Mitchell, MD,^c Mark A. Farber, MD,^d Mohammad Hassan Murad, MD, MPH,^e Alan B. Lumsden, MD,^f Roy K. Greenberg, MD,^g Hazim J. Sali, MD,^h and Ronald M. Fairman, MD,ⁱ for the Society for Vascular Surgery, Gainesville, Fla; Palo Alto, Calif; Chapel Hill, NC; Rochester, Minn; Houston, Tex; Cleveland, Ohio; and Philadelphia, Pa

The Society for Vascular Surgery pursued development of clinical practice guidelines for the management of the left subclavian artery with thoracic endovascular aortic repair (TEVAR). In formulating clinical practice guidelines, the society selected a panel of experts and conducted a systematic review and meta-analysis of the literature. They used the grading of recommendations assessment, development, and evaluation (GRADE) method to develop and present their recommendations. The overall quality of evidence was very low. The committee issued three recommendations:

Recommendation 1: In patients who need elective TEVAR where achievement of a proximal seal necessitates coverage of the left subclavian artery, we suggest routine preoperative revascularization, despite the very low-quality evidence (GRADE 2, level C).

Recommendation 2: In selected patients who have an anatomy that compromises perfusion to critical organs, routine preoperative LSA revascularization is strongly recommended, despite the very low-quality evidence (GRADE 1, level C).

Recommendation 3: In patients who need urgent TEVAR for life-threatening acute aortic syndromes where achievement of a proximal seal necessitates coverage of the left subclavian artery, we suggest that revascularization should be individualized and addressed expeditiously on the basis of anatomy, urgency, and availability of surgical expertise (GRADE 2, level C). (J Vasc Surg 2009;50:1155-8.)