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Invited Commentary

Commentary on 'Aortomonoiliac Endografting after Failed Endovascular Aneurysm Repair: Indications and Long-term Results'

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All vascular surgeons/radiologists are aware of the higher rate and the implied costs of re-intervention after EVAR[1]: with peripheral angioplasty, for instance, given that these are smaller amounts often mean that these costs are swept under the carpet. With EVAR and the associated higher costs of both procedure and device, this becomes a significant issue. Furthermore, all is fine when things are going well, but it is of course in the nature of medicine for things to get complicated, particularly in this group of patients who by default come with a host of co-morbidities; the real issue is then with getting problems fixed with minimal disruption, i.e. **an endovascular problem should ideally have an endovascular solution**. This is especially so with the authors indicating a high mortality with open conversions, indicated in a sense in their own cohort with a V-POSSUM score exceeding 11%.

There are several points to examine: firstly, the premise of the paper itself. The authors present salvage AMI-redoEVAR for mostly type I or type III endoleaks, and no one would debate the issue with the need to deal with these *and* an increasing sac, though, as referenced, even endotension has been treated as such. Importantly this has also shown up shortcomings with older devices, and certainly if the fabric in one Vanguard device disintegrated, how many more are there waiting for the same to happen?

Secondly, follow-up. In the UK repeated outpatient follow-up post-EVAR simply does not occur; this would likely upset the balance in new-to-follow-up ratios, a criterion that is closely performance managed. Yes, pulse examination can pick out reduction in pulses, but reliable duplex examination can interrogate the flow aspects in any case. I understand this has now been modified. The ESVS guidelines for EVAR surveillance would be a useful reference in this regard.[2]

Thirdly, access still remains an issue even the second time around as indicated by the one failure, even though the authors have experience with conduits. Low-profile (LP) AMI devices are now available, but following on from my own correspondence with Cook regarding my own patients, the turnover time for these is about 8 weeks. AMI conversion with/without femorofemoral (if the contralateral limb is asymptomatically occluded)[3] crossover provides a simple and effective solution to the problems with endoleaks and sac expansion as presented.

The future step in addressing top end migration, with a view to reducing type Ia endoleaks, may well be to look at primary endostapling/endofixation using, for instance, the HeliFX Aortic Securement System (Aptus Endosystems, Sunnyvale, CA,USA) particularly for short/conical necks. A large trial/cohort study in this context may well have a bearing on altering device IFUs related to neck morphology.[4]

The authors provide real-life endovascular solutions, including a clear report of the complications that still occur, that are easily applicable in all centres undertaking EVAR. The next thing to see is how much all this costs, financially (given that an AMI conversion would have pretty much doubled endograft cost *per aneurysm*) and otherwise, especially if older devices start declaring their frailties!

References

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