**Re: ‘Endovascular Treatment of Ruptured Abdominal Aortic Aneurysms with Hostile Aortic Neck Anatomy’**

We read with great interest the article by Broos and colleagues. The authors reported encouraging outcomes of EVAR in ruptured AAA with hostile aortic neck anatomy (HNA). We congratulate them for such a wonderful result, which may broaden the selection criteria of the current endovascular strategy to include patients previously excluded from EVAR.

As the authors advocated, it is technically feasible and safe to perform EVAR in rupture AAA with HNA at experienced endovascular centres. However, their results may not be generalisable to less experienced centres, and they did not tell inexperienced surgeons what to do under these circumstances. Previously, Brownrigg and colleagues reported that endovascular aneurysm sealing (EVAS) is effective for AAA with challenging aortic anatomy, which seems suitable for treating a greater proportion of patients than EVAR. As stent length is the only sizing variation, EVAS is of benefit in the emergency setting for ruptured aneurysm repair. Ruptured AAA with HNA can be repaired by experienced or inexperienced surgeons with the revolutionary EVAS.

**REFERENCES**


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Response to ‘Re: Endovascular Treatment of Ruptured Abdominal Aortic Aneurysms with Hostile Aortic Neck Anatomy’

We would like to thank Zhou et al. for sharing their views on the treatment of ruptured abdominal aortic aneurysms (rAAAs) with hostile infrarenal aortic neck anatomy. The current EVAR devices have proven their safety and efficacy, in both highly specialized and less experienced centers. In contrast, the endovascular aneurysm sealing (EVAS) technique is relatively new and information on intra- and post-operative complications is sparse. For this reason we feel that great care should be taken in emergency use.

The first real world EVAS registry data have only been published recently. These data consist of selected patients treated in internationally renowned vascular centers. Technical success is promising, but secondary interventions were required in 9% of patients within 12 months. These clinical failures were associated with patient selection and deployment techniques. Current literature on EVAS for rAAA treatment consists of a mere nine patients. All patients were treated in large vascular centers with substantial elective EVAS experience.

In addition, endobag filling in EVAS is performed under pressure monitoring of 180–220 mmHg, which allows the correct dosage of the polymer to seal the aneurysm. Theoretically, this pressure guided strategy could increase the aortic tear in a rAAA.

Although EVAS proposes sizing benefits, experience in “less experienced hands” is not available. In contrast, there is extensive experience with standard EVAR devices in treating rAAA. While EVAS aims at treating hostile anatomy, the current instructions for use are the same as those applied in our patients.

We feel that it is too early to speculate on the use of EVAS for rAAA, especially in hostile anatomy and most certainly by less experienced operators. In our opinion, the emergency outside IFU use of any device should only be