Flow Modulator (MFM) to treat these aneurysms and try to avoid some major complications. 

Methods: This MFM is a 3 Dimensional braided tube made of several interconnected layers without any covering. Our earlier tests through studies as theoretical simulation, computerized Fluid Dynamics, Molecular Modeling, Finite Elements Analysis and through in vivo tests demonstrate that in an Aortic Aneurysm this MFM: - eliminates the damaging flow vortex pressure, - laminates and redirects its flow along the wall, - directs and increases the flow in the collateral branches which remain patent (any artery can be covered with the stent without compromising the flow). This MFM prevents the aneurysmal rupture and leads to progressive thrombosis and shrinkage of this aneurysm. 

Results: 9 TAAA, 5 AAA (4 extended to both iliac arteries) in 14 very high risk compassionate cases (Male: 12, mean age 66 y) were treated with the MFM. Technical success: 100%. Average MFM used: 1 to 4 units implanted by femoral approach. No periprocedural complications. 30 day outcomes • Branch patency 100% • No death • No rupture and no re-intervention. Follow up: 1 to 36 months at M6 MS not stent related (stroke) • Branch patency: 100% • Progressive sac thrombosis and shrinkage depending on importance of collateralars. Diapers and volume evolution of aneurysms will be presented.

Conclusions: A new concept of stent, the MFM (without any covering) is developed to treat aneurysms. It laminates the flow inside the aneurysmal sac reducing the risk of rupture and allows to cover any artery. It opens a new approach to treat TAAA and AAA. 
The first results seem promising, avoiding some major complications encountered with endografts. A larger study is ongoing.

TCT-117

Peri-procedural and Follow Up Outcomes After Endovascular Abdominal Aortic Aneurysm Repair by Interventional Cardiologists

Abhiqet Basso1, Kiril Patel2, Abdul Hajarbali3, Nishit Choksb, Thanh Phanb, Michael DeGregoria1,2,3
1St. Joseph Mercy Oakland Hospital, Rochester Hills, MI, 2St. Joseph Mercy Oakland Hospital, Pontiac, MI

Background: Endovascular repair of abdominal aortic aneurysm (AAA) is a minimally invasive treatment for AAA and has recently been made a class I indication in the treatment of AAA. In comparison to the conventional open surgical treatment, endovascular aortic repair (EVAR) is associated with equivalent long-term morbidity and mortality rates. Vascular surgeons perform majority of the procedures. There are no reports for the long-term results of this intervention performed by Interventional Cardiologists. We hypothesized that EVAR performed by Interventional Cardiologists can have good peri-procedural and long-term success rates.

Methods: Retrospective chart review on patients with attempted EVAR between September 2005 and January 2011 was performed. Included cases were all consecutive patients who had attempted EVAR by Interventional Cardiologists with available peri-operative and follow-up data. Collection included demographics, aneurysm specific data, comorbidities, length of stay, peri-procedural complications and follow up outcomes.

Results: During the study period EVAR was attempted in 170 patients, with 27% being women. The mean age was 72.1 years (range 52 to 93). The endovascular graft placement was successful in 96% (163/170) of patients. Procedure failures were more common in women (6 of 46 Vs 1 of 124, p = 0.002). There was no significant difference for failure rate based on neck length (0 of 18 Vs 7 of 175; p=NS). Short-necked aneurysms required non-covered balloon expandable stents more commonly for either proper fixation or for type I endoleak (16 of 18 Vs 25 of 152; p=0.001). In patients with successful EVAR the mean follow up was 30 months (range 2 to 66). Major peri-procedural complications were noted in 7% patients (12 of 167). There was no significant difference in short necked and other AAA in terms of 30-day mortality, development of renal failure, leg ischemia, development of endoleaks or other complications. During follow up, re-intervention was needed in 0 of 18 short-necked Vs 5 of 152 other AAA (p=NS).

Conclusions: Modifying EVAR by using balloon expandable stents can successfully treat short-necked AAA, suggesting a potential novel approach to such patients. This is one of the first reports showing high peri-procedural and long-term success rates for such aneurysms performed by Interventional Cardiologists.

TCT-118

The Clinical Significance Of Coronary Angiography In Elderly Patients Undergoing Endovascular Repair For Type B Aortic Dissection

Pengcheng He1, Jiyan Chen1, Jianfang Luo2, Nin Tam3
1Guangdong Provincial Cardiovascular Institute, Guangzhou, China, 2Guangdong Provincial Cardiovascular Institute, Guangzhou, China

Background: Although sharing some common risk factors with and predicting worse prognosis of type B aortic dissection, the incidence of concomitant coronary artery disease in patients with type B dissection has not been studied comprehensively.

Methods: From January 2008 to December 2010, coronary angiography was routinely performed before aortography and endovascular repair to detect and quantify CAD in 134 consecutive Stanford type B AD patients who were older than 50 years. Data pertaining to clinical and imaging details were prospectively collected and evaluated. Test for the Fisher exact test was used when the expected frequency was <5. was used to analyses the data. Logistic regression was applied to determine the predictors of concomitant CAD.

Results: Coronary angiography showed 35 patients (26.1%) had CAD, among them, 22 (16.4%) had single-vessel disease (SVD), 9 (6.7%) had 2VD and 4 (3.0%) had 3VD. SVD and left main disease (LMD): Multi-variace logistic analysis showed that male gender (OR=6.682, 95% CI:1.01-44.13, p=0.049) and smoking (OR=3.513, 95% CI: 1.05-11.70, p=0.041) were the strongest predictors of Stanford type B AD coexisting with CAD.

Conclusions: The incidence of CAD in patients older than 50 years with Stanford type B AD is relatively high. Given the significantly negative impact on the prognosis, concomitant coronary artery disease should be screened routinely by coronary angiography before endovascular repair in type B dissection patients who are older than 50 years.

TCT-120

The Policy Of Total Percutaneous Abdominal Aortic Aneurysm Repair: One-year Follow-up

Juraj Madarić1, Marek Toš1, Tibor Balázs1, Rastislav Bazák1, Juraj Mikula1, Terezie Urlandová1, Daniela Hladkova1, Erika Drangova1, Jana Margitňová1, Andrej Klepčian1, Ivan Vuleč1
1National Cardiovascular Institute, Bratislava, Slovakia

Background: Endovascular abdominal aortic aneurysm repair (EVAR) is accepted therapeutic strategy. The use of a total percutaneous approach to endovascular repair of aortic pathology is becoming more common and further extends the EVAR indications. The aim of our retrospective analysis was assessment of safety, technical success, and mid-term results of elective patients scheduled for total percutaneous EVAR implantation (PEVAR).

Methods: Sixty-two consecutive patients (MF 57,5; age 70±9 years, maximal AAA diameter 61±14mm) underwent elective PEVAR between 1/2009 and 12/2010. All patients were treated in local anesthesia by total percutaneous approach via femoral access using the precise technique with the Prostar XL suture-mediated closure device (Abbott Vascular, US). The immediate technical success of stent graft deployment and the presence of 30-days and 1-year complication rate were assessed.

Results: In all 62 patients (100%) there was immediate technical success of procedure, with no need of conversion to open surgery. There was one case of renal failure (1.6%), an episode of acute bowel ischemia (1.6%) at 30-days follow-up. Repeat intervention was needed in 8% (5pts). Event-free survival at 30-days was 89% (55/62pts). There were 16 cases of the femoral artery pseudoaneurysm per 124 punctures (13%), all treated by compression or by percutaneous thrombin injection. Antiocclusion therapy emerged as the risk factor for the femoral artery pseudoaneurysm occurrence (OR 5.75, 95% CI 1.01-44.13, p=0.049). At one year Deteriorory 2010, 30-day mortality increased to 9.6% (6 pts), overall event-free survival was 81% (Mortality/MI/stroke/reintervention/ severe ischemic complication).

Conclusions: The policy of total percutaneous endovascular abdominal aortic aneurysm repair is linked with low mortality and acceptable complication rate in pts scheduled for EVAR implantation. Anticoagulation therapy is the risk factor for the femoral artery pseudoaneurysm occurrence after PEVAR. The correct indication, technical realization, and adequate periprocedural management are essential for further reduction of adverse events after PEVAR.