An Endovascular Aortic Dissection Approach
With An Ultra-low Profile Stent Graft

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Introduction
A chronic aortic dissection Stanford type B can be treated when symptomatic or complicates with aneurysm degeneration, ischemia or its distal propagation. Since the first intraluminal stent graft device described by Parodi\(^1\) for an abdominal aortic aneurysm therapy, the endovascular techniques have evolved and expanded to treat other vascular pathologies. In an aortic dissection, an endovascular approach is a less invasive alternative to surgical graft replacement, especially in the thoracic segment. Due to the increase of thoracic aortic endografting repair, challenging aortic anatomies and small access vessels, low-profile endografts have been developed\(^2\).

Case Report
A 54 year-old male patient with arterial hypertension, dyslipidemia and an asymptomatic aortic dissection Stanford type A associated with a 66 mm ascending aortic aneurysm was submitted to a conventional open cardiac surgery with a Dacron supracoronary tube and a E-VITA open plus 28X28X150 mm graft (FIG 1, 2).

He presented with an acute abdominal pain associated to paraplegia. The angio-CT revealed the same aortic dissection from the descendent segment to the bilateral common iliacs with maintained visceral perfusion. No endoleak or increase of the aneurysm sac were observed. Due to his significant symptoms, a ZENITH DISSECTION 42X42X123 mm endoprosthesis was placed near the left subclavian artery till the celiac trunk proximity through a dissected right femoral and a punctured left femoral common arteries. Furthermore, it was complemented with a SIOXX DS 40x50 mm endograft (FIG 2 e 3), closing the bilateral femoral common arteries puncture with Perclose Proglide.

In behalf of the abdominal pain persistence, an inferior mesenteric and right internal iliac arteries embolization, associated with an infra-renal INCRAFT endoprosthesis (Main Body 30X98 mm / 20X100 mm Contralateral graft /13X120 mm Ipsilateral graft) were performed to complete the aortic dissection treatment. The right femoral common artery was dissected and the left closed with Perclose Proglide. The patient evolved with no pain and there were no complications related until present. The control angio-CT is scheduled for February 2016.

Conclusion
Chronic aortic dissection is a complex vascular pathology; each patient is a singular case that must be followed. The endovascular techniques development allowed a less invasive treatment. The ultra-low profile stent graft reflects the device’s endovascular improvement and has emerged as a secure therapy for complicated vessel access, especially when the artery has already been surgically manipulated.

REFERENCES: