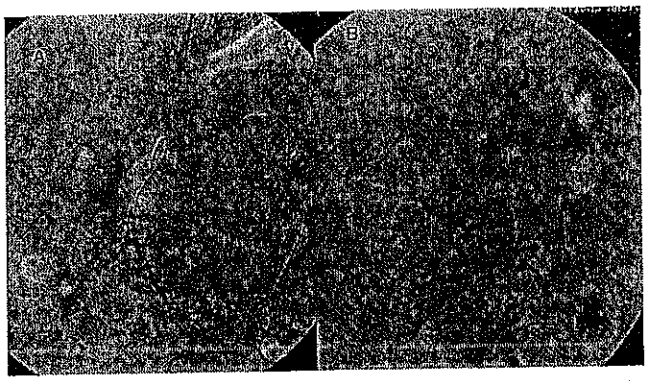


Figure 1.—Pre (A) and post (B) inferior mesenteric artery coil embolization for resistant Type 2 endoleak.

ferior mesenteric artery and coil embolization of inferior mesenteric artery origin and the second was transabdominal ultrasound guided sac catheterization and embolization of the sac with Onyx injection.
Results. Of 226 patients that were treated with EVAR, there was 35% (n=79 patients)Type 2 endoleak caused by inferior mesenteric artery. Eighty percent of them (n= 63 patients) were resolved spontaneously within 3 months and all were thrombosed. There were 20 % (n=16 patients) resistant Type 2 endoleak derived from inferior mesenteric artery. Only 37 % (n=6 patients) of resistant Type 2 endoleak caused sac expansion during the folloow ups. There was a total of 2.6% (6/226) patients that had resistant Type 2 endoleak derived from inferior mesenteric artery that caused sac expansion after EVAR. Four of them were treated with trans-superior mesenteric artery to reach inferior mesenteric artery and coil embolization of inferior mesenteric artery origin. Two of them were treated with was transabdominal ultrasound guided sac catheterization and embolization of the sac with Onyx injection. During follow ups no sac expansion or recurrence was observed. All sacs were thrombosed wtihin 3 months. There was no procedure related mortality or morbidity. No rupture was observed.
Conclusions. Trans-superior mesenteric artery, inferior mesenteric artery embolization with coils or transabdominal ultrasound guided Onyx embolization of the sac for resistant Type 2 Inferior mesenteric artery endoleak that causes sac expansion is a safe and effective method.

Key words: EVAR, Type 2 endoleak, embolization, inferior mesenteric artery, Onyx, coil

OP-156
Early Evaluation of the Precise Deployment with New Low Profile Zenith Alfa Thoracic Endoprosthesys in Thoracic Aortic Disease

Maria Cecilia Perfumo, Bianca Pane, Giovanni Spinella, Valerio Gazzola, Debora Musio, Domenico Palombo

Vascular and Endovascular Surgery, IRCCS San Martino IST, University of Genoa, Genova, Italy

Objective. The aims of the study is to evaluate the early results of the low profile Zenith Alfa Thoracic Endoprosthesis (ZATE).
Methods. Between October 2012 and March 2014, 13 asymptomatic patients were treated with ZATE. 9 patients were male, mean age was 71, 7 years (range 58 – 85 years). 8 patients presented with atherosclerotic aortic aneurysm (7 thoracic aneurysm and 1 type I thoracoadbominal aneurysm), 2 chronic type B aortic dissection, 1 type IV endoleak 5 years after TEVAR, 2 aortic arch penetrating ulcer complicated by pseudoaneurysm. Hybrid staged procedures in 9 patients included 6 total aortic arch debranching (1 single (innominate) chimney stent graft + Carotid-Carotid-Subclavian), 1 carotid-carotid-subclavian artery bypass, 1 carotid-subclavian artery bypass.
Results. No 30-day mortality or major complications were observed. The mean length of stay was 7.3 days (range 4-14 days). Mean procedure time, X ray time and Contrast load were 115 min (range 90-150 min), 20 min (range 10-30) and 79 mL (range 40-120 mL) respectively. 24 stent grafts implanted. The mean follow up was 15 months (range 8- 24 months). No mortality and no major complications were observed during the follow-up. In case of arch debranching the mean distance between the beginning of the endoprosthesis and the debranching inflow vessel was 4,5 mm (±2,4 mm)
Conclusions. The use of ZATE could be a viable alternative for treating patients with aortic arch proximal landing zone to facilitate the precise deployment. Larger case studies and longer follow-up are needed.

Key words: TEVAR, thoracic aneurysm

NEW SOLUTIONS FOR CAROTID ARTERIAL DISEASE

17.30-19.00 (Hall 9)

OP-140
Is Simultaneous or Two Stage Invertion Safer For Patients With Coronary Artery Disease and Severe Carotid Artery Stenosis?

Hüseyin Saskın[1], Mustafa Idiz[2], Çağrı Düzyol[1], Rezan Aksoy[1], Hüseyin Maçika[3], Özgür Barış[1], Hakan Parlar[1], Orhan Fındık[1], Atike Tekeli Kunt[1]

[1]*Derince Education and Research Hospital, Department of Cardiovascular Surgery, KOCAELI*
[2]*Private Acibadem Hospital, Department of Cardiovascular Surgery, KOCAELI*
[3]*Private Acibadem Hospital, Anesthesiology and Reanimation Clinic, KOCAELI*

Objective. There are still arguments about options of surgical therapy and timing of surgery when carotid artery stenosis accompanies coronary artery disease requiring surgical intervention. This study was designed to answer whether one of the two strategies (simultaneous or staged intervention) were safer or not in terms of myocardial infarction, neurologic event and mortality in the postoperative period, if carotid endarterectomy and coronary artery bypass grafting operations were done together.
Methods. In two different centers between November 2006 and May 2014, 103 cases of simultaneous or staged carotid endarterectomy and coronary artery bypass grafting operations of which 31 patients were female and 72 were male were evaluated retrospectively. Seventy one patients in Group 1 were operated coronary bypass grafting under cardiopulmonary bypass following carotid endarterectomy under general anesthesia, whereas 32 patients in Group 2 were operated carotid endarterectomy under general anesthesia at first and coronary bypass grafting under cardiopulmonary bypass were performed one month later.

TABLE I.—*Demographic, clinical characteristics and neurological events in the two groups of patients.*

	Simultaneous carotid endarterectomy+ CABG (n=71)= Grup 1	Two-stage carotid endarterectomy+ CABG(n=32)= Grup 2	P-Value
Characteristic			
Mean age (years)	64.7±7,9 (45-82)	65.2±8,0 (50-80)	0.76
Ejection fraction (%)	52,3±12,4	57,4±9,5	0.04
Female	16(%22,5)	15(%46,9)	0.01
Hypertension	56(%78,9)	22(%68,8)	0,26
Diabetes mellitus	32(%45,1)	17(%53,1)	0.44
Smoking history	46(%64,8)	20(%62,5)	0.82
Hyperlipidemia	13(%18,3)	23(%71,9)	0.001
Symptom within a 6-month period	22(%31)	18(%56,3)	0.01
Left main >50% stenosis	14(%19,7)	8(%25)	0.54
Three-vessel disease	54(%76,1)	24(%75)	0.90
Bilateral carotid stenosis (>50%)	28(%39,4)	13(%40,6)	0.90
History of acute myocardial infarction	25(%35,2)	7(%21,9)	0.17
Obesity	8(%11,3)	13(%40,6)	0.001
Family history	58(%81,7)	11(%34,4)	0.0001
Peripheral arterial disease	13(%18,3)	7(%21,9)	0.67
Chronic obstructive pulmonary disease	2(%2,8)	9(%28,1)	0.0001
Neurological Events			
Transient Ischemic Attack	2(%2,8)	3(%9,3)	0.17
Right Hemiplegia	3(%4,2)	1(%3,1)	0.63
Left Hemiplegia	2(%2,8)	1(%3,1)	0.68
Peripheral Nerve Injury	1(%1,4)	2(%6,2)	0.22
Total	8(%11,2)	7(%21,7)	0.23

Results. The mean age of the patients were 64.84±7.89 years (range 45 to 82). Twenty two of the patients in Group 1 (31%) and 18 of the patients in Group 2 (56.3%) were symptomatic which was significantly different between the two groups. Neurologic event rate was detected as 14.6% (15 of 103), mortality rate was 3.9% (4 of 103), stroke/death rate was 1.95% (2 of 103) and myocardial infarction rate was 6.8% (7 of 103) in the early (first month) postoperative period. There were no significant differences between the groups in terms of postoperative mortality and acquired neurologic events. There was a significant difference between the groups in terms of myocardial infarction.

Conclusions. Carotid endarterectomy operation together with coronary artery bypass grafting can be performed with acceptable morbidity and mortality in two different surgical techniques (simultaneous or staged). It is still controversial whether the operations should be performed simultaneous or two staged, and if two staged, which one to be performed at first. We believe that both surgical techniques result similarly, however preoperative and intraoperative risk factors should be minimized to reduce postoperative myocardial infarction, neurologic events and mortality.

Key words: Carotid artery stenosis, coronary artery bypass grafting, stroke

OP-141
Carotid Endarterectomy in The Octogenarian With Bilateral Disease

Onur Selçuk Goksel[1], Mehmet Akif Onalan[1], Didem Melis Oztas[1], Bayer Cınar[2], Celalettin Karatepe[3], Ufuk Alpagut[1]

[1]Cardiovascular Surgery Department, Istanbul Medical Faculty, Istanbul University, Istanbul, Turkey
[2]Cardiovascular Surgery Department, Medical Park Hospital, Istanbul, Turkey
[3]Cardiovascular Surgery Department, Medical Faculty, Mustafa Kemal University, Antakya, Turkey

Carotid endarterectomy (CEA) has proven efficacious and safe in symptomatic patients and to a lesser degree in asymptomatic patients with high-grade carotid stenosis in large randomized controlled trials, serious concern remains about the risk/benefit ratio in short and longer terms in this particular group of elderly patients. In this retrospective analysis of our single center cohort, we aimed to determine the outcome of carotid endarterectomy in the octogenarians with or without contralateral carotid stenosis (CCS) or occlusion (CCO) and compared the results with a similar cohort of younger age.

From 2005 to 2013, 142 CEAs were performed by a single surgical team on 128 patients were reviewed for early outcome in regards to hospital mortality and stroke following institutional review board approval.Patients at the age of 80 and older were identified

In the 7-year period, 128 patients 111 males; mean 68.5±9.3 years-old, range 49-85) underwent CEA by the same surgical team.14 patients had severe bilateral disease and underwent bilateral CEAs in a staged fashion.A total of 32 CEAs were performed in 27 octogenarians.Contralateral carotid artery occlusion was seen in a total of 14 patients.

Carotid endarterectomy,despite the general perception,is a viable option for patients with CCO or bilateral disease even in the octogenarian group with CEA outcomes not different in the latter group than the younger patient population.Adherence to appropriate cerebral monitoring and liberal use shunting whenever appropriate yield comparable outcomes after CEA and better survival than the natural history.

Key words: carotid endarterektomy,octogenerian

OP-142
Treatment of Stroke After Carotid Endarterectomy

Igor Koncar[1], Nikola Ilic[2], Natasa Ristanovic[1], Milos Sladojevic[1], Perica Mutavdzic[1], Ivan Tomic[1], Lazar Davidovic[1]

[1]Clinic for Vascular and Endovascular Surgery, Serbian Clincial Centre
[2]Medical school, University of Belgrade

Rate of neurological complications after carotid endarterectomy (CEA) is decreasing but still it is not annulated. Multiple publications are reporting incidence of minor and major stroke after carotid surgery however very few are describing methods for treatment of this catastrophic complication.

Objective. Aim of this paper is to present experience in treatment of early stroke after CEA

Methods. In the period January 2007 - November 2014, 2450 patients with carotid stenosis were operated. This prospective study collected data of 64 (2.6%) patients that suffered neurological complication after CEA. Clinical presentation, time of onset, diagnostic procedures and therapy were analyzed.

Results. There were 3 (4.7%) intraoperative neurogical complica-



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