EVAS and EVAR: What are the differences in case selection, deployment and surveillance?

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Disclosure

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I have the following potential conflicts of interest to report:

- [ ] Consulting
- [ ] Employment in industry
- [ ] Shareholder in a healthcare company
- [ ] Owner of a healthcare company
- [x] Proctorship and educational fees (Endologix)
- [ ] I do not have any potential conflict of interest
EVAS

Different concept
Sealing, not fixation
Stents + “endobags”
EVAS planning
anatomical constraints

Absence of infra-renal segment

Angulation

“Diseased” neck

Aneurysm length

Narrow aortic bifurcation

Large aorto-iliac lumen
Suitability for EVAR/EVAS by IFU

776 AAAs

EVAR IFU compliant: 29.3-68.1%
EVAS IFU compliant: 70.1%

Karthikesalingam et al., EJVES 2013 46, 440-445 DOI: (10.1016/j.ejvs.2013.06.017)
EVAS outside IFU

- Neck diameter
- Aneurysm length
- Lumen diameter
- Narrow bifurcation
EVAS
outside IFU
EVAS deployment

- Technically easy, quick
- Two operators
- No contra-lateral limb cannulation
- Pressure is key
- Less radiation
EVAS deployment

3 steps

1. Position the devices

2. Deploy stents

3. Fill endobags
EVAS deployment
Pressure
Theatre time

$P < .001$
Radiation
DAP

$P < 0.01$

Gy cm$^2$

EVAS
EVAR
Follow-up

D’Abate et al., JEVT, doi:10.1177/1526602815576098
Mc Williams et al., JEVT doi:10.1177/1526602815582209
Karthikesalingam et al., JEVT doi:10.1177/1526602815583455
Follow-up
endobags
Follow-up
endobags

a

b
Follow-up
thrombus compression
EVAS

Radically different concept from EVAR

Easier deployment, less radiation

New surveillance findings

New pitfalls