rAAA

“How Do I Do It”

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rAAA

"What I Learned From My Cases That Did Not Go As Planned"

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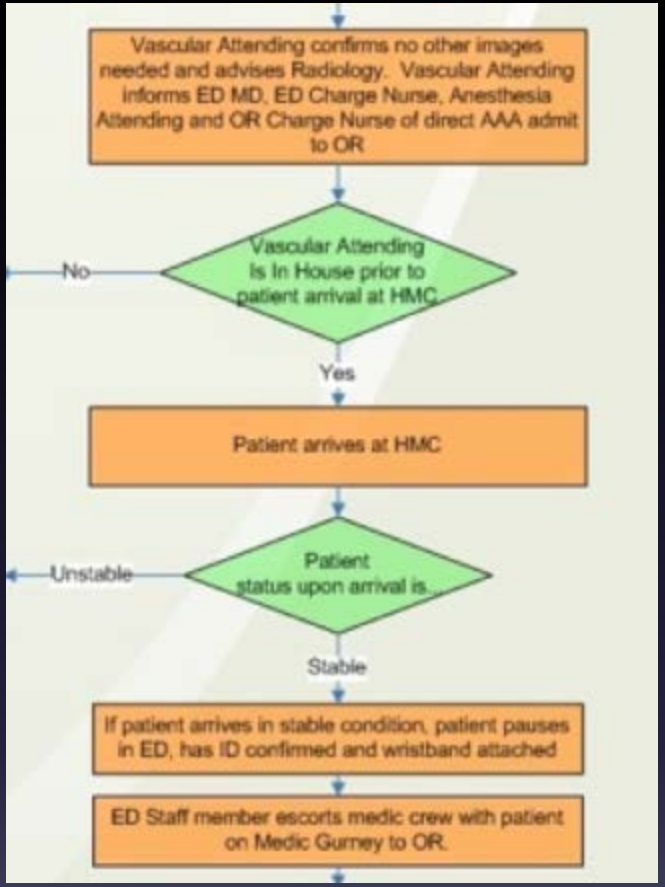
Agenda

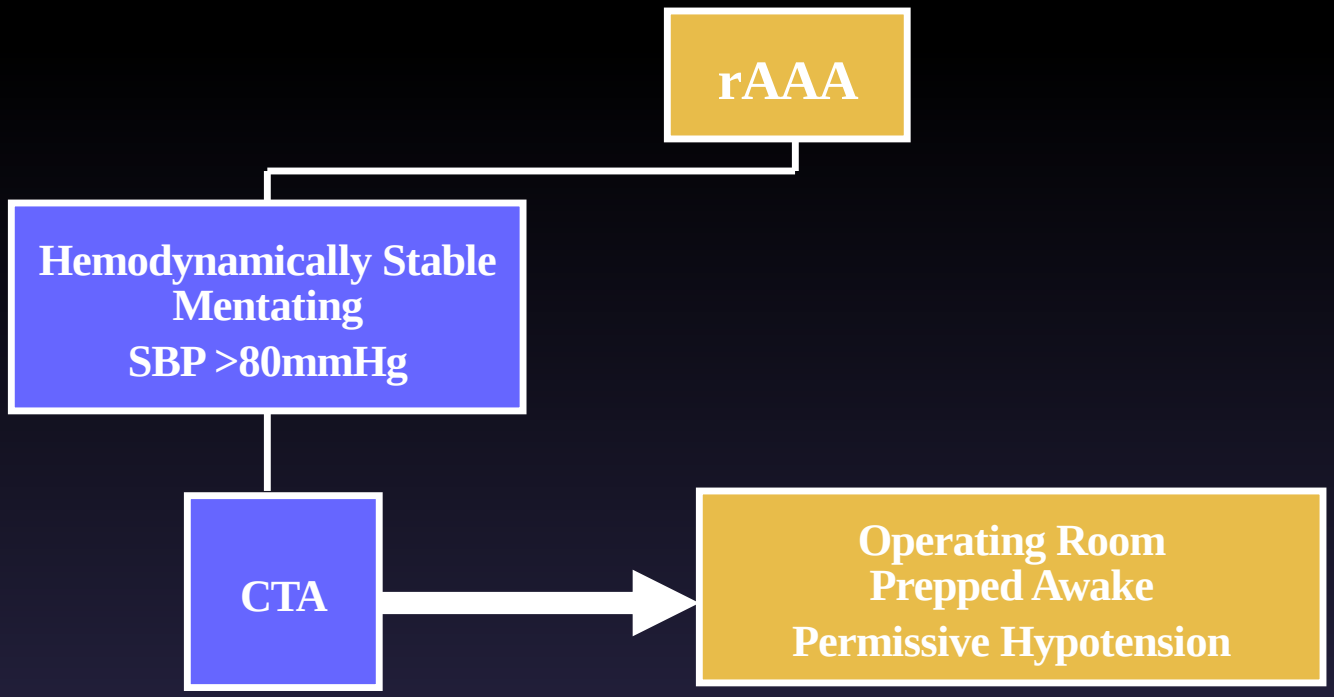
- Direct to OR algorithm and rAAA protocol
- General approach
  - Unstable rAAA
  - rAAA without adequate (CTA) pre-op imaging
  - Balloon occlusion dependent patients

Direct to OR Protocol

- Vascular to be in the ED to meet the patient at the door and escort to OR front desk
- Facilitate patient prep in the OR

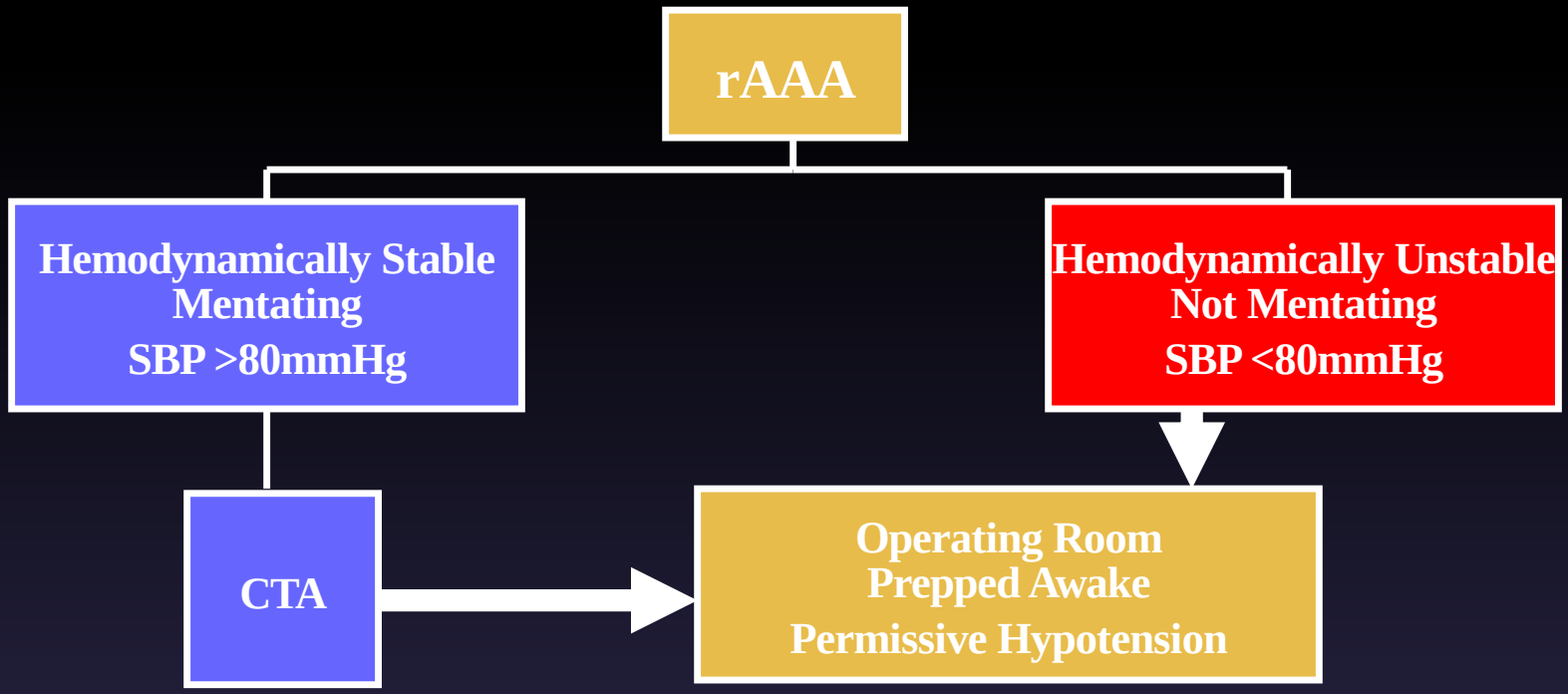


UW Ruptured Protocol



Mehta et al JVS 2006;44:1-8

UW Ruptured Protocol



Mehta et al JVS 2006;44:1-8

The Unstable Pt.

- 62 yo male presented to ED with abdominal pain
- Eventually underwent CTA

11/1/2017 10:00
100
Information not p...
5
6.86 (d) C
63 H
275 H
11 L
Test Not Required
20.5 (d) H
Calculated O2 SA...

15.0 H
5.2 (d) C
17 (d) L

11/1/2017 10:00
100
Information not p...
5
6.86 (d) C
63 H
275 H
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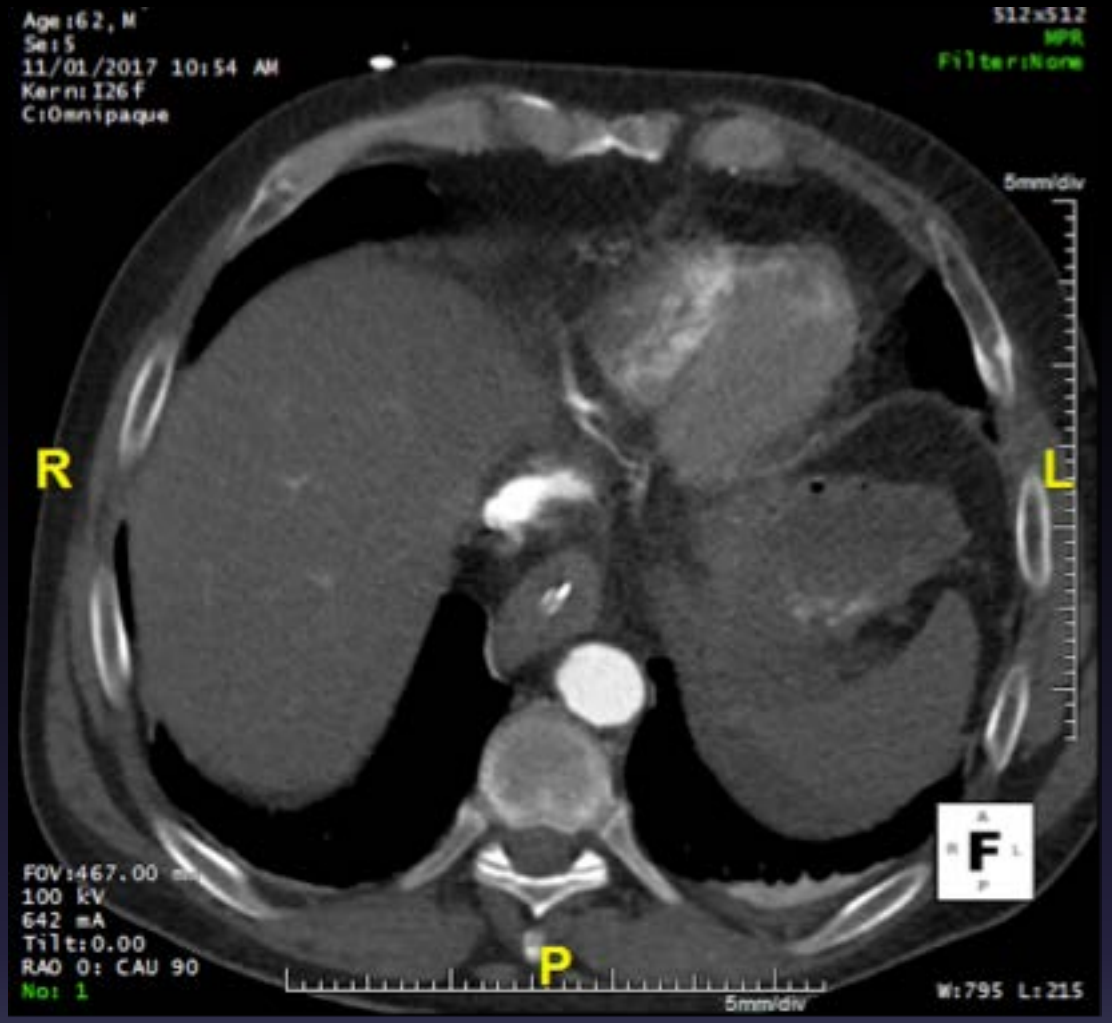
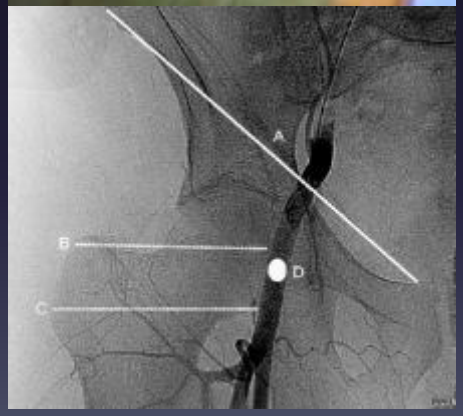


The Unstable Pt.

- Direct to OR
- No longer fluid responsive
- Awake, difficult femoral access
- Balloon eventually placed
- GA induction

The Unstable Pt.

- Aortic Control Is Critical
- Arterial Access Based on Landmark and Fluoroscopy
- Venous Access Can Be Used for Resuscitation

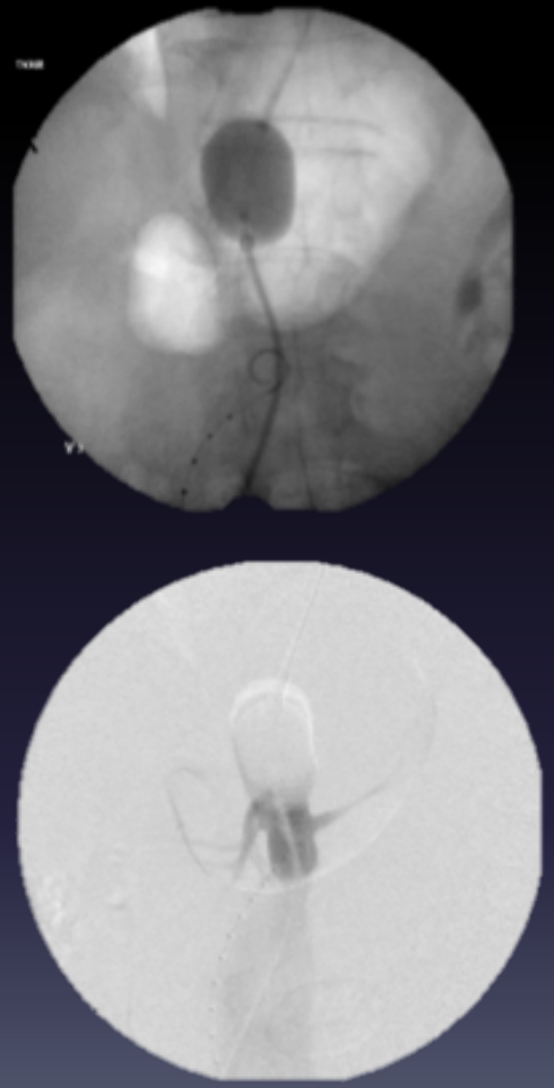


Aortic Control

- 5 Fr sheath
- Kumpe cath, glide wire to navigate aortic neck
- Exchange for stiff wire (Lunderquist)
- 12 Fr long sheath, CODA balloon
- Applicable to both rEVAR and OSR

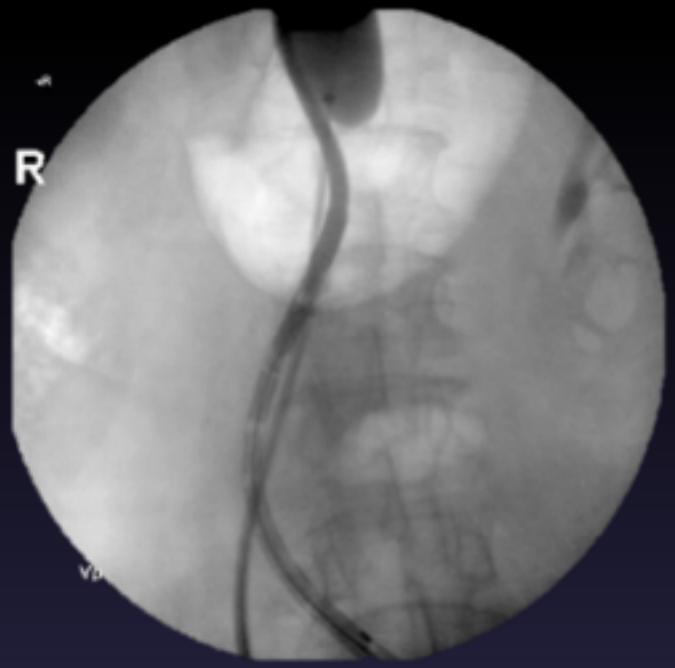
AOB Dependent

- AOB up one side
- Pigtail from contralateral side for aortogram
- Place pigtail pass balloon into thoracic aorta to exchange for Lunderquist wire



AOB Dependent

- Partially deflate balloon to allow for main body to be placed
- Pull back sheath and inject to localize renals
- Deploy main body

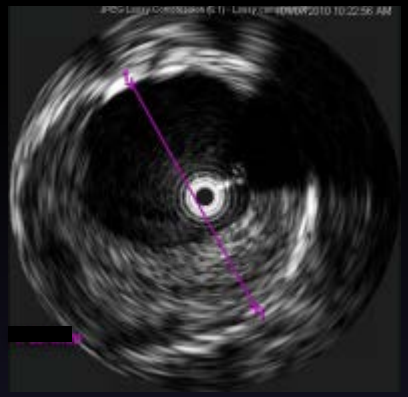


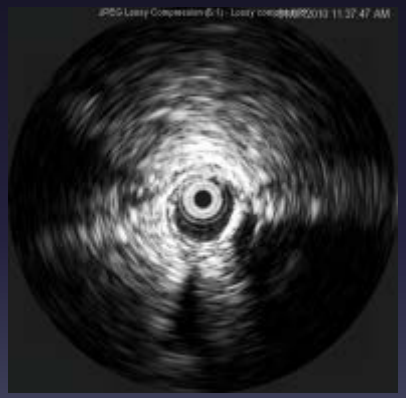
AOB Dependent

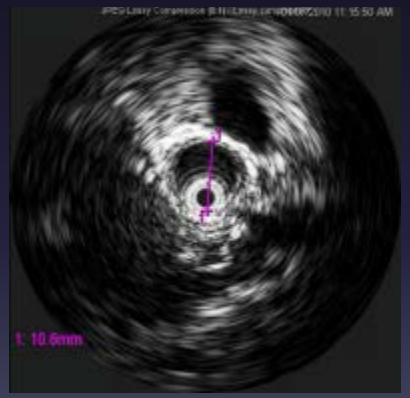
- If patient still unstable, then finish ipsilateral side, place balloon into main body
- Finish the contralateral side

Patient Without Pre-op Imaging

- Initial flush aortogram to assess quality of aortic neck
- Sizing can be done with IVUS for neck and distal landing zones
- *Do not delay OR/transport to obtain CTA*
- *Unstable patient should go directly to the OR without imaging*







Gate Cannulation

- Need to be done quickly – sometimes easier said than done
- AUI does work but can lead to potential problems later

Gate Cannulation

- Have a limit in your head of time spent
  - Move on if > 5 minutes
    - Up and over to snare
    - Brachial approach
- Set yourself up for success
  - Main body via more tortuous side
  - Long body to place gate close to bifurcation

Gate Cannulation

- Rotate C-arm to determine if contralateral wire is anterior or posterior as related to the ipsilateral side
- Orient the gate based on location of the wire

Conclusions

- Being efficient and calm, NOT fast, is the key to a successful outcome
  - Aortic control
  - Minimize time in the OR
  - Have multiple back up plans
  - Know your endograft
- Manage yourself, your team, and your patient

What About The Pt?

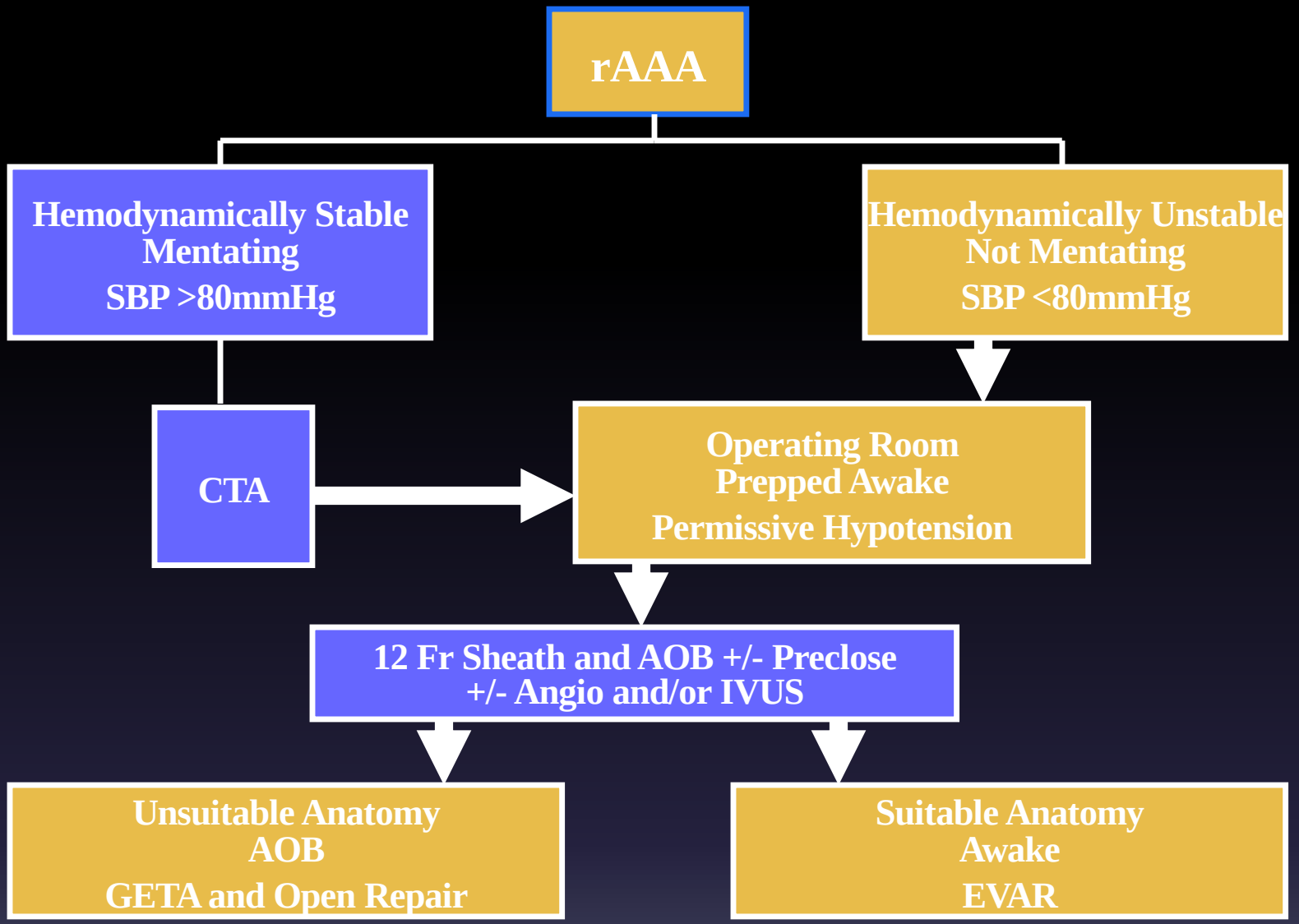
11/1/2017 10:00
100
Information not p...
5
6.86 (d) C
63 H
275 H
11 L
Test Not Required
20.5 (d) H
Calculated O2 SA...

11/1/2017 17:21
50
Information not p...
5
7.39
43
104 H
25
0.4
Test Not Required
Calculated O2 SA...

15.0 H

3.5 H


Study Date:12/14/2017
Study Time:13:09:31
MRN:H4216095
[L]
[F]
C40
W400



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Balloon Dependent