Case Report

Late Retrograde Aortic Dissection after Hybrid Thoracic Endovascular Aortic Repair (TEVAR): A Case Report

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Abstract

Open total arch replacement is allied to high rates of mortality and morbidity; surgeons, therefore, tend to choose hybrid aortic arch repair as a less invasive operative procedure for the treatment of aortic arch aneurysms, especially in high-risk patients. However, studies on the early and late outcomes of patients undergoing hybrid aortic arch repair have revealed high rates of reintervention and reoperation compared with open total arch replacement. Here, we describe a male patient with late retrograde aortic dissection after hybrid thoracic endovascular aortic repair for aortic arch aneurysms. The patient returned 3 years after the procedure with signs of dyspnea on exertion and chest pain. Transthoracic echocardiography and computed tomography showed dissection of the ascending aorta, for which he underwent a redo Bentall procedure. The patient was weaned from cardiopulmonary bypass without any problem and discharged after 7 days.

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Introduction

The management strategy for aortic arch aneurysms persists as a clinical challenge. The complexity and high mortality and morbidity rates of open total arch replacement (OAR) have prompted surgeons to draw upon thoracic endovascular aortic repair (TEVAR) or hybrid aortic arch repair (HAR) procedures. HAR, defined as the debranching of the arch vessels and endovascular stent-grafting, assumes greater significance in patients who cannot tolerate OAR. Although long-term studies have indicated a drop in the rates of mortality and morbidity following TEVAR, the application of this modality for the treatment of aortic arch aneurysms (more frequently in zone 0 and zone 1) is associated with such adverse effects as retrograde type A aortic dissection.\textsuperscript{1,2}

We herein report a case of late retrograde type A aortic dissection 3 years after hybrid TEVAR.

Case Report

The applied method in this study for a case report was
approved by the Research Ethics Committee of Tehran University of Medical Sciences, and written informed consent was obtained from the patient before any intervention.

A 43-year-old man was referred to Tehran Heart Center with dyspnea, hoarseness, and pulsatile mass at the base of the neck. The patient had a history of hypertension, hyperlipidemia, smoking, and opium addiction, as well as a family history of heart disease. Physical examination revealed a pulsatile mass at the base of the neck. Chest X-ray showed a widening in the upper mediastinum, and electrocardiography indicated left ventricular hypertrophy due to hypertension. Transthoracic echocardiography illustrated diastolic dysfunction, a mildly dilated left atrium, mild mitral and tricuspid regurgitation, a normal aortic valve, a hypertrophic interventricular septum, and a dilated aortic arch (53 mm) (Figure 1). Computed tomography (CT) angiography showed a 65 mm aneurysm in the aortic arch and a normal ascending and descending aorta.

The patient was candidated for the debranching of the aortic arch branches, followed by TEVAR. In the debranching procedure, through a median sternotomy, the brachiocephalic trunk and the left common carotid arteries were moved to the ascending aorta with a 16×8 mm 2-branched Dacron graft under normothermic cardiopulmonary bypass due to the displacement of the arch branches by the aneurysm.

The left subclavian artery was left alone for trans-arterial occlusion in the next stage because it originated from the top of the aneurysm and it was dangerous for debranching. Vascular access for hybrid TEVAR was the right femoral artery. The left subclavian artery was occluded with the device to prevent possible type II endoleaks, and it was filled from the left vertebral artery after the occlusion of the left subclavian artery/stent-graft implantation. A radiopaque marker was implanted around the aorta, 2 to 3 cm proximal to the aneurysm, as a guide for the retrograde implantation of the stent-graft (Cook Medical) into the aortic arch and the proximal descending aorta (Figure 2).

Three years after the hybrid TEVAR procedure, the patient returned with dyspnea on exertion and chest pain. Transthoracic echocardiography showed severe aortic valve insufficiency and aneurysmal dilatation in the ascending aorta (69 mm), resembling a dissection flap, with linear echogenicity in the ascending aorta. Computed tomography angiography showed dissection of the ascending aorta originating from the proximal edge of the previously inserted stent-graft and extending toward the left coronary sinus (Figure 3).

The patient was candidated for a redo Bentall operation via the femoral artery and radial artery cannulation. The aorta was cross-clamped at the level of the common trunk of the
debranching graft. Afterward, aortotomy was performed, followed by direct cardioplegia infusion into the ostium of the coronary arteries. The common trunk of the debranching graft was cannulated, and selective cerebral perfusion was maintained during the entire hypothermic circulatory arrest. Next, the ascending aorta was transected, and the Bentall procedure was performed (Figure 4) with a 25 mm composite graft. Afterward, the composite graft was distally anastomosed to the proximal end of the previous TEVAR stent-graft. Thereafter, the debranching graft was reinserted end-to-side into the ascending aortic graft. The patient was weaned from cardiopulmonary bypass without any problem and discharged on the seventh postoperative day.

**Discussion**

An aortic aneurysm is defined as aortic dilatation at least 1.5 times the normal aortic diameter that can affect 1 or more sites of the thoracic aorta (aortic root, ascending aorta, aortic arch, and descending aorta). Aortic aneurysms are classified by Mitchell and Ishimaru based on the zone; however, isolated aortic arch aneurysms are rare and are usually associated with aneurysms in the ascending or descending aorta.³

Thoracic aortic arch aneurysms (TAAs) constitute a life-threatening condition given the risk of rupture. The misdiagnosis of TAAs can lead to the rupture of the aorta and result in malperfusion in extremities (25%–60%) as well as renal (23%–75%), mesenteric (10%–20%), coronary (5%–11%), cerebral (3%–13%), and spinal (2%–9%) arteries. The pathophysiology of aneurysms in the ascending aorta and the aortic arch could be due to some kinds of familial syndromes with changes in connective tissue. Additionally, some other conditions such as infection and inflammation are responsible for insufficiency in connective tissue, which may lead to aneurysm formation in the ascending aorta and the aortic arch.⁴

Most aortic aneurysms are clinically silent and could be incidentally revealed during chest X-ray or echocardiography. Nonetheless, when they are symptomatic, the most important signs are chest or back pain, hoarseness, cough, and shortness of breath. TAAs can cause unilateral vocal cord palsy, and hoarseness can be a predictor of an impending rupture.⁵.⁶ Often, an unremarkable physical examination is expected for a TAA. Chest X-ray can reveal a TAA as a convex contour of the right superior mediastinum caused by an enlarged ascending aorta and a diminished retrosternal air space. Transesophageal echocardiography is an invasive imaging modality that can differentiate a TAA from dissection or intramural hematoma.⁴

The diagnosis of TAAs becomes beneficial if established before rupture. Although the growth rate and influencing factors of TAAs are still unclear, it is vital that they be diagnosed before surgery is mandated and that they be followed up meticulously via periodic CT and magnetic resonance imaging.⁷ Further, patients need education concerning not only the warning signs of TAA rupture but also the importance of life-style alteration, smoking cessation, and hypertension and hyperlipidemia control.⁸ Bickerstaff et al⁹ reported a survival rate of 13% at 5 years’ follow-up of patients with untreated TAAs in comparison with a 75% rate in the control group, who had no aortic aneurysm. These results underscore the significance of appropriate management strategies for TAAs.⁸.⁹

The standard management method for aortic arch diseases

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Figure 3. Computed tomography demonstrates the dissection, involving the ascending aorta and extending toward the left coronary sinus.

Figure 4. The image presents an intraoperative view, with the blue arrow pointing to the Dacron graft of the ascending aorta and the green arrow pointing to the cannula for the selective cerebral perfusion of the debranching graft.
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