

Yamume TSHOMBA

AORTIC OCCLUSIVE DISEASE

New insights into an old pathology



EDIZIONI MINERVA MEDICA

The ideal facility and the new technologies for the treatment of aorto-iliac occlusive disease

Pietro Dioni, Andrea Melloni, Luca Bertoglio, Stefano Bonardelli

INTRODUCTION

The average age of patients with critical limb-threatening ischemia (CLTI) is steadily increasing due to healthier lifestyle and advancements in medicine.¹ Consequently, patients with CLTI today are older than in the past, and traditional open surgery for aortoiliac occlusive disease can be particularly challenging in this population, which often presents with multiple advanced comorbidities.² In this scenario, open surgery is reserved as a secondary option in cases where endovascular intervention is not feasible or has failed, as indicated in the most recent Global Vascular Guidelines on the Management of Chronic Limb-Threatening Ischemia.³ For patients with disabling claudication and iliac stenosis/occlusion, endovascular revascularization is the first option unless the patient is very fit and has a lesion extending up to the infra- or juxtarenal aorta.⁴ The excellent outcomes achieved with endovascular procedures, combined with the continuous development of new materials and techniques, have completely transformed the treatment of this patient group.

Although endovascular revascularization is now the preferred option for aortoiliac occlusive disease, the modern vascular surgeon should master both endovascular and open surgical skills because femoral artery disease is often associated with aortoiliac stenosis or occlusions and still best managed by open surgery and because not all patients are suitable for endovascular treatment. Besides the specific innovations introduced in this chapter and detailed elsewhere in the present volume, the most efficient and effective patient management should consider the best management of the surgical workspace.

HYBRID OPERATING ROOM: SPACE AND RESOURCE MANAGEMENT

Considering the complexity of aortoiliac lesions, the frequency of associated outflow and below-the-groin disease, and the frailty of the patients, it is reasonable to assume that treatment should