

# 46. Aortic Disease

## 1) Thoracic Aortic Dissections

- **Stanford A** dissections represents nearly two-thirds of all thoracic aorta dissections, surgical or endovascular repair is indicated.
- **Stanford B** dissections represent only a third of dissections and are generally treated with aggressive medical management. Indications to operate include an enlarging hematoma, involvement of the aortic arch (i.e., conversion to Stanford A), aortic dilation >5 cm, saccular aneurysm development, progressive narrowing of the true lumen with side-branch occlusion, or inability to control blood pressure. Most transluminal endovascular stent-graft studies have focused on the Stanford B dissections that meet surgical criteria.

DX CT

TX Labetalol

## 2) Aortic Atheroma

- a) Atheroma discrete growths in wall (5 mm = Coumadin?)

## 3) Thoracic Aortic Aneurysms

- Ascending: 40–50% Arch: 10–15% (Surgical)
- Descending (including thoracoabdominal):
- 35–45% Endovascular therapy
- Operative events are high

## 4) Abdominal Aortic Aneurysm: 2% of the elderly population

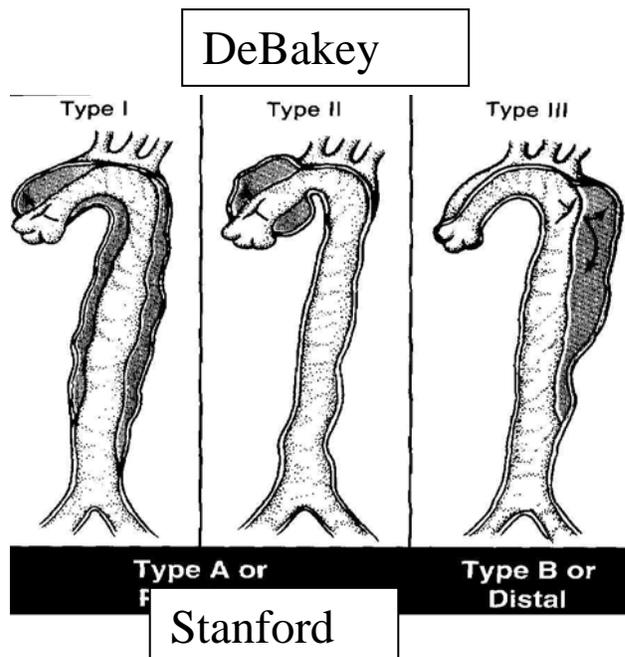
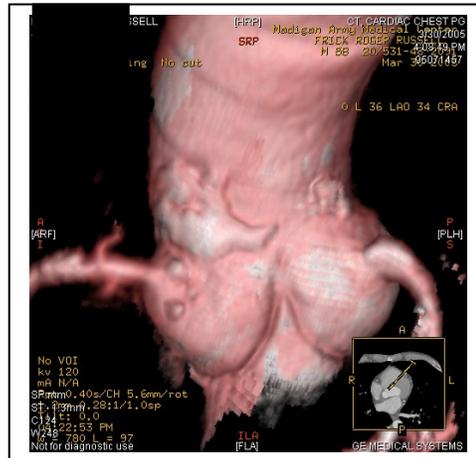
- grow at 0.2 cm/year up to 3 cm/year
- >5–6 cm have a 6–20% risk of rupture per year
- Surgical repair carries a 2–5% mortality rate
- self-expanding nitinol stent with 0.1 mm woven polyester fabric

Location:

- Infrarenal: 95%,
  - Type A-AAA (no involvement of the aortic bifurcation)
  - Type B-AAA involving Iliacs
- Proximal or Suprarenal: 5%

## 5) Aortoarteritis Syndromes

- Takayasu's Arteritis, Giant Cell (Temporal) Arteritis, Spondylitis, Reiter's



Infrarenal AAA (95%)  
Type A

