

Navigating the Aorta: TAVR in a patient with prior EVAR, FEVAR, and aortic dissection

USC Keck School of Medicine

Hunter Launer, MD; Jubin Joseph, MD PhD



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Disclosure of Relevant Financial Relationships

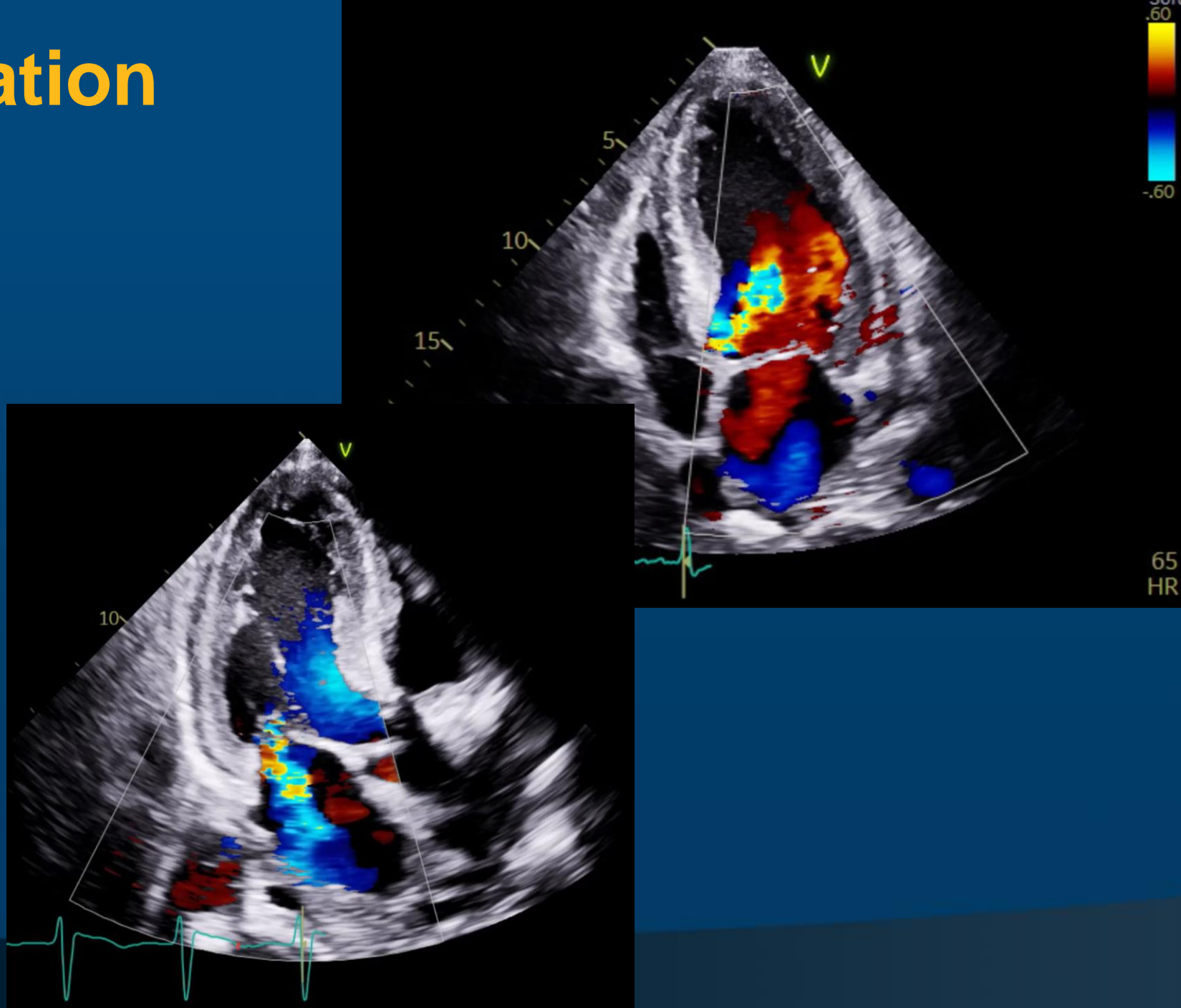
I, Hunter Launer, DO NOT have any financial relationships to disclose.

Special thanks to Dr. Jubin P. Joseph, MD PhD.

Case Presentation

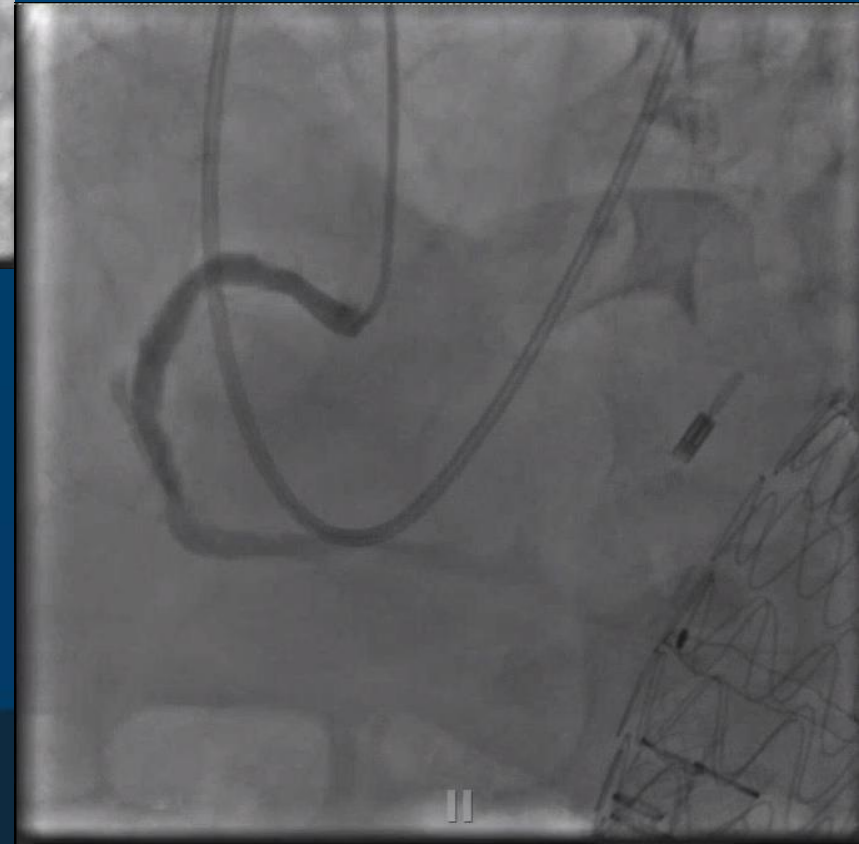
An 88-year-old male with **severe aortic regurgitation**, CAD, HTN, HLD, and extensive aortic pathology presented with upper GIB and **progressive dyspnea**.

- 6/2023: infrarenal abdominal aortic aneurysm w/ dissection s/p FEVAR
- 2/2024: Type II endoleak coil embolization of IMA
- 9/2024: FEVAR w/ TAMBE and splenic embolization complicated by type B (Zones 3/5) aortic dissection



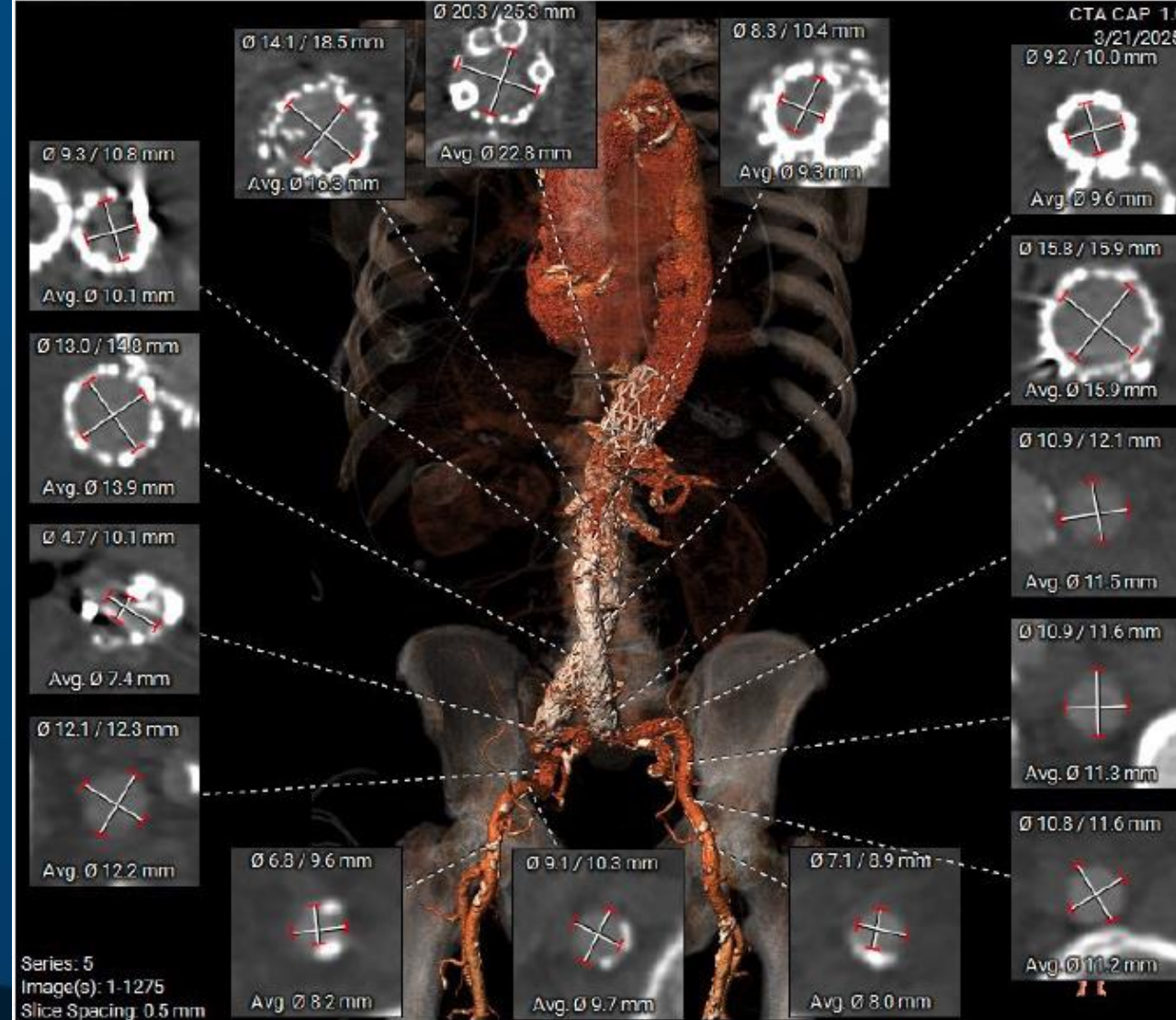
Clinical Course

Patient evaluated by Structural Heart team. Given recent UGIB and comorbid conditions the patient deemed not an operative candidate and **recommended evaluation for TAVR.**



Diagnostics

Dimmed background



Snake View - Left Iliac

CTA CAP 1.0
3/21/2025

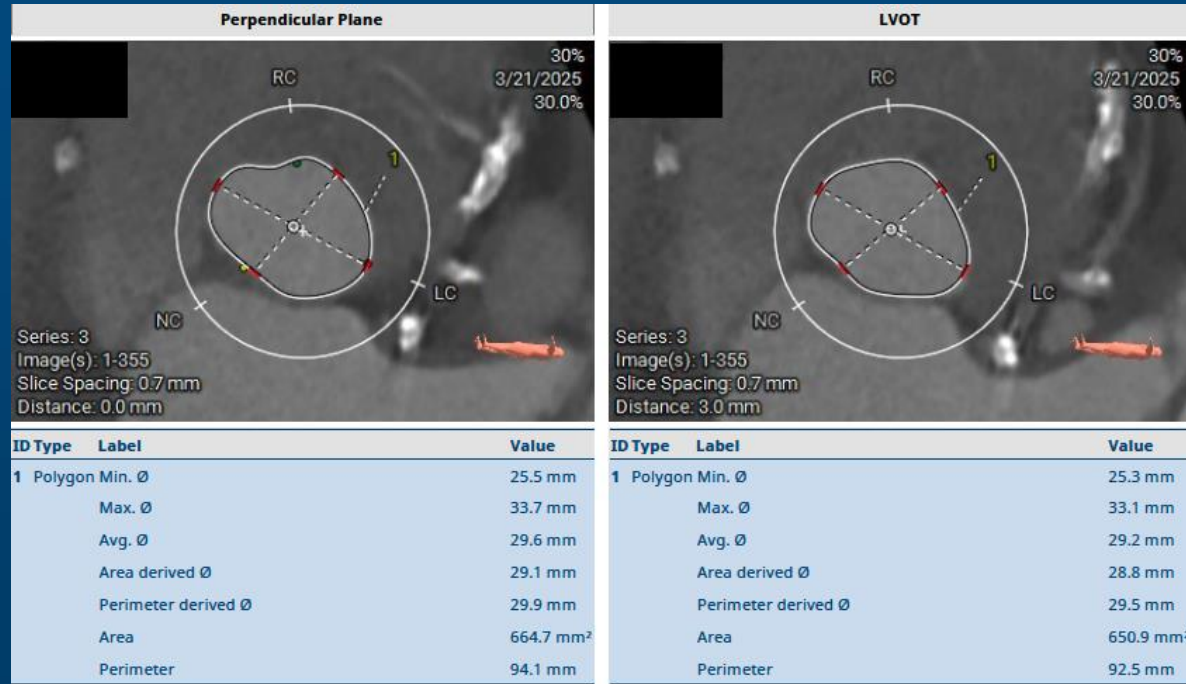


Snake View - Left Iliac

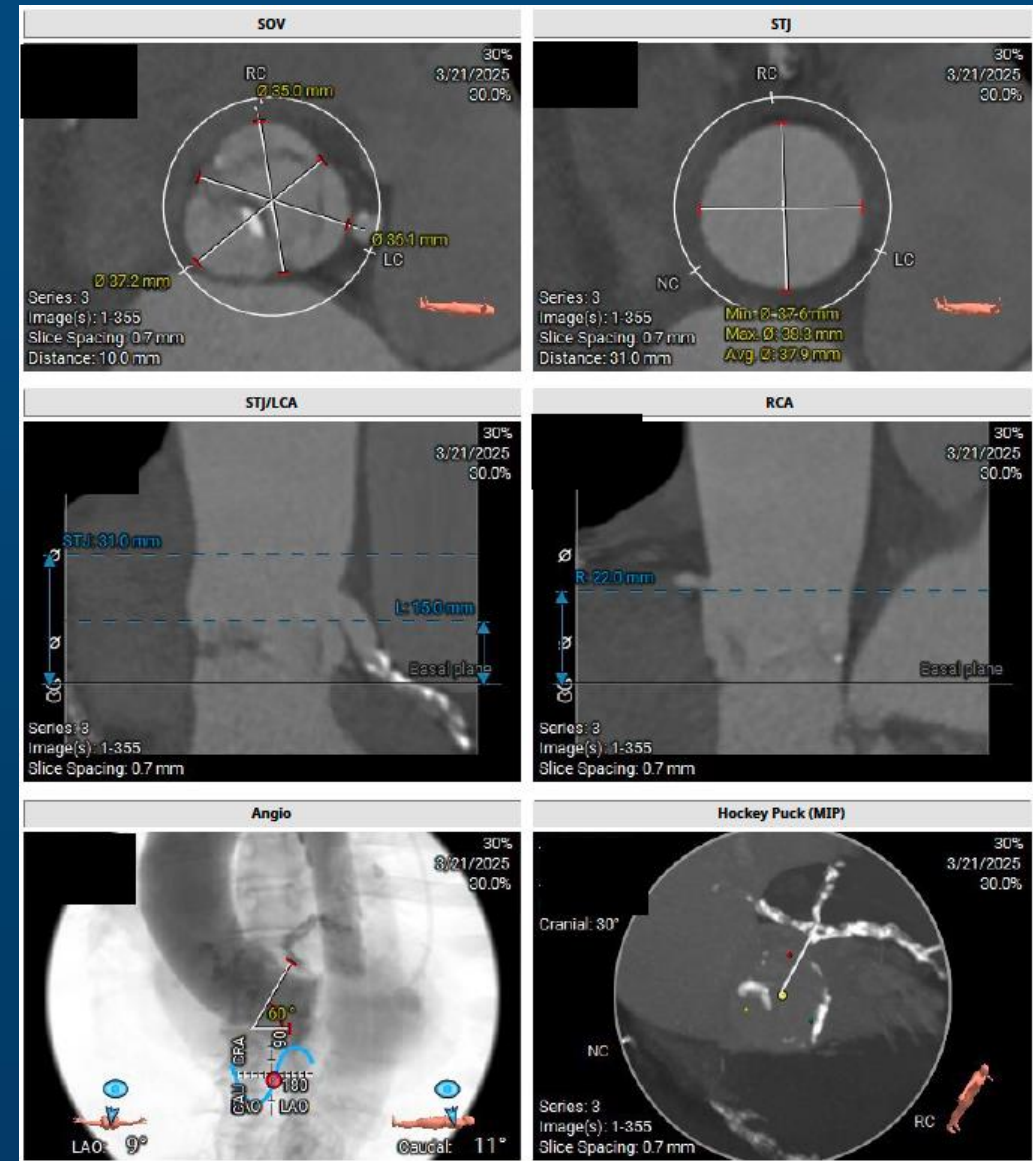
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Diagnostics

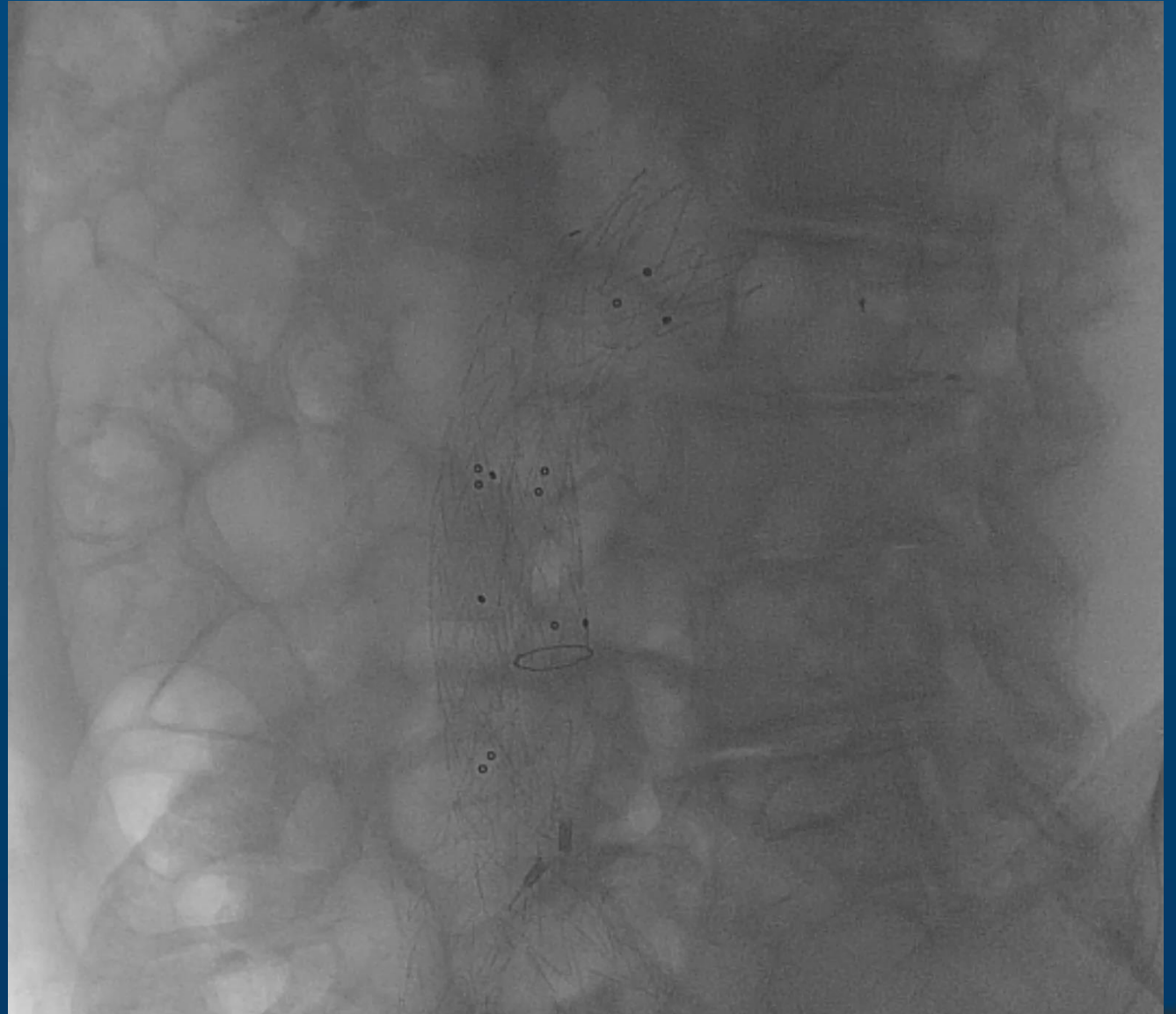


**29-mm balloon-expandable
Sapien 3 Ultra Resilia valve**



Procedure

- 16 Fr e Sheath in LFA after serial dilation of 14/16/18Fr over a Lunderquist wire
- An 18fr dilator advanced within the 16Fr sheath to pre-dilate
- A 29-mm balloon-expandable Sapien 3 Ultra Resilia valve

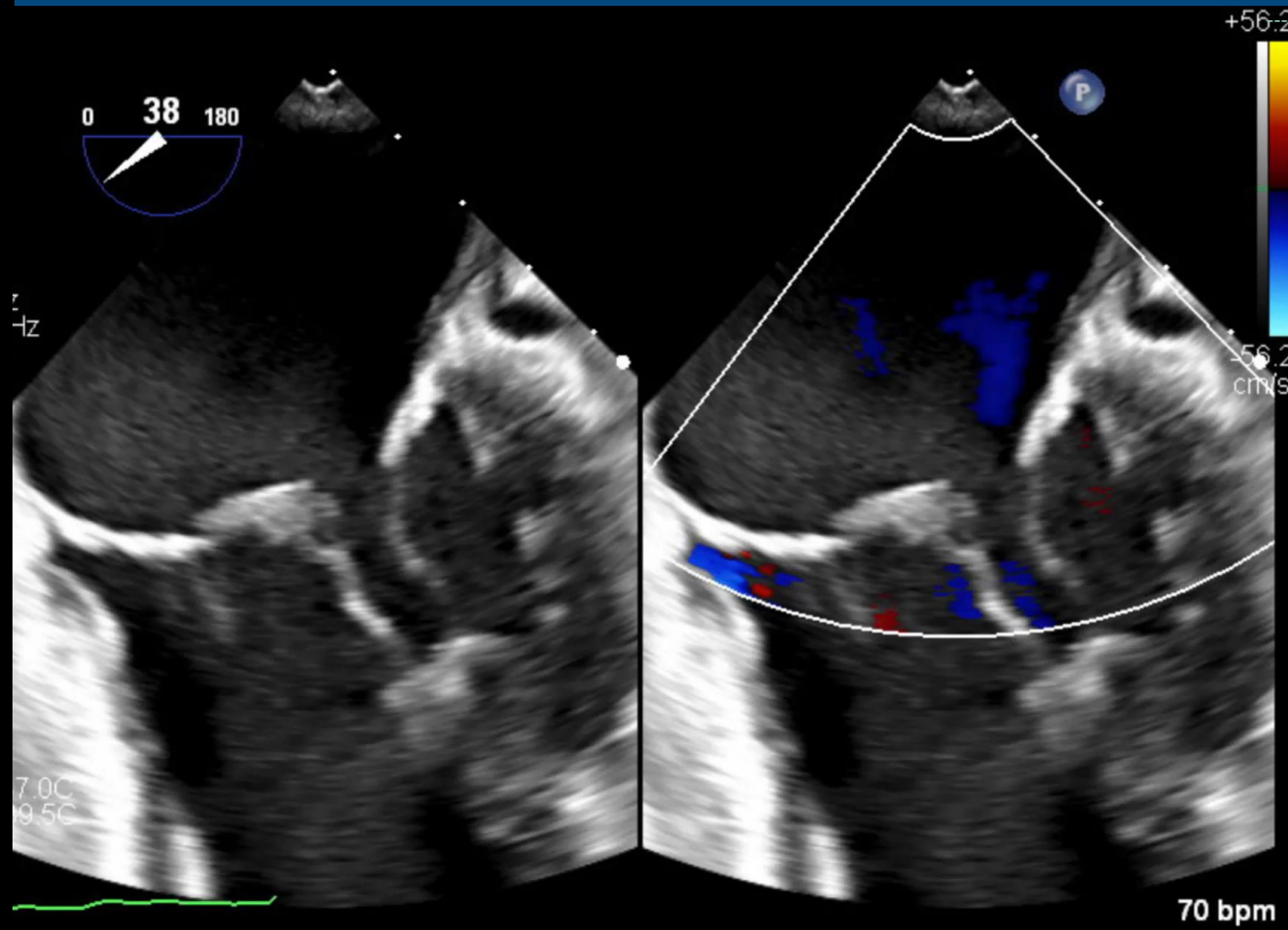
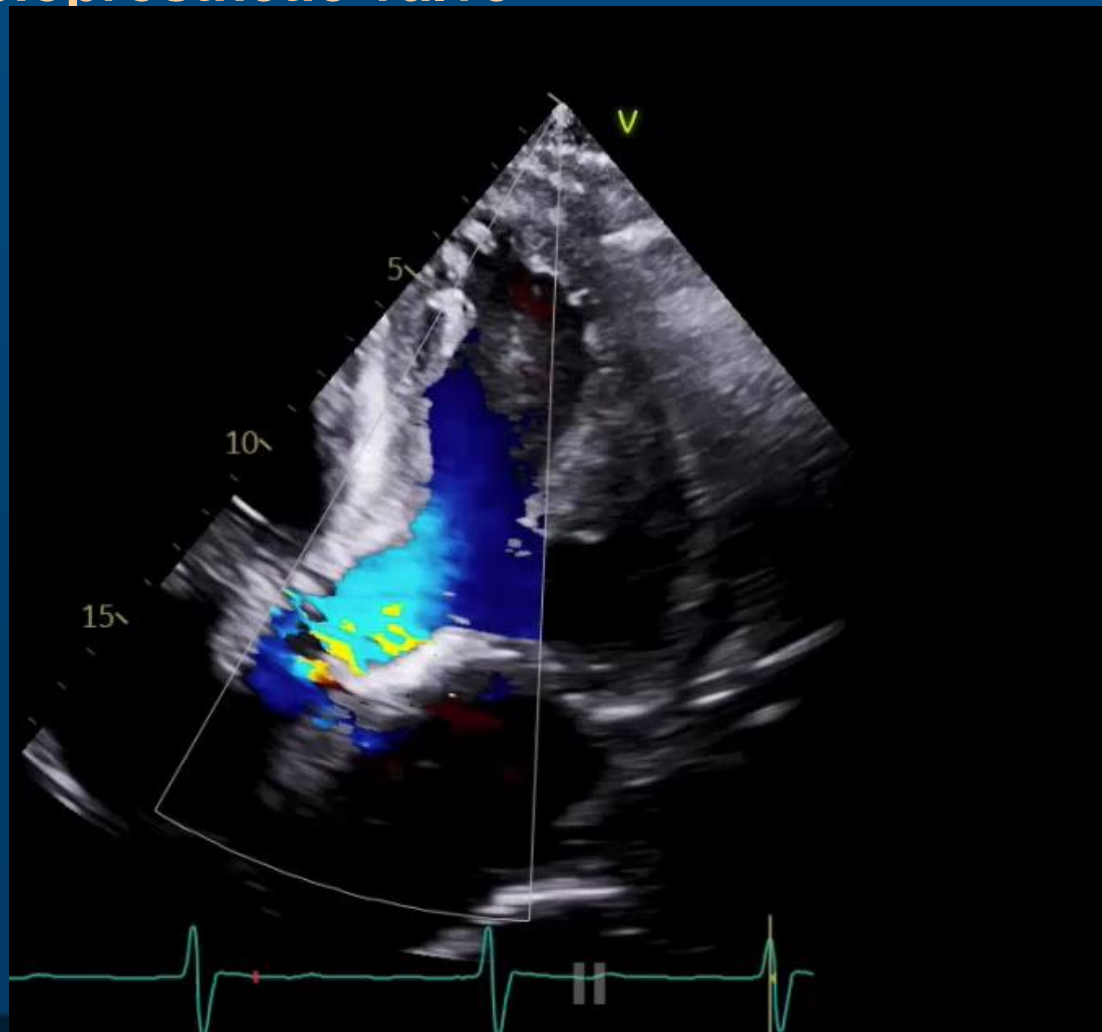


Procedure



Conclusion

Successful TAVR with a 29-mm balloon-expandable Sapien 3 Ultra Resilia bioprosthetic valve



Conclusion

- Off-label TAVR successfully treated severe aortic regurgitation despite hostile aortic anatomy and absence of annular calcification
- Lack of aortic root calcification required meticulous procedural planning and device selection to ensure adequate anchoring
- Correction of severe AR led to significant functional MR improvement at 7-month follow-up
- Conservative CAD management strategy pursued given high bleeding risk and recent GI bleed.