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=== EVAR (non-ruptured) ====

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REPORT OF OPEERATIVE PROCEDURE

NAME: \_\_\_\_

FACILITY: \_\_\_\_\_\_\_\_\_\_ (Operating Room | Cath Lab | Interventional Radiology Suite)

DATE OF PROCEDURE: \_\_\_\_

SURGEON: Peter Lin, MD

ASSISTANT: Mathew Cheung, DO

PREOPERATIVE DIAGNOSIS: Abdominal aortic aneurysm

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURES:

1. Percutaneous access of right femoral artery with deployment of femoral artery closure device (CPT# 34713-RT)

2. Percutaneous access of left femoral artery with deployment of femoral artery closure device (CPT#34713-LT)

3. Endovascular abdominal aortic aneurysm with aorto-bi-iliac stent graft placement for non-ruptured aortic aneurysm (CPT# 34705)

4. Intravascular ultrasound evaluation (non-coronary) of abdominal aorta during therapeutic interventions (CPT# 37252)

5. Intravascular ultrasound evaluation (non-coronary) of right common iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

6. Intravascular ultrasound evaluation (non-coronary) of right external iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

7. Intravascular ultrasound evaluation (non-coronary) of left common iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

8. Intravascular ultrasound evaluation (non-coronary) of left external iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

ANESTHESIA: General endotracheal anesthesia

SPECIMEN: None

ESTIMATED BLOOD LOSS: 20 ml

BLOOD ADMINISTERED: 0 unit(s) PRBC transfusion

IV FLUID: 200 ml

DRAIN / TUBE PLACED: None

COMPLICATIONS: None

CONDITION: Stable

INDICATIONS: This is a \_\_\_ year-old male patient who was recently diagnosed with a \_\_ cm abdominal aortic aneurysm which was confirmed by an abdominal CT scan. The patient has been under the care of Dr. \_\_\_\_. It was determined that the patient's aortic aneurysm anatomy is amenable to endovascular stent-graft repair. We therefore plan to perform endovascular abdominal aortic aneurysm repair using a bifurcated aortic stent graft. I've discussed with the patient regarding the benefits and risks of the procedure. The patient is aware of the benefits of the planned procedure which is to reduce the risk of aneurysm rupture and aneurysm-related death. The patient is also aware of the potential risks and complications of the procedure, which include contrast allergy, contrast induced renal failure requiring hemodialysis, wound infection, bleeding, endograft limb thrombosis, lower leg ischemia, pneumonia, MI, stroke, spinal cord paralysis, and death. The patient is aware that the overall risk of these complications is 2%. The patient has accepted these benefits and risks of the procedure, and the patient agreed to proceed with the planned treatment.

PROCEDURE IN DETAIL: The patient was brought to the cath lab and placed on the cath lab table in the supine position. The patient was given general anesthesia and maintained throughout the entire procedure. The patient's abdomen and bilateral lower extremities were prepped sterilely and draped in the standard fashion. Appropriate time out was performed whereby the patient and site of surgery were identified. Next we proceeded with ultrasound guided percutaneous access of the right groin. Under ultrasound visualization, we obtained percutaneous access in the right femoral artery, which was followed by the placement of an introducer sheath. Next we placed two percutaneous closure devices in the right femoral artery using the Perclose closure device, which was followed by an introducer sheath exchange in which we placed an 18 French introducer sheath. Next under ultrasound visualization, we obtained percutaneous access in the left femoral artery, which was followed by the placement of an introducer sheath. We next placed two percutaneous closure devices in the left femoral artery using the Perclose device, which was followed by an introducer sheath exchange in which we placed a 14 French introducer sheath. Systemic heparin was given intravenously for anticoagulation.

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We performed intravascular ultrasound examination of the aorta by positioning an intravascular ultrasound catheter in the aorta to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used. We performed intravascular ultrasound examination of the right common iliac artery and right external iliac artery by positioning an intravascular ultrasound catheter in these vessels to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used. We performed intravascular ultrasound examination of the left common iliac artery and left external iliac artery by positioning an intravascular ultrasound catheter in these vessels to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used.

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We next placed a stiff Amplatz guidewire via the right femoral artery sheath and a stiff Glidewire via the left femoral artery. A marker pigtail catheter was introduced via the left femoral guidewire so the pigtail catheter was advanced and positioned in the abdominal aorta. Using power injection, we performed abdominal aortogram using the marker pigtail catheter to identify the renal artery, aortic aneurysm, and bilateral iliac arteries. The locations of the renal arteries were identified. Next we inserted a

-------- Gore EXCLUDER vs. COOK Zenith ----------

bifurcated aortic endovascular prosthesis from the right groin sheath approach and positioned the device in the infrarenal aorta. The device was next deployed in the infrarenal portion of the abdominal aorta. Next we removed the pigtail from the left groin and inserted a selective catheter in which we cannulate the contralateral gate of the bifurcated endoprosthesis from the left groin approach. We next inserted a contralateral iliac endograft limb from the main body of the bifurcated device and extended to the common iliac artery as well as the external iliac artery. Next we finished the deployment of the main bifurcated endoprosthesis in which the device was removed. The endoprosthesis device was next removed from the right groin. Following that, balloon angioplasty of the bilateral iliac endografts using an aortic molding balloon in which we dilated the aortic portion of the bifurcated main device. Following completion of the above deployment of the main body device with one iliac endograft docking limb, we performed a completion angiogram using a pigtail catheter, which revealed successful aortic aneurysm exclusion by the endografts with satisfactory radiographic results. Bilateral renal arteries and hypogastric arteries were patent and visualized. Bilateral percutaneous closure devices were deployed following the removal of bilateral femoral sheaths. Hemostasis was achieved satisfactorily. Flow was reestablished to the bilateral lower extremities, and protamine was given to reverse the heparin. Dermabond dressing was applied in bilateral groin which was followed by gauze dressing placement. The patient tolerated the procedure well without any complication, and she was taken to the recovery room in a stable condition. I was present throughout the entire operation.

SUPERVISION AND INTERPRETATION OF ENDOVASCULAR AORTIC ANEURYSM REPAIR: Completion angiogram following endovascular aortic stent graft placement demonstrated successful exclusion of the aortic aneurysm without endoleak. Bilateral renal arteries and hypogastric arteries were patent.

TREATMENT DISPOSITION: The patient will be admitted to the ICU for postoperative monitoring.

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=== EVAR (non-ruptured) + hypogastric embo ====

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REPORT OF OPEERATIVE PROCEDURE

NAME: \_\_\_\_

FACILITY: \_\_\_\_\_\_\_\_\_\_ (Operating Room | Cath Lab | Interventional Radiology Suite)

DATE OF PROCEDURE: \_\_\_\_

SURGEON: Peter Lin, MD

ASSISTANT: Mathew Cheung, DO

PREOPERATIVE DIAGNOSIS: 1. Abdominal aortic aneurysm; 2. Right iliac artery aneurysm

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURES:

1. Percutaneous access of right femoral artery with deployment of femoral artery closure device (CPT# 34713-RT)

2. Percutaneous access of left femoral artery with deployment of femoral artery closure device (CPT#34713-LT)

3. Percutaneous embolization of right hypogastric artery with 14mm microcoils for right iliac artery aneurysm (CPT# 37243)

4. Endovascular abdominal aortic aneurysm with aorto-bi-iliac stent graft placement for non-ruptured aortic aneurysm (CPT# 34705)

5. Intravascular ultrasound evaluation (non-coronary) of abdominal aorta during therapeutic interventions (CPT# 37252)

6. Intravascular ultrasound evaluation (non-coronary) of right common iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

7. Intravascular ultrasound evaluation (non-coronary) of right external iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

8. Intravascular ultrasound evaluation (non-coronary) of left common iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

9. Intravascular ultrasound evaluation (non-coronary) of left external iliac artery during therapeutic interventions (add-on vessel, CPT# 37253)

ANESTHESIA: General endotracheal anesthesia

SPECIMEN: None

ESTIMATED BLOOD LOSS: 20 ml

BLOOD ADMINISTERED: 0 unit(s) PRBC transfusion

IV FLUID: 200 ml

DRAIN / TUBE PLACED: None

COMPLICATIONS: None

CONDITION: Stable

INDICATIONS: This is a \_\_\_ year-old male patient who was recently diagnosed with a \_\_ cm abdominal aortic aneurysm as well as a large iliac artery aneurysm which was confirmed by an abdominal CT scan. The patient has been under the care of Dr. \_\_\_\_. It was determined that the patient's aortoiliac aneurysm anatomy is amenable to endovascular stent-graft repair. We therefore plan to perform endovascular abdominal aortic aneurysm repair using a bifurcated aortic stent graft. I've discussed with the patient regarding the benefits and risks of the procedure. The patient is aware of the benefits of the planned procedure which is to reduce the risk of aneurysm rupture and aneurysm-related death. The patient is also aware of the potential risks and complications of the procedure, which include contrast allergy, contrast induced renal failure requiring hemodialysis, wound infection, bleeding, endograft limb thrombosis, lower leg ischemia, pneumonia, MI, stroke, spinal cord paralysis, and death. The patient is aware that the overall risk of these complications is 2%. The patient has accepted these benefits and risks of the procedure, and the patient agreed to proceed with the planned treatment.

PROCEDURE IN DETAIL: The patient was brought to the cath lab and placed on the cath lab table in the supine position. The patient was given general anesthesia and maintained throughout the entire procedure. The patient's abdomen and bilateral lower extremities were prepped sterilely and draped in the standard fashion. Appropriate time out was performed whereby the patient and site of surgery were identified. Next we proceeded with ultrasound guided percutaneous access of the right groin. Under ultrasound visualization, we obtained percutaneous access in the right femoral artery, which was followed by the placement of an introducer sheath. Next we placed two percutaneous closure devices in the right femoral artery using the Perclose closure device, which was followed by an introducer sheath exchange in which we placed an 18 French introducer sheath. Next under ultrasound visualization, we obtained percutaneous access in the left femoral artery, which was followed by the placement of an introducer sheath. We next placed two percutaneous closure devices in the left femoral artery using the Perclose device, which was followed by an introducer sheath exchange in which we placed a 14 French introducer sheath. Systemic heparin was given intravenously for anticoagulation.

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We performed intravascular ultrasound examination of the aorta by positioning an intravascular ultrasound catheter in the aorta to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used. We performed intravascular ultrasound examination of the right common iliac artery and right external iliac artery by positioning an intravascular ultrasound catheter in these vessels to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used. We performed intravascular ultrasound examination of the left common iliac artery and left external iliac artery by positioning an intravascular ultrasound catheter in these vessels to determine the vessel diameter, as this was necessary to determine the appropriate size of the stent graft to be used.

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We next catheterized the right hypogastric artery and placed four microcoils in the right hypogastric artery for selective embolization. This effectively prevents type II endoleak from the hypogastric artery once endograft is placed. We next placed a stiff Amplatz guidewire via the right femoral artery sheath and a stiff Glidewire via the left femoral artery. A marker pigtail catheter was introduced via the left femoral guidewire so the pigtail catheter was advanced and positioned in the abdominal aorta. Using power injection, we performed abdominal aortogram using the marker pigtail catheter to identify the renal artery, aortic aneurysm, and bilateral iliac arteries. The locations of the renal arteries were identified. Next we inserted a

-------- Gore EXCLUDER vs. COOK Zenith ----------

bifurcated aortic endovascular prosthesis from the right groin sheath approach and positioned the device in the infrarenal aorta. The device was next deployed in the infrarenal portion of the abdominal aorta. Next we removed the pigtail from the left groin and inserted a selective catheter in which we cannulate the contralateral gate of the bifurcated endoprosthesis from the left groin approach. We next inserted a contralateral iliac endograft limb from the main body of the bifurcated device and extended to the common iliac artery as well as the external iliac artery. Next we finished the deployment of the main bifurcated endoprosthesis in which the device was removed. The endoprosthesis device was next removed from the right groin. Following that, balloon angioplasty of the bilateral iliac endografts using an aortic molding balloon in which we dilated the aortic portion of the bifurcated main device. Following completion of the above deployment of the main body device with one iliac endograft docking limb, we performed a completion angiogram using a pigtail catheter, which revealed successful aortic aneurysm exclusion by the endografts with satisfactory radiographic results. Bilateral renal arteries and hypogastric arteries were patent and visualized. Bilateral percutaneous closure devices were deployed following the removal of bilateral femoral sheaths. Hemostasis was achieved satisfactorily. Flow was reestablished to the bilateral lower extremities, and protamine was given to reverse the heparin. Dermabond dressing was applied in bilateral groin which was followed by gauze dressing placement. The patient tolerated the procedure well without any complication, and she was taken to the recovery room in a stable condition. I was present throughout the entire operation.

SUPERVISION AND INTERPRETATION OF ENDOVASCULAR AORTIC ANEURYSM REPAIR: Completion angiogram following endovascular aortic stent graft placement demonstrated successful exclusion of the aortic aneurysm without endoleak. Bilateral renal arteries and were patent.

TREATMENT DISPOSITION: The patient will be admitted to the ICU for postoperative monitoring.

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=== EVAR - Aortic cuff, renal Viabahn ====

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REPORT OF OPEERATIVE PROCEDURE

NAME: \_\_\_\_

FACILITY: \_\_\_\_\_\_\_\_\_\_ (Operating Room | Cath Lab | Interventional Radiology Suite)

DATE OF PROCEDURE: \_\_\_\_

SURGEON: Peter Lin, MD

ASSISTANT: Mathew Cheung, DO

PREOPERATIVE DIAGNOSIS: 1. s/p endovascular abdominal aortic aneurysm repair, 2. Presence of endoleak

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURES:

1. Percutaneous access of right femoral artery with deployment of femoral artery closure device (CPT# 34713-RT)

2. Percutaneous access of left femoral artery with deployment of femoral artery closure device (CPT#34713-LT)

3. Abdominal aortogram with radiological supervision and interpretation (CPT# 75625)

4. Placement of proximal aortic stent-graft cuff (CPT# 34825)

5. Catheter placement in bilateral renal artery for renal artery angiogram (CPT# 36252)

6. Left renal artery stent placement with Viabahn stent-graft (CPT# 37236)

7. Supervision and interpretation of aortic cuff placement (CPT# 75953)

ANESTHESIA: General endotracheal anesthesia

SPECIMEN: None

ESTIMATED BLOOD LOSS: 50 ml

BLOOD ADMINISTERED: 0 unit(s) PRBC transfusion

IV FLUID: 200 ml

DRAIN / TUBE PLACED: None

COMPLICATIONS: None

CONDITION: Stable

INDICATIONS: This is a \_\_\_ year-old male patient who recently underwent endovascular abdominal aortic aneurysm repair due to a ruptured aortic aneurysm. A recent CT angiogram of the abdomen revealed type I endoleak. Due to the presence of the aortic endoleak, we plan to perform aortogram with possible intervention to repair the endoleak. I've discussed with the patient and family regarding the benefits and risks of the procedure. The patient is aware of the benefits of the planned procedure which is to eliminate the endoleak which will eliminate the risk of aneurysm rupture and aneurysm-related death. The patient is also aware of the potential risks and complications of the procedure, which include contrast allergy, contrast induced renal failure requiring hemodialysis, wound infection, bleeding, endograft limb thrombosis, lower leg ischemia, pneumonia, MI, stroke, spinal cord paralysis, and death. The patient is aware that the overall risk of these complications is 2%. The patient has accepted these benefits and risks of the procedure, and the patient agreed to proceed with the planned treatment.

PROCEDURE IN DETAIL: The patient was brought to the cath lab and placed on the cath lab table in the supine position. The patient was given general anesthesia and maintained throughout the entire procedure. The patient's abdomen and bilateral lower extremities were prepped sterilely and draped in the standard fashion. Appropriate time out was performed whereby the patient and site of surgery were identified. Next we proceeded with ultrasound guided percutaneous access of the right groin. Under ultrasound visualization, we obtained percutaneous access in the right femoral artery, which was followed by the placement of a 7 French introducer sheath. Next we placed two percutaneous closure devices in the right femoral artery using the Perclose device, which was followed by an introducer sheath exchange in which we placed a 7 French introducer sheath. Next under ultrasound visualization, we obtained percutaneous access in the left femoral artery, which was followed by the placement of a 7 French introducer sheath. We next placed two percutaneous closure devices in the left femoral artery using the Perclose device, which was followed by an introducer sheath exchange in which we placed a 7 French introducer sheath. Systemic heparin was given intravenously for anticoagulation. We next placed a stiff Amplatz guidewire via the right femoral artery sheath and a stiff Glidewire via the left femoral artery. A marker pigtail catheter was introduced via the left femoral guidewire so the pigtail catheter was advanced and positioned in the abdominal aorta. Using power injection, we performed abdominal aortogram using the marker pigtail catheter to identify the renal artery, aortic aneurysm, and bilateral iliac arteries. The locations of the renal arteries were identified. The aortogram identified a type I proximal neck endoleak. Due to the proximity of the aortic endoleak to the renal artery, placement of an aortic cuff would occlude the renal artery flow. Therefore decision was made to place renal artery stent-graft along with aortic cuff placement to exclude the endoleak while preserving the renal flow. We selectively catheterized bilateral renal arteries for selective bilateral renal artery angiogram. We next placed a 6F introduce sheath into the left renal artery. Due to the acute angulation of the right renal artery, we were unable to place an introduce sheath in the right renal artery. Once the left renal artery sheath is placed, we deployed a 23mm aortic cuff in the supra-renal portion of the proximal aortic stent-graft. A 6mm x 5cm Viabahn stent-graft was also deployed in the left renal artery adjacent to the aortic cuff, which preserved the renal artery flow. Balloon angioplasty of the aortic cuff was performed to ensure full deployment of the aortic cuff. Next we performed a completion angiogram using a pigtail catheter, which revealed successful aortic aneurysm exclusion by the endografts with satisfactory radiographic results. Adequate blood flow the left renal artery was identified. Right renal artery blood flow as also identified via collateral flow. Arterial flow to the left renal artery with sufficient renal flow. Bilateral percutaneous closure devices were deployed following the removal of bilateral femoral sheaths. Hemostasis was achieved satisfactorily. Flow was reestablished to the bilateral lower extremities, and protamine was given to reverse the heparin. Dermabond dressing was applied in bilateral groin which was followed by gauze dressing placement. The patient tolerated the procedure well without any complication, and she was taken to the recovery room in a stable condition. I was present throughout the entire operation.

SUPERVISION AND INTERPRETATION OF ENDOVASCULAR AORTIC CUFF STENT GRAFT PLACEMENT: An GORE EXCLUDER 23mm x 3.5cm aortic cuff was deployed in the proximal aortic neck which successfully sealed the aortic endoleak. Left renal artery stent graft was successfully placed in the left renal artery which preserved the renal artery flow.

TREATMENT DISPOSITION: The patient will return to ICU for postoperative monitoring. Will continue blood transfusion as needed. Continue monitor his GI bleeding.

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=== EVAR - ilio-iliac endograft (non-ruptured) ====

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REPORT OF OPEERATIVE PROCEDURE

NAME: \_\_\_\_

FACILITY: \_\_\_\_\_\_\_\_\_\_ (Operating Room | Cath Lab | Interventional Radiology Suite)

DATE OF PROCEDURE: \_\_\_\_

SURGEON: Peter Lin, MD

ASSISTANT: Mathew Cheung, DO

PREOPERATIVE DIAGNOSIS: 1. Abdominal aortic aneurysm; 2. s/p endovascular aortic aneurysm repair; 3. presence of endoleak following endovascular aortic aneurysm repair

POSTOPERATIVE DIAGNOSIS: Same

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PROCEDURES:

1. Percutaneous access of right femoral artery with deployment of femoral artery closure device (CPT# 34713-RT)

3. Endovascular abdominal aortic aneurysm with right ilio-iliac stent graft placement (CPT# 34707-RT)

PROCEDURES:

1. Percutaneous access of left femoral artery with deployment of femoral artery closure device (CPT#34713-LT)

2. Endovascular abdominal aortic aneurysm with left ilio-iliac stent graft placement (CPT# 34707-LT)

PROCEDURES:

1. Percutaneous access of right femoral artery with deployment of femoral artery closure device (CPT# 34713-RT)

2. Percutaneous access of left femoral artery with deployment of femoral artery closure device (CPT#34713-LT)

3. Endovascular abdominal aortic aneurysm with right ilio-iliac stent graft placement (CPT# 34707-RT)

4. Endovascular abdominal aortic aneurysm with left ilio-iliac stent graft placement (CPT# 34707-LT)

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ANESTHESIA: General endotracheal anesthesia

SPECIMEN: None

ESTIMATED BLOOD LOSS: 20 ml

BLOOD ADMINISTERED: 0 unit(s) PRBC transfusion

IV FLUID: 200 ml

DRAIN / TUBE PLACED: None

COMPLICATIONS: None

CONDITION: Stable

INDICATIONS: This is a \_\_\_ year-old male patient who was previously diagnosed with a \_\_ cm abdominal aortic aneurysm which was confirmed by an abdominal CT scan. The patient previously underwent endovascular aortic aneurysm with GORE stent-graft in 2016. The patient recently developed acute onset of left leg pain. A CT scan was performed which showed left iliac endograft occlusion. Due to his left leg iliac artery occlusion with left leg ischemia, we plan to perform endovascular aortic aneurysm repair using an ilio-iliac stent graft.

INDICATIONS: This is a \_\_\_ year-old male patient who was previously diagnosed with a \_\_ cm abdominal aortic aneurysm which was confirmed by an abdominal CT scan. The patient previously underwent endovascular aortic aneurysm with \_\_\_\_\_ stent-graft in 2016. The patient recently underwent CT of abdomen and abdominal ultrasound which showed the present of endoleak with possible aortic aneurysm enlargement. Due to the presence of endoleak with aortic aneurysm enlargement, we plan to perform endovascular aortic aneurysm repair using iliac stent graft placement.

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I've discussed with the patient regarding the benefits and risks of the procedure. The patient is aware of the benefits of the planned procedure which is to improve left leg arterial flow, reduce the risk of aneurysm rupture and aneurysm-related death. The patient is also aware of the potential risks and complications of the procedure, which include contrast allergy, contrast induced renal failure requiring hemodialysis, wound infection, bleeding, endograft limb thrombosis, lower leg ischemia, pneumonia, MI, stroke, spinal cord paralysis, and death. The patient is aware that the overall risk of these complications is 2%. The patient has accepted these benefits and risks of the procedure, and the patient agreed to proceed with the planned treatment.

PROCEDURE IN DETAIL: The patient was brought to the cath lab and placed on the cath lab table in the supine position. The patient was given general anesthesia and maintained throughout the entire procedure. The patient's abdomen and bilateral lower extremities were prepped sterilely and draped in the standard fashion. Appropriate time out was performed whereby the patient and site of surgery were identified. Next we proceeded with ultrasound guided percutaneous access of the right groin. Under ultrasound visualization, we obtained percutaneous access in the bilateral femoral arteries, which was followed by the placement of a 12 French introducer sheath. Systemic heparin was given intravenously for anticoagulation. We next placed a stiff Amplatz guidewire via the femoral artery sheath. A marker pigtail catheter was introduced via the left femoral guidewire so the pigtail catheter was advanced and positioned in the abdominal aorta. Using power injection, we performed abdominal aortogram using the marker pigtail catheter to identify the renal artery, abdominal aorta, and bilateral iliac arteries. The locations of the renal arteries were identified.

---------- right iliac endograft placement only ---------------------------

Next we inserted a Gore EXCLUDER iliac endovascular prosthesis from the right groin sheath approach and positioned the device in the aortic stent-graft to reinforce the right iliac endograft. The iliac endograft was deployed followed by the removal of the device catheter. Following that, balloon angioplasty of the iliac endograft was performed using a molding angioplasty balloon.

 ---------- left iliac endograft placement only ---------------------------

Next we inserted a Gore EXCLUDER iliac endovascular prosthesis from the left groin sheath approach and positioned the device in the aortic stent-graft to reinforce the right iliac endograft. The iliac endograft was deployed followed by the removal of the device catheter. Following that, balloon angioplasty of the iliac endograft was performed using a molding angioplasty balloon.

 ---------- bilateral iliac endograft placement ---------------------------

Next we inserted a Gore EXCLUDER iliac endovascular prosthesis from the right groin sheath approach and positioned the device in the aortic stent-graft to reinforce the right iliac endograft. The iliac endograft was deployed followed by the removal of the device catheter. Following that, balloon angioplasty of the iliac endograft was performed using a molding angioplasty balloon. We next inserted a Gore EXCLUDER iliac endovascular prosthesis from the left groin sheath approach and positioned the device in the aortic stent-graft to reinforce the left iliac endograft. The iliac endograft was deployed followed by the removal of the device catheter. Following that, balloon angioplasty of the iliac endograft was performed using a molding angioplasty balloon.

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We next performed a completion angiogram using a pigtail catheter, which revealed successful aortic aneurysm exclusion by the endografts with satisfactory radiographic results. Bilateral renal arteries and satisfactory aortic flow within the aortoiliac endograft was visualized. No radiographic evidence of endoleak was identified. Percutaneous closure devices were deployed and femoral hemostasis was achieved satisfactorily. Flow was reestablished to the bilateral lower extremities, and protamine was given to reverse the heparin. Dermabond dressing was applied in bilateral groin which was followed by gauze dressing placement. The patient tolerated the procedure well without any complication, and she was taken to the recovery room in a stable condition. I was present throughout the entire operation.

SUPERVISION AND INTERPRETATION OF ENDOVASCULAR AORTIC ANEURYSM REPAIR: Completion angiogram following endovascular iliac stent graft placement demonstrated successful exclusion of the aortic aneurysm without endoleak with successful restoration of bilateral lower leg arterial circulation. Bilateral renal arteries were patent.

TREATMENT DISPOSITION: The patient will be admitted to the ICU for postoperative monitoring.

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