

Revascularization of the Iliac Artery with the GORE VIABAHN® Endoprosthesis with Heparin Bioactive Surface*

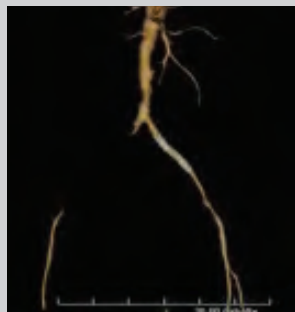


Figure 1. CT angiogram demonstrating the right iliac occlusion

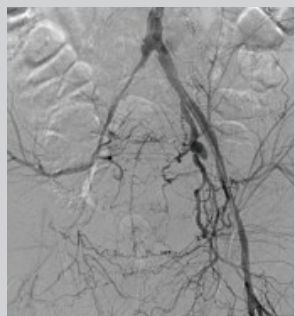


Figure 2. Initial angiogram demonstrating occlusion of right external iliac artery

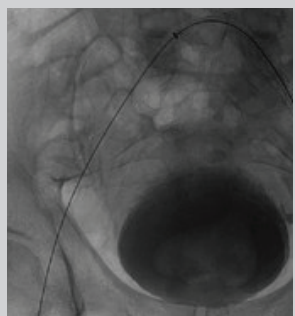


Figure 3. Successful crossing of the aortic bifurcation to gain access to the right external iliac artery

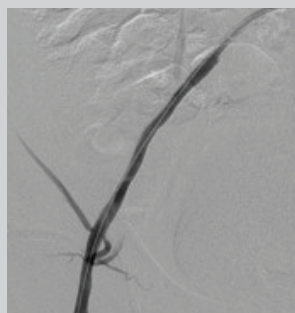


Figure 4. GORE VIABAHN® Endoprosthesis with Heparin Bioactive Surface deployed in right external iliac artery

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CLINICAL CHALLENGE

The patient is a 62-year-old man with known peripheral arterial disease who is status post stenting of the left common iliac and superficial femoral arteries in 1998. The patient presented with worsening short distance claudication of right lower leg. His past medical history includes coronary artery disease, hypertension and hypercholesterolemia. He is a former smoker, having quit in 2005. His current medications include atorvastatin, diltiazem and aspirin. His ankle brachial index on the right was 0.52 and on the left was 0.84. Arterial duplex suggested a right iliac occlusion and this was confirmed by CT angiogram (Figure 1).

PROCEDURE

The patient underwent angiography via a left femoral approach. This showed diffuse disease of the right common iliac artery, mild atherosclerotic plaquing of the left common iliac artery and complete occlusion of the right external iliac artery. The previously placed left common iliac artery stent was patent (Figure 2). The occluded right external iliac artery was crossed and a 7 x 100 mm GORE VIABAHN® Endoprosthesis with Heparin Bioactive Surface was subsequently implanted (Figures 3 and 4). Right femoral access was then achieved and the proximal common iliac arteries were then stented with a balloon expandable stent.

Continued on back



PERFORMANCE
through experience

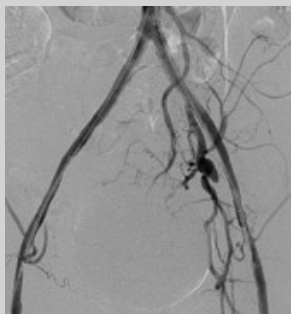


Figure 5. Completion angiogram demonstrating patency of the bilateral iliac arteries

RESULTS

Completion angiogram demonstrates patency of both iliac arteries with filling of the pelvic vasculature via the hypogastric artery on the left and via the medial and lateral circumflex iliac arteries on the right (Figure 5). The patient was discharged the next morning. On follow up two weeks later the patient reported complete resolution of his claudication symptoms. His repeat ABIs were 1.1 on the right and 0.95 on the left.

PHYSICIAN COMMENTS

The GORE VIABAHN® Endoprosthesis with Heparin Bioactive Surface offers the unique combination of flexibility and covered stent technology which makes it particularly well-suited to treat subacute and chronic occlusions of the external iliac artery.



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* This case study describes a specific clinical challenge and chosen approach. Individual results may vary.

INDICATIONS FOR USE: The GORE VIABAHN® Endoprosthesis is indicated for improving blood flow in patients with symptomatic peripheral arterial disease in superficial femoral artery lesions with reference vessel diameters ranging from 4.0 – 7.5 mm. The GORE VIABAHN® Endoprosthesis is indicated for improving blood flow in patients with symptomatic peripheral arterial disease in iliac artery lesions with reference vessel diameters ranging from 4.0 – 12 mm. **CONTRAINDICATIONS:** The GORE VIABAHN® Endoprosthesis is contraindicated for non-compliant lesions where full expansion of an angioplasty balloon catheter was not achieved during pre-dilatation, or where lesions cannot be dilated sufficiently to allow passage of the delivery system. Do not use the GORE VIABAHN® Endoprosthesis with Heparin Bioactive Surface in patients with known hypersensitivity to heparin, including those patients who have had a previous incidence of Heparin-Induced Thrombocytopenia (HIT) type II. Refer to *Instructions for Use* at goremedical.com for a complete description of all warnings, precautions and adverse events. ^{Rx only}

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