In recent years, thoracic endovascular aortic repair (TEVAR) has been established as a reliable alternative to conventional surgical repair. The success of endovascular repair is critically dependent on adequate stent-graft deployment. Catheter-based 2-dimensional angiography is routinely performed before, during, and after stent-graft placement to ensure accurate positioning and confirm the absence of complications such as perigraft endoleaks. Computed tomography angiography (CTA) is also used to plan stent-graft deployment before intervention. Recent advances in imaging technology allow reusing the diagnostic volumetric data sets during intervention by overlaying live fluoroscopy over the preacquired CTA. This article describes the first case of TEVAR under guidance of CTA superimposed on live fluoroscopy without the use of iodinated contrast agent before, during, and after deployment.

An 82-year-old man was admitted to the hospital with an asymptomatic thoracic aneurysm of 65-mm diameter on the descending aorta extending from 85 mm below the left subclavian artery to 120 mm above the celiac trunk (Figure 1). Ten years earlier, the patient had undergone surgical repair of an abdominal aortic aneurysm. No other comorbidities existed. Given the age of the patient, he was scheduled for endovascular treatment with a thoracic aortic stent graft.

Endovascular navigation and stent-graft deployment were achieved using superimposition of preacquired volumetric CTA data on live 2-dimensional fluoroscopy (MR/CT Roadmap, Philips Healthcare, Best, the Netherlands). The CTA was acquired 1 hour before the patient was transferred to the interventional suite for placement of the thoracic stent graft. For registration of the live fluoroscopy with the CTA volume, a low-dose cone-beam CT acquisition (XperCT, Philips Healthcare) without injection of iodinated contrast was acquired after induction of general anesthesia and before draping the patient. During patient preparation, the preacquired CTA volume was fused with the intraoperative cone-beam CT. This has the effect of bringing the CTA volume into the same coordinate space as the live fluoroscopy, thus allowing fluoroscopic navigation over the diagnostic CTA.

Under guidance of the CT roadmap, the thoracic aortic stent graft (Valiant, Medtronic, Minneapolis, MN) was inserted through the right common femoral artery, positioned to cover the aneurysm, and deployed into the descending thoracic aorta (Figure 2 and online-only Data Supplement Movie). A transesophageal echography transducer introduced at the level of the aneurysm was used as a second control and to detect possible complications, particularly endoleaks. The stent graft used was 155-mm long and had a 46-mm proximal diameter and a 42-mm distal diameter. After deployment, a final cone-beam CT scan without contrast was acquired to confirm complete aneurysm coverage by the stent graft (Figure 3). Transesophageal echography control showed no complications. The procedure time was 20 minutes, with 7 minutes of fluoroscopy time. The radiation dose measured by the dose area product was 55.3 Gy cm². Three days later, the patient was discharged from the hospital with no postinter-
ventional complications. The control CTA performed at 6
days postintervention further confirmed complete coverage
and the absence of endoleaks (Figure 4).

The use of standard angiography during TEVAR is often
suboptimal, because it may not provide anatomic information
on the aortic wall, which is necessary for target site identi-
fication and the correct selection and deployment of the stent
graft. In the case illustrated in this article, 2-dimensional
angiography would have failed to show the exact location and
extent of the thrombotic aneurysm (Figure 1). Instead, pre-
acquired CTA data provided the required information not
only for planning, but also for guiding the deployment of the
stent graft. This technique reduces the need for periprocedural
contrast usage in TEVAR, which has been reported to
average around 130 mL.1 Given the high prevalence of renal
insufficiency after endovascular aortic repair (reported to be
as high as 20%3) and its dependence on nephrotoxic contrast
injections, the ability to minimize contrast load confers a
benefit to patients. Minimizing contrast use during TEVAR
also provides more options to the interventionists for the
detection and repair of periprocedural complications without
compromising renal function.

Other authors have shown how intravascular ultrasound
has the potential to minimize the use of angiography in
endovascular thoracic aneurysm repair.4 However, intravas-
cular ultrasound is costly. The technique requires specialized
interpretation skills, and it requires an additional endovascu-
lar device. The use of CT Roadmap, on the other hand, allows
straightforward interpretation through the direct coupling
with fluoroscopy and makes it possible to select optimal
working angles throughout the procedure on the basis of the
3-dimensional diagnostic CTA.

In conclusion, TEVAR using CT Roadmap is feasible; this
technique provides more information for planning, naviga-
tion, and more accurate deployment of the stent graft and may
decrease the reliance on contrast angiography during endo-
vascular aortic aneurysm repair.

Disclosures
None.

References
1. Feezor RJ, Huber TS, Martin TD, Beaver TM, Hess PJ, Klodell CT,
Nelson PR, Berceli SA, Seeger JM, Lee WA. Perioperative differences
between endovascular repair of thoracic and abdominal aortic diseases.
Overlying fluoroscopy and preacquired CT angiography for road-
mapping in cerebral angiography. AJNR Am J Neuroradiol. 2010;31:
494–495.
3. Carpenter JP, Fairman RM, Barker CF, Golden MA, Velazquez OC,
Mitchell ME, Baum RA. Endovascular AAA repair in patients with renal
insufficiency: strategies for reducing adverse renal events. Cardiovasc
Endovascular thoracic aortic aneurysm repair without angiography.

Figure 2. Snapshot recorded during live
3-dimensional navigation with MR/CT
Roadmap. Live fluoroscopy (A) was super-
imposed on a preacquired CTA data set,
showing the deployment of the stent graft
in the aneurysm of the thoracic aorta (B).

Figure 3. A, Cone-beam CT without con-
trast injection showing fully deployed
stent graft. B, Fusion of the cone-beam
CT (in red) with the volume-rendered pre-
treatment CTA, demonstrating complete
aneurysm coverage.
Figure 4. Postoperative CTA performed at 6 days after placement of the stent graft further confirms complete coverage of the aneurysm. Note the correlation with the image shown in Figure 3B.
Zero-Contrast Thoracic Endovascular Aortic Repair Using Image Fusion
Hicham Kobeiter, Julien Nahum and Jean-Pierre Becquemin

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In the article by Kobeiter et al, “Zero-Contrast Thoracic Endovascular Aortic Repair Using Image Fusion,” which appeared in the September 13, 2011 issue of the journal (*Circulation*. 2011;124:e280–e282), an incorrect email address was provided for the corresponding author, Professor Hicham Kobeiter. Professor Kobeiter’s email address should read: hicham.kobeiter@hmn.aphp.fr.

This has been corrected in the current online version of the article. The authors regret the error.

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