

CAS CLINIQUE

ANEVRISME AORTE ABDOMINALE

BOUVET NADÈGE

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SERVICE MÉDECINE VASCULAIRE

PR SARLON

CAS CLINIQUE

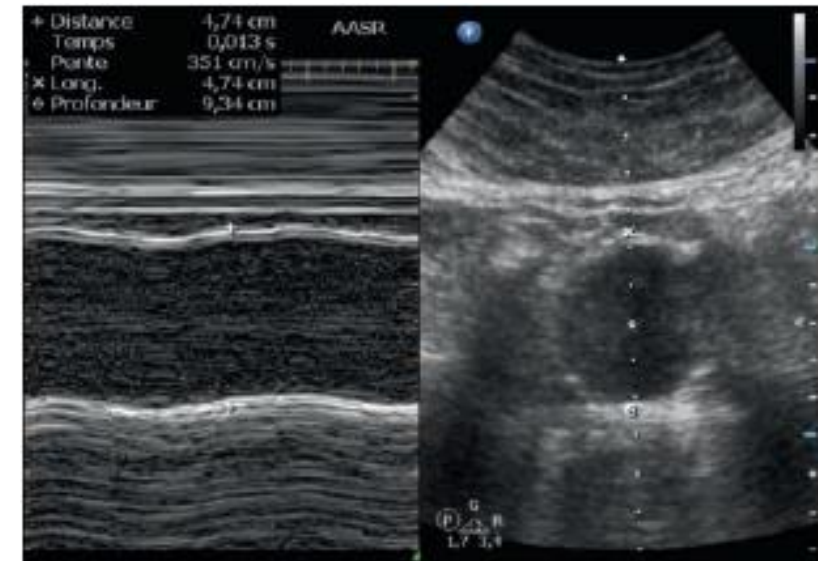
- Mr A, 75 ans
- Antécédents médicaux : HTA depuis 15 ans
- Facteurs de risque cardiovasculaire : dyslipidémie non traitée, tabagisme actif (50PA), alcool occasionnel.
- Traitements :
 - Amlor 10 mg : 1 cpr le matin
 - Irbesartan 150 mg : 1 cpr le matin
- AMT : 175/95 mmHg
- IMC : 36
- Biologie : LDL : 1,6 g/l, HbA1c : 5,3%

CAS CLINIQUE

➤ Adressé par son médecin traitant pour écho- doppler TSAO

➤ Athérome minime, absence de sténose significative.

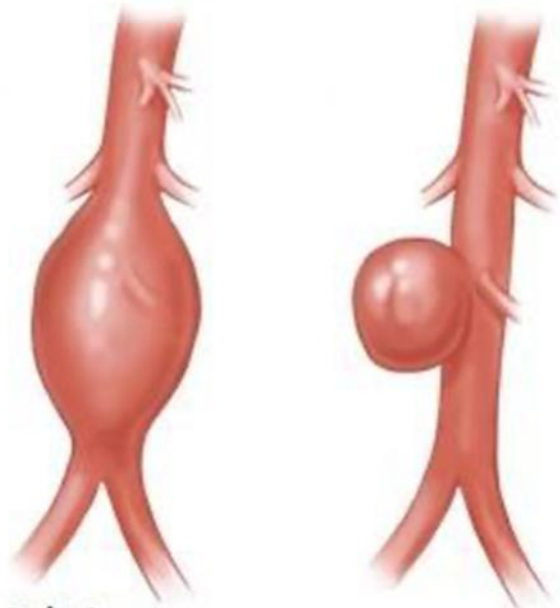
➤ Ao abdominale : AAA fusiforme, DAP : 47 mm



DEFINITION/EPIDEMIOLOGIE

- Dilatation focale permanente > 50% d'une artère, par rapport au diamètre attendu.
- 80% mortalité en cas de rupture vs 5% en intervention programmée.
- Prévalence et incidence en baisse ces 20 dernières années
- ➔ Diminution tabagisme
- ➔ Meilleure gestion du risque cardiovasculaire
- Prévalence négligeable <55-60 ans, majoration >60 ans

DEFINITION

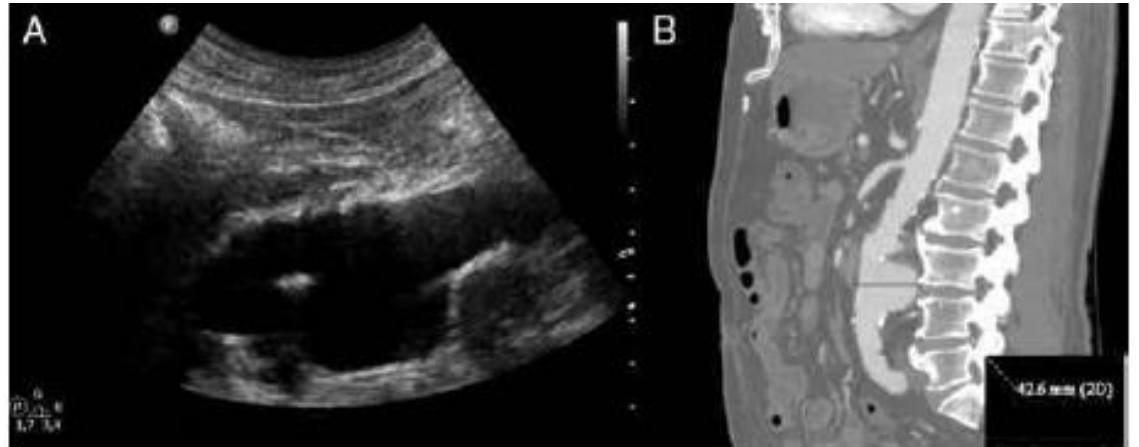


Anévrisme
Fusifforme

Anévrisme
Sacciforme

80%

Patho dégénérative ou du tissu
conjonctif



Infection, ulcère athéroscléreux pénétrant, traumatique,
maladie inflammatoire.

FACTEURS DE RISQUE/EVOLUTION

Facteurs de risque majeurs

- Tabagisme ++ OR>3, Femme +
- Âge +65 ans
- Homme (ratio 13/1, risque vie entière 8,2%)
- Antécédent familial au premier degré d'anévrisme de l'aorte abdominale

Autres facteurs de risque: hypertension, dyslipidémie, origines caucasiennes, vascularite, athérosclérose.

Diabète de type 2 diminue le risque.

Evolution → croissance progressive → majoration risque de rupture.

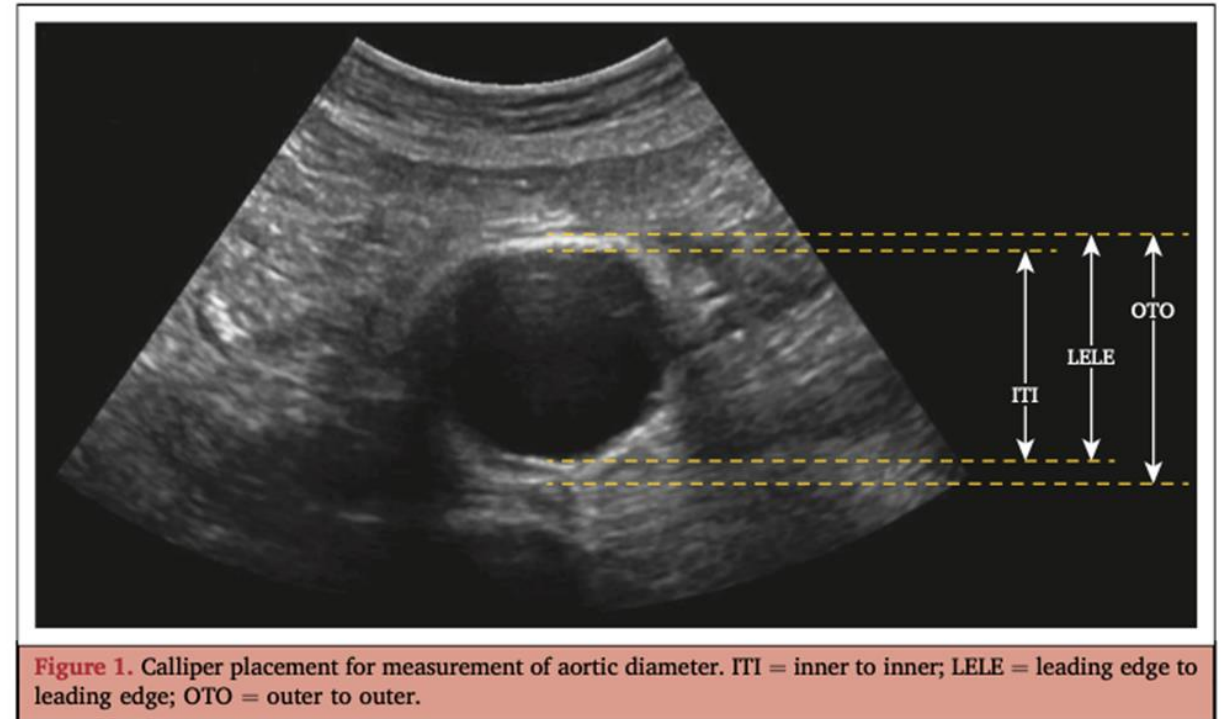
R rupture <1% à 1 an AAA 50mm, à 4 ans AAA 40mm, à 8 ans AAA 30mm)

CLINIQUE

- Asymptomatique ++
 - Douleur à la palpation, irradiation dos ou OGE
- Symptômes en lien avec complications : compression d'organes de voisinage (VCI, duodénum, uretères), ou embolisation distale
- Signes de rupture : instabilité hémodynamique, pâleur cutanée, douleur abdominale ou dorsale.
- Examen clinique : masse pulsatile (Se 33-100%, Sp 75-100%)

ECHO DOPPLER

- 1 ère intention pour diagnostic et surveillance
 - Se et Sp > 97%
- DAP (2-8mm) (grade II a)



SCANNER

- Pré opératoire
- Evaluation extension anévrisme
- Autres localisations
- Diagnostic de rupture et suivi post rupture



DEPISTAGE

Table 6. Potential for abdominal aortic aneurysm screening in different risk populations.

Risk group	Potential for screening	
	Men	Women
65 year old	+	—
65 year old former or current smoker	++	—
Non-white ethnicity	—	—
First degree relative with abdominal aortic aneurysm	+++	+++
Other peripheral aneurysms	+++	+++
Cardiovascular disease	—	—
Organ transplanted	++	++

+ indicates different degrees of suitability for screening and — indicates not suitable for screening.

Recommendations	Class ^a	Level ^b
Screening for AAA with DUS:		
Is recommended in men aged ≥ 65 years with a history of smoking to reduce the risk of death from ruptured AAA. ^{221–224,234}	I	A
May be considered in men aged ≥ 75 years (irrespective of smoking history) or in women aged ≥ 75 years who are current smokers, hypertensive, or both. ^{227,228,235–237}	IIb	C
Family AAA screening with DUS:		
Is recommended for FDRs of patients with AAA aged ≥ 50 , unless an acquired cause can be clearly identified. ²³¹	I	C
Opportunistic AAA screening with DUS:		
Should be considered in symptomatic/asymptomatic PAD patients. ²³³	IIa	B
Should be considered in men aged ≥ 65 years and in women aged ≥ 75 years during TTE. ²³²	IIa	B

BILAN

Recommendations	Class ^a	Level ^b
When an aortic aneurysm is identified at any location, assessment of the entire aorta is recommended at baseline and during follow-up. ^{874,875}	I	C
When a TAA is identified, assessment of the aortic valve (especially for BAV) is recommended. ^{879,880}	I	C
When an AAA is identified, evaluation of the presence of aneurysm in the femoro-popliteal arterial segment should be considered. ^{876–878,881}	IIa	C
Patients with aortic aneurysm are at increased risk of CVD, thus general CV prevention should be considered. ^{26,882,883}	IIa	C

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SUIVI



PRISE EN CHARGE MEDICALE

Recommendation 16		Changed
All patients with an abdominal aortic aneurysm should receive cardiovascular risk factor management with smoking cessation*, blood pressure control*, statin and antiplatelet therapy*, and lifestyle advice (including exercise and healthy diet).		
Class	Level	References
I	B	Bahia <i>et al.</i> (2016), ⁸⁸ Bath <i>et al.</i> (2015), ¹⁸² Niebauer <i>et al.</i> (2021), ¹⁸⁸ Bhak <i>et al.</i> (2015), ¹⁸⁹ Robertson <i>et al.</i> (2017), ¹⁹⁰ Wemmelund <i>et al.</i> (2014) ¹⁹¹

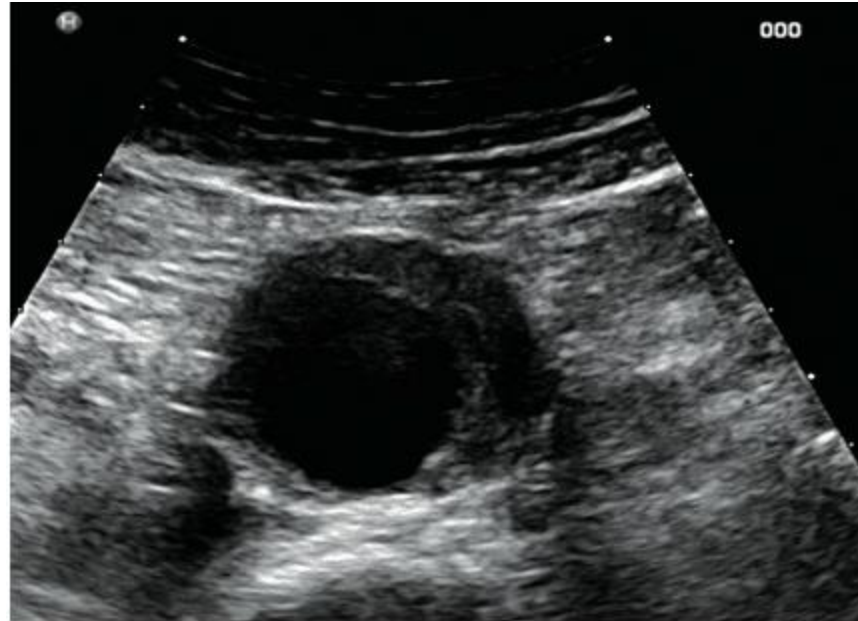
- Metformine → ralentirait possiblement la croissance anévrisme.
- Arrêt tabac → ralentit la croissance et le risque de rupture.

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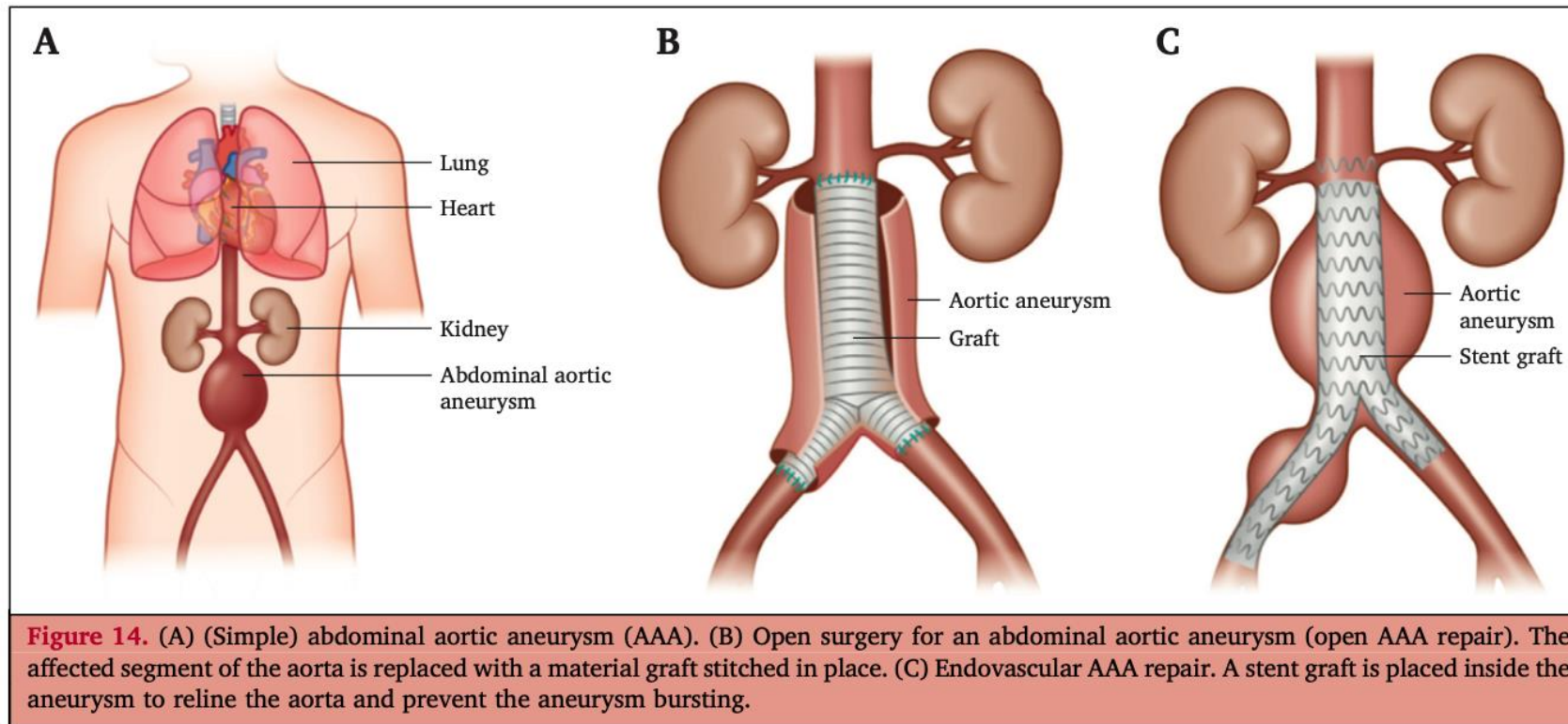
- Prise en charge cardio vasculaire globale :
 - Statine
 - Majoration du traitement anti hypertenseur
 - AAP
 - Règles hygiéno diététiques
 - Arrêt du tabac +++
- Absence d'anévrisme ilio-fémoro-poplitée associé.
- Surveillance à 6 mois.

CAS CLINIQUE

Echo doppler à 5ans → DAP : 57 mm, thrombose pariétalisée.

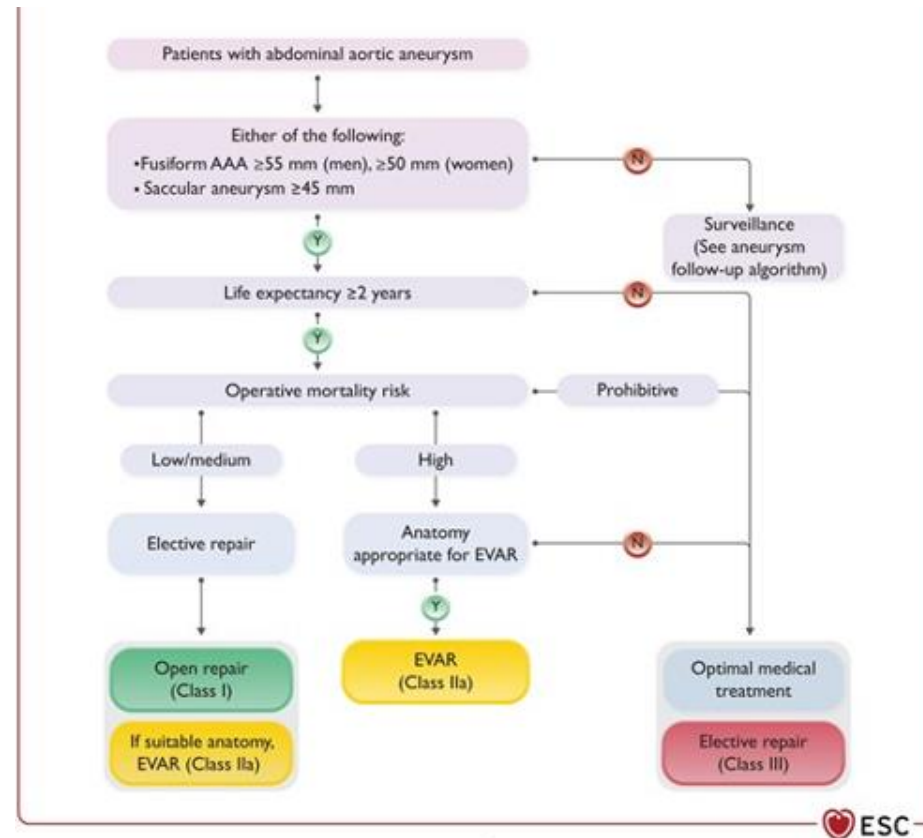


PRISE EN CHARGE CHIRURGICALE

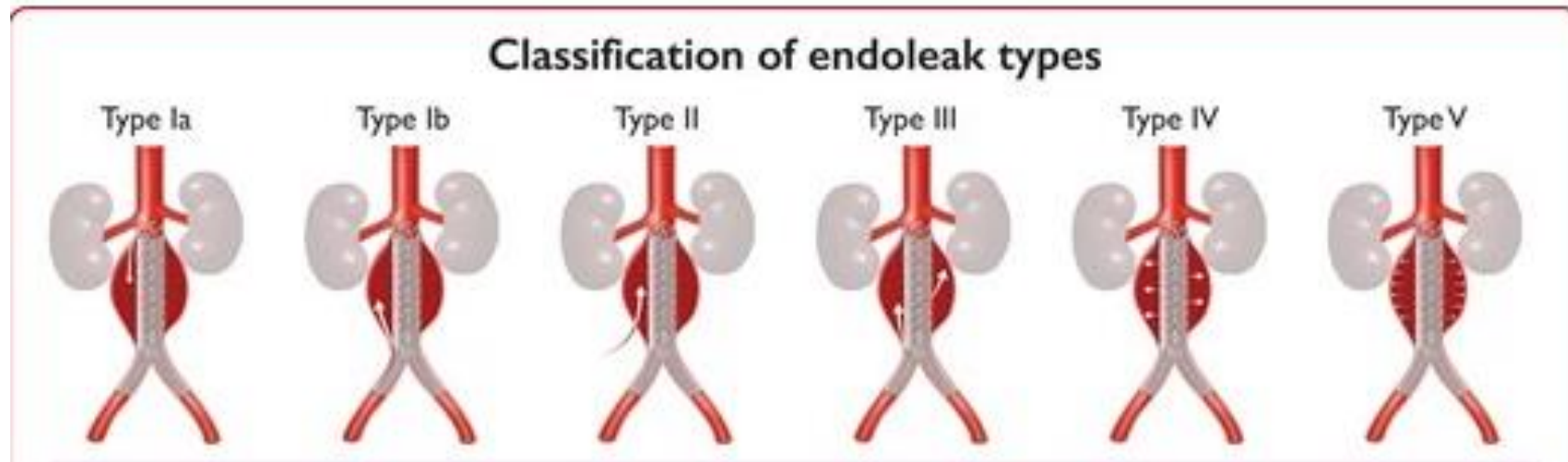


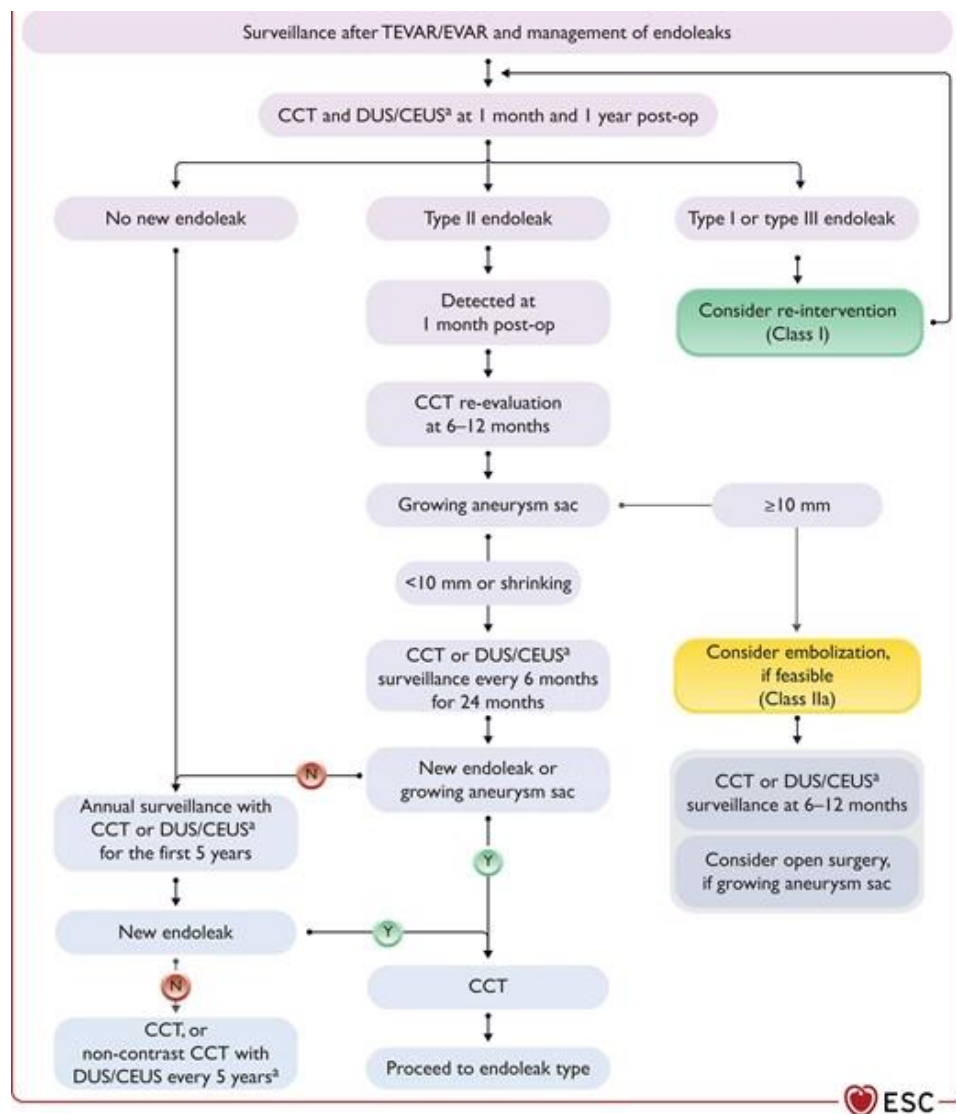
H → DAP > 55 mm
F → DAP > 50 mm
Croissance > 10 mm/an

PRISE EN CHARGE CHIRURGICALE



SURVEILLANCE POST OPERATOIRE (EVAR)





Recommendations	Class ^a	Level ^b
It is recommended to perform 30 day imaging after TEVAR/EVAR, by CCT and DUS/CEUS, to assess the success of intervention. ¹⁰⁹⁶	I	B
It is recommended to re-intervene to achieve a seal in patients with type I endoleak after TEVAR/EVAR. ^{1137,1148}	I	B
It is recommended to re-intervene, principally by endovascular means, to achieve a seal in patients with type III endoleak after TEVAR/EVAR. ¹¹³⁹	I	B
Re-intervention, principally with an endovascular approach or embolization, should be considered in patients with type II or V endoleak and significant sac expansion ≥ 10 mm or significantly decreasing proximal or distal seal. ^{1096,1149}	IIa	C

SURVEILLANCE POST EVAR

After EVAR, follow-up imaging is recommended with CCT (or CMR) and DUS/CEUS at 1 month and 12 months post-operatively, then, if no abnormalities ^d are documented, DUS/CEUS is recommended every year, repeating CCT or CMR (based on potential artefacts) every 5 years. ^{70,1079,1100,1163–1165,1167}	I	A
In higher-risk patients, i.e. with inadequate sealing or type II endoleak at first CCT control, more frequent DUS/CEUS imaging should be considered. ^{e,1096,1161,1164,1165,1167}	IIa	B
In low-risk ^f patients, from 1 year post-operatively after EVAR, repeating DUS/CEUS every 2 years should be considered. ¹⁰⁹⁶	IIa	B
If any abnormality during DUS/CEUS is found, confirmation should be considered using additional CCT or CMR (based on potential artefacts). ^{1163,1166}	IIa	B
In post-treatment surveillance, administration of OMT (see 8.1.2.2 and 8.2.4) and assessment of aneurysm development/growth in other arterial segments should be considered.	IIa	C

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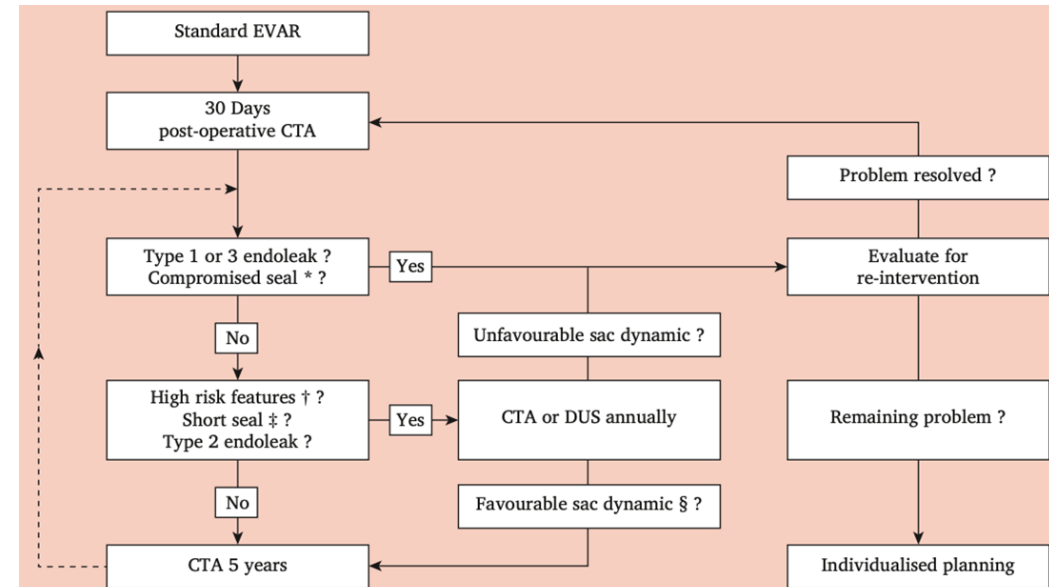


Figure 6. Recommended follow up algorithm after standard endovascular aneurysm repair (EVAR), according to Recommendations 112, 113, and 114. Not applicable to new EVAR device systems, non-standard technology, or complex EVAR. * Degradation of seal zones with impending endoleak, † Proximal neck diameter > 30 mm, proximal neck angulation > 60°, iliac diameter > 20 mm, investigational/new device, ‡ Proximal and distal seal < 10 mm, § Shrinkage > 5 mm from baseline when measured with same imaging modality. DUS = duplex ultrasound; CTA = computed tomography angiography.

SURVEILLANCE POST CHIRURGIE OUVERTE

Table 19. Long term complications after open surgical repair of abdominal aortic aneurysm, and their incidence within five and 10–15 years. [403,404,465,468,706–710](#)

Complication	Estimated incidence within five years	Estimated incidence within 10–15 years
Para-anastomotic aneurysm	1–2%	4% at 10 years – 12% at 15 years
Graft occlusion	1%	5% at 15 years
Incisional hernia	5–12%	5–21%
Graft infection	0.5–5%	—
Secondary aorto-enteric fistula	< 1%	—

Abdominal aortic aneurysm

After open repair of AAA, first follow-up imaging is recommended within 1 post-operative year, and every 5 years thereafter if findings are stable. [1079,1096](#)



CAS CLINIQUE

- Traitement endo vasculaire par endo prothèse aortique
- Surveillance par écho doppler à un mois



Fuite type 2 → surveillance par écho- doppler ou scanner dans 6-12 mois