

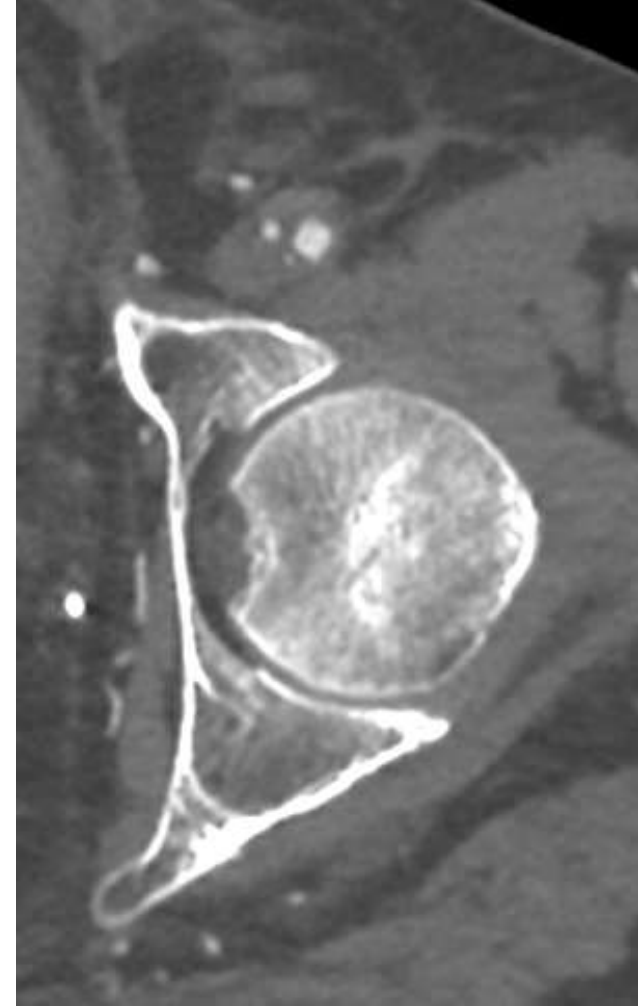
Quelle est la place restante de la chirurgie dans le cadre de la claudication artérielle?

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- ***Exercice supervisé***
- ***Chirurgie conventionnelle***
- ***Chirurgie endovasculaire***



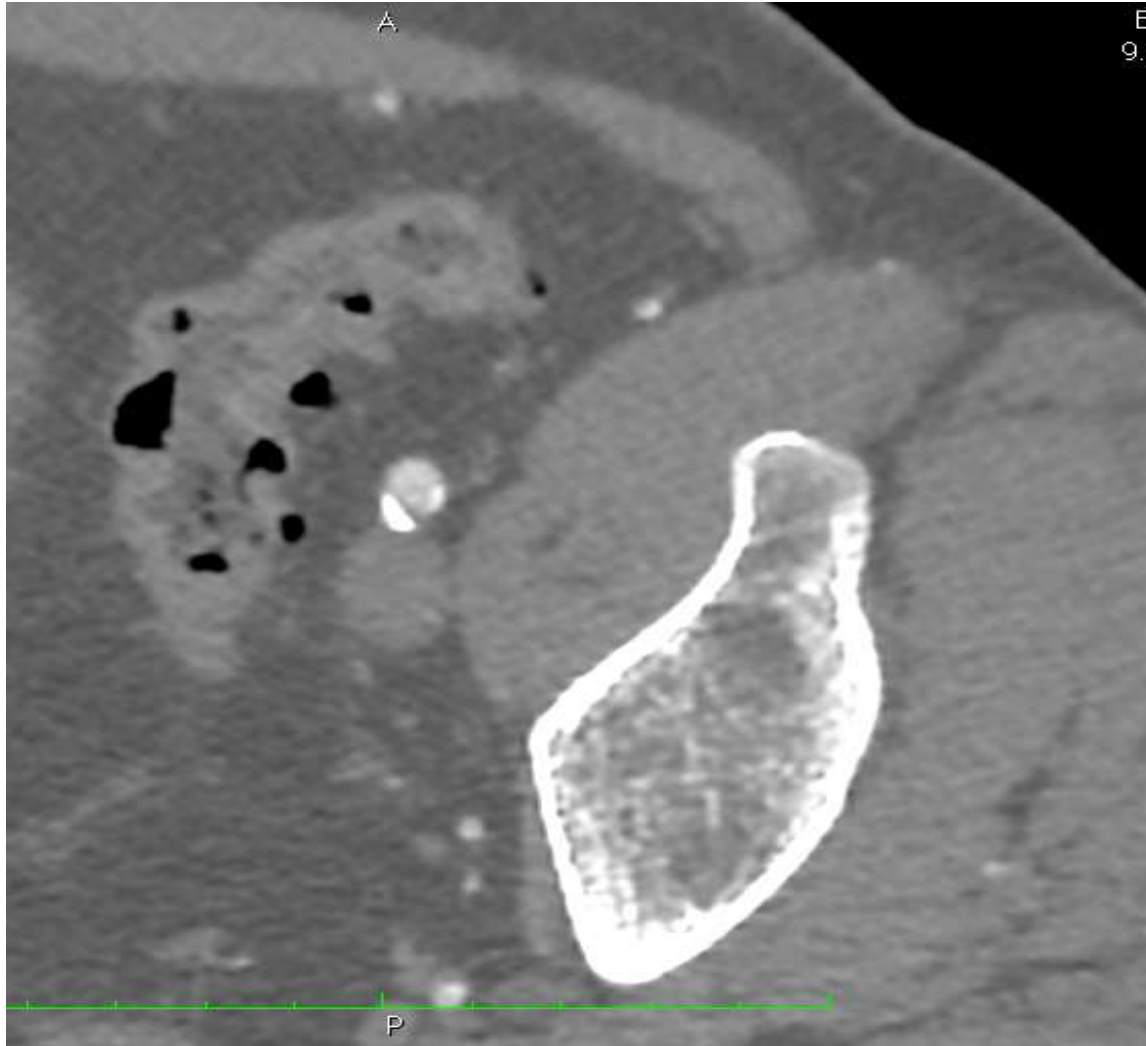


Occlusion aortique sous rénale

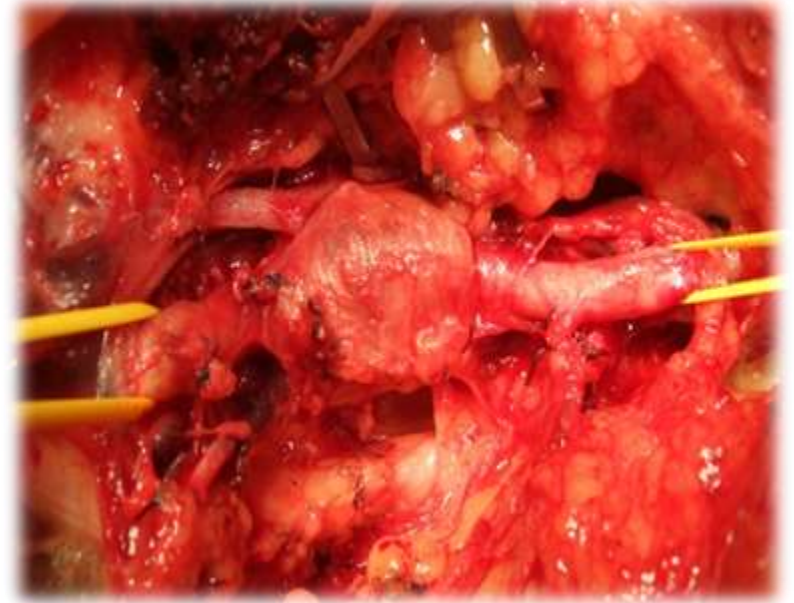
Pontage aorto bifemoral ?

Recanalisation aorto biiliaque?

La chirurgie du trépied fémoral

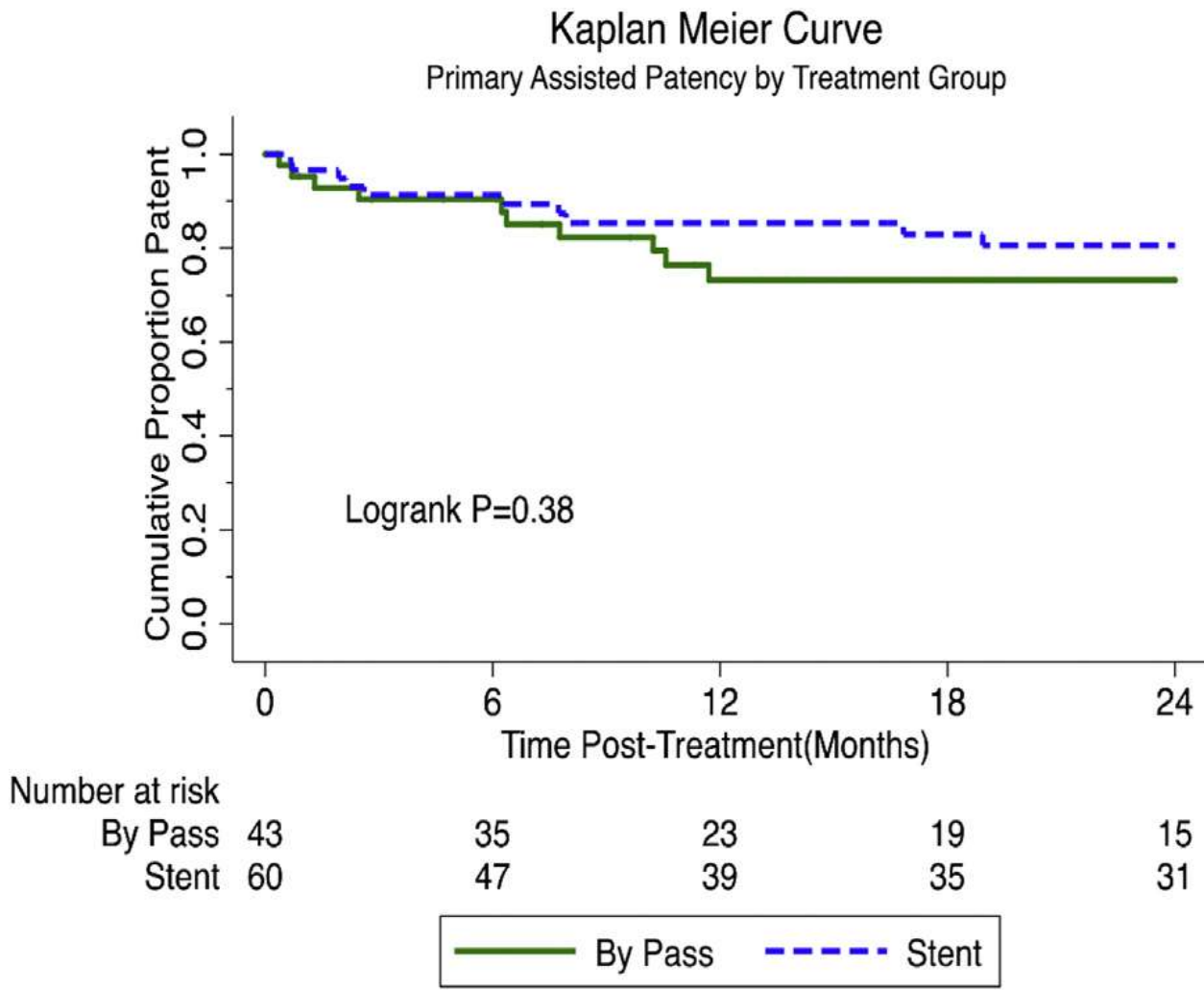
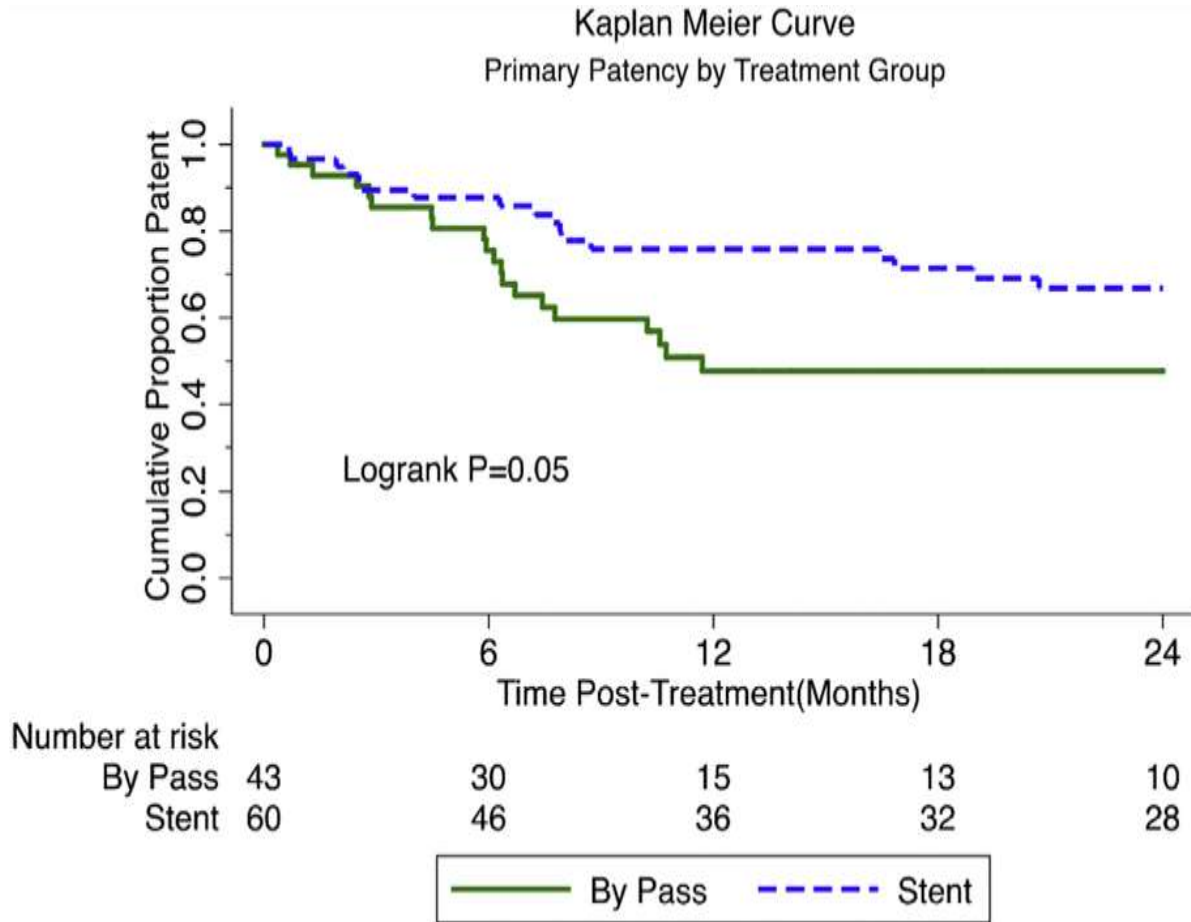


Anévrysme poplitée thrombosé

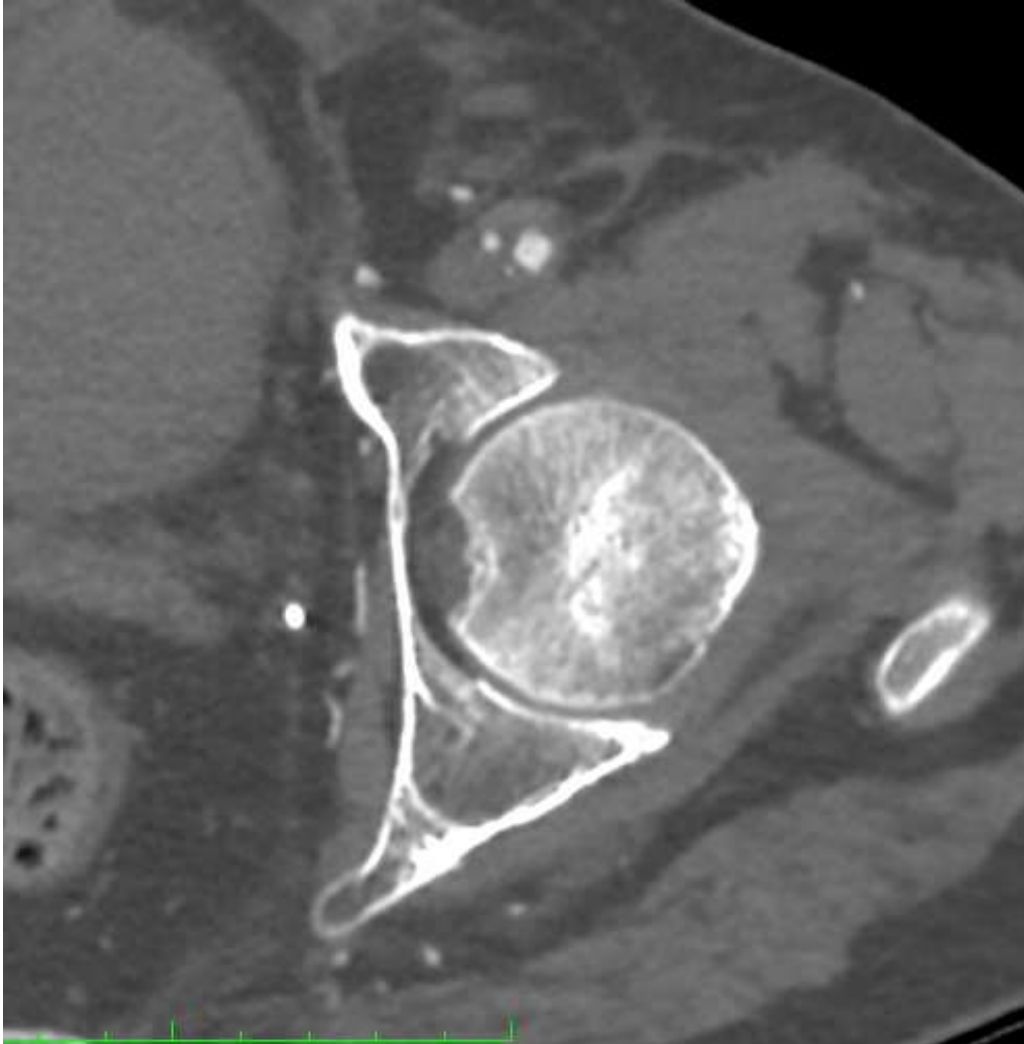


Restauration du segment fémoro-poplitée

Mahmoud B. Malas *j Vasc Surg* 2014;

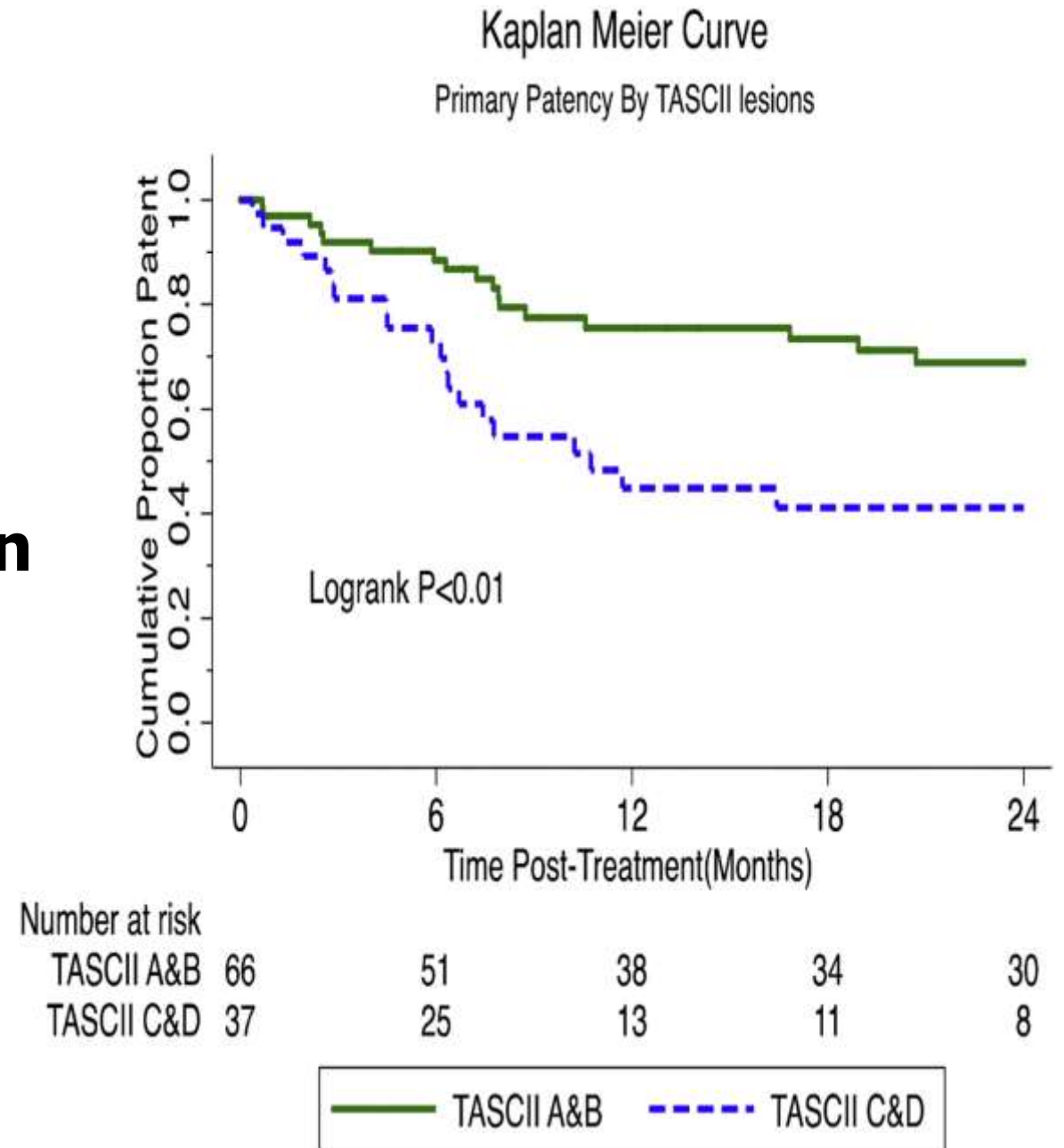


Restauration du segment fémoro-poplitée



- **Le challenge thérapeutique demeure les TASC C et D**
- **Interet des DES et des DEB?**
- **Le traitement endovasculaire doit s'inscrire dans une stratégie de traitement a long terme afin de préserver le maximum d'option thérapeutique dans le temps**

Les revascularisations chirurgicales de seconde intentions après échec endovasculaire ont de moins bon résultats que les revascularisations primaires .





2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in collaboration with the European Society for Vascular Surgery (ESVS)

Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

Recommendations on revascularization of aorto-iliac occlusive lesions^c

Recommendations	Class ^a	Level ^b
An endovascular-first strategy is recommended for short (i.e. <5 cm) occlusive lesions. ²⁹¹	I	C
In patients fit for surgery, aorto-(bi)femoral bypass should be considered in aorto-iliac occlusions. ^{281,292,293}	IIa	B
An endovascular-first strategy should be considered in long and/or bilateral lesions in patients with severe comorbidities. ^{288,294,295}	IIa	B
An endovascular-first strategy may be considered for aorto-iliac occlusive lesions if done by an experienced team and if it does not compromise subsequent surgical options. ^{76,281–283,286}	IIb	B
Primary stent implantation rather than provisional stenting should be considered. ^{294–296}	IIa	B
Open surgery should be considered in fit patients with an aortic occlusion extending up to the renal arteries.	IIa	C
In the case of ilio-femoral occlusive lesions, a hybrid procedure combining iliac stenting and femoral endarterectomy or bypass should be considered. ^{297–300}	IIa	C
Extra-anatomical bypass may be indicated for patients with no other alternatives for revascularization. ³⁰¹	IIb	C

Recommendations on revascularization of femoro-popliteal occlusive lesions^c

Recommendations	Class ^a	Level ^b
An endovascular-first strategy is recommended in short (i.e. <25 cm) lesions. ^{302,303}	I	C
Primary stent implantation should be considered in short (i.e. <25 cm) lesions. ^{304,305}	IIa	A
Drug-eluting balloons may be considered in short (i.e. <25 cm) lesions. ^{77,306–310}	IIb	A
Drug-eluting stents may be considered for short (i.e. <25 cm) lesions. ^{302,303,311}	IIb	B
Drug-eluting balloons may be considered for the treatment of in-stent restenosis. ^{312,313}	IIb	B

Recommendations	Class ^a	Level ^b
In patients who are not at high risk for surgery, bypass surgery is indicated for long (i.e. ≥ 25 cm) superficial femoral artery lesions when an autologous vein is available and life expectancy is >2 years. ³¹⁴	I	B
The autologous saphenous vein is the conduit of choice for femoro-popliteal bypass. ^{284,315}	I	A
When above-the-knee bypass is indicated, the use of a prosthetic conduit should be considered in the absence of any autologous saphenous vein. ²⁸⁴	IIa	A
In patients unfit for surgery, endovascular therapy may be considered in long (i.e. ≥ 25 cm) femoro-popliteal lesions. ³¹²	IIb	C

