EVAR 2014

Each passing year provides new data and technological advances to consider as we continue our efforts toward making the most informed therapeutic decisions possible. Interestingly, or perhaps frustratingly, the advent of new data rarely keeps pace with the arrival of new devices and advanced techniques, leaving even the most attentive physicians in a perpetual state of evaluating today's therapies against yesterday's data. As we await the next informative data set, and the one after that, we must continually keep in touch with colleagues around the world as our global endovascular aneurysm repair (EVAR) experience grows.

With this goal in mind, my colleagues and I open this year's EVAR feature with a discussion encompassing the current state of this procedure. EVAR has a long and proven history and a current foundation that is relatively solid. But, key questions remain. Given that our long-term data are from earlier-generation platforms and also an earlier point in the learning curve, the aforementioned data application quandary begs the question of whether we need another large-scale trial. Jean-Pierre Becquemin, MD, and Charles Swaelens, MD, examine the proposition that large clinical trials are no longer the best path to obtain the necessary information for effective decision making. They conclude that large cohort studies using propensity scores may provide better perspective of real-world outcomes for EVAR patients, and postmarket registry analysis may offer the solution to the problem of an expensive clinical trial.

With the introduction of advanced techniques and devices, new problems can arise, and endoleaks, migration, and iliac limb occlusion remain among the causes of EVAR failure even after more than 2 decades performing the procedure. As we strive for a more complete understanding of aneurysmal disease, we also search for more efficient methods to survey its progression. Proper follow-up is important, and when we do not have data on new protocols, we must constantly assess our surveillance regimens.

An esteemed group, including Felice Pecoraro, MD; Thomas Pfammatter, MD; Mario Lachat, MD; Dieter Mayer, MD; Zoran Rancic, MD, PhD; Michael Glenck, MD; Gilbert Puippe, MD; and Frank J. Veith, MD, share valuable tips and tricks for chimney and periscope procedures. Our colleagues Jill K. Johnstone, MD, and Gustavo S. Oderich, MD, from the Mayo Clinic, offer their insights on how we may update our surveillance protocols.

Devices and techniques are not the only facets of EVAR that are changing. Image quality has improved, and there is growing belief radiation exposure can and should be reduced. Image fusion and new modalities facilitate an overall safer EVAR procedure, and Stephan Haulon, MD, PhD, and Olivier H.J. Koning, MD, along with their colleagues, have each provided articles on the latest in EVAR imaging.

In this issue, we also highlight developments in EVAR in China. Two leading groups from Chinese vascular centers have provided an in-depth perspective on AAA prevalence in China and an article on special considerations for assessing and treating patients with particularly challenging necks. We have also have polled several specialists from around the world on how they manage or prevent stent graft migration, often dubbed the Achilles' heel of EVAR.

In closing, we include a remembrance of Roy K. Greenberg, MD: a true pioneer, phenomenally gifted surgeon, and valued friend across specialties. He is gone from us far too soon, but he will remain in our memories forever. ■

Hence Verhagen, MD, PhD
Guest Chief Medical Editor