Optimal techniques in 2024 for treating infected aortoiliac prosthetic grafts and endografts (including EVAR, TEVAR, F/B/EVAR): from a large national cohort and the GRANDPA global registry

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ESVS Guidelines on AGEI

CLINICAL PRACTICE GUIDELINE DOCUMENT

Editor's Choice – European Society for Vascular Surgery (ESVS) 2020 Clinical Practice Guidelines on the Management of Vascular Graft and Endograft Infections [1]

Update 2026

CLINICAL PRACTICE GUIDELINE DOCUMENT

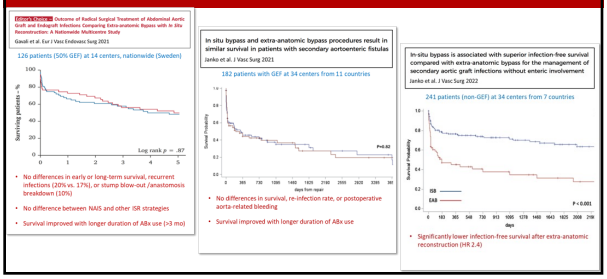
European Society for Vascular Surgery (ESVS) 2024 Clinical Practice Guidelines on the Management of Abdominal Aorto-Iliac Artery Aneurysms [2]

Lack of high-quality evidence

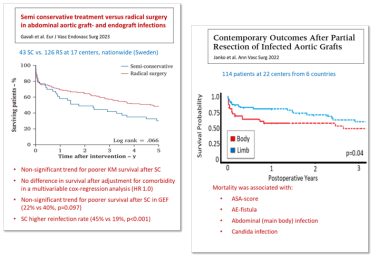
- Evidence is limited to retrospective single-center and single-arm data (with no head-to-head comparative data available), which is burdened with significant bias

- Publication bias
- Selection bias
- Confirmation bias

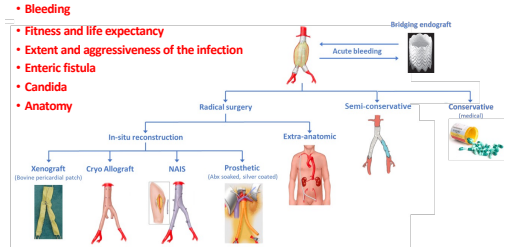
In situ bypass vs. extra-anatomic bypass



Partial graft resection

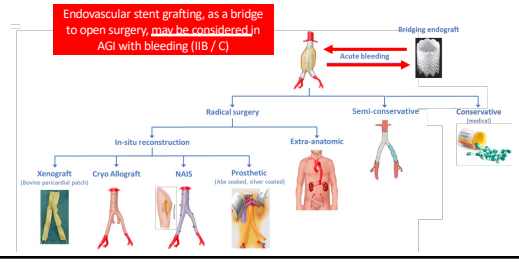


No single method is generally superior to another
Individualized approach



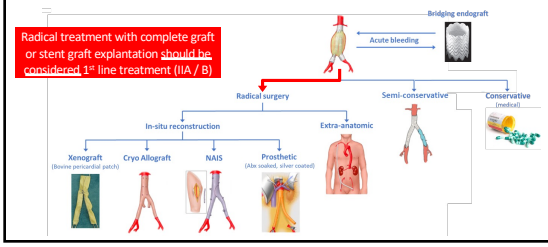
Bleeding

Endovascular stent grafting, as a bridge to open surgery, may be considered in AGI with bleeding (IIB / C)



General treatment strategy

Radical treatment with complete graft or stent graft explantation should be considered 1st line treatment (IIA / B)



General treatment strategy

Partial graft removal may be considered in selected high-risk patients with an isolated infection, and no Candida or enteric fistula (IIB / C)

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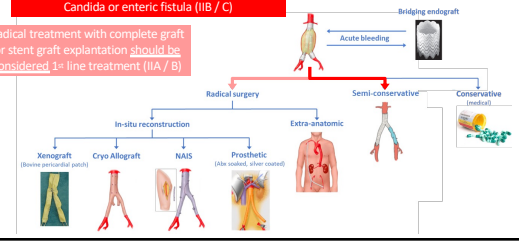
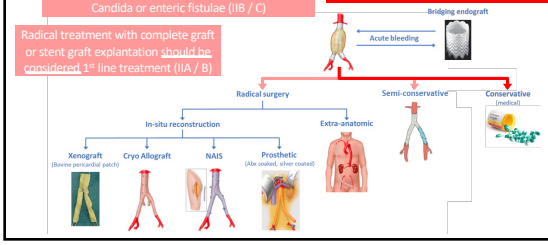


General treatment strategy

Partial graft removal may be considered in selected high-risk patients with an isolated infection, and no Candida or enteric fistulae (IIB / C)

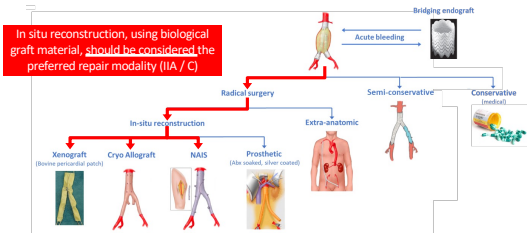
Conservative and or palliative options should be considered in selected high-risk patients unfit for surgical treatment (IIA / C)

Radical treatment with complete graft or stent graft explantation should be considered 1st line treatment (IIA / B)



Radical surgery

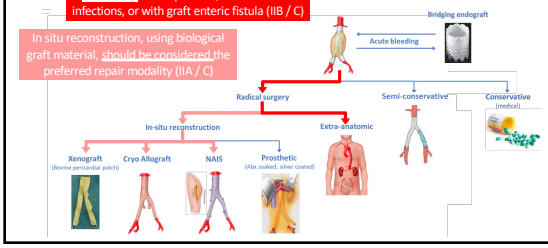
In situ reconstruction, using biological graft material, should be considered the preferred repair modality (IIA / C)



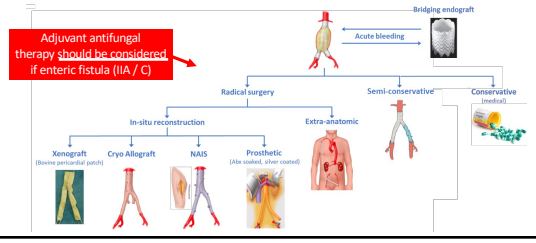
Radical surgery

Extra-anatomic reconstruction may be considered in frail patients, with extensive infections, or with graft enteric fistula (IIB / C)

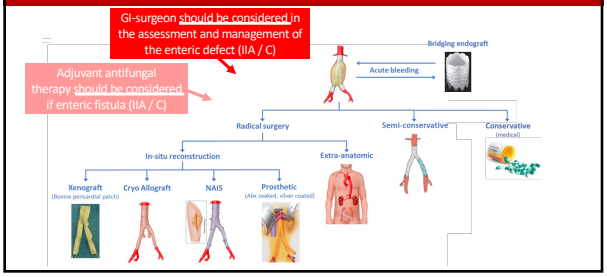
In situ reconstruction, using biological graft material, should be considered the preferred repair modality (IIA / C)



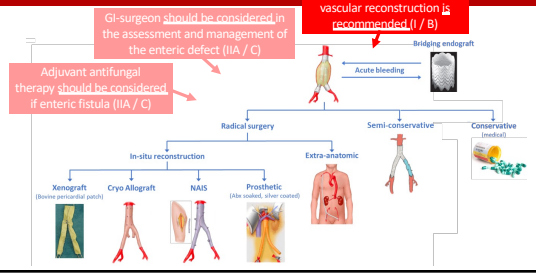
Enteric fistula



Enteric fistula



Enteric fistula



Infected complex EVAR devices

Rarely feasible with radical surgical treatment

Uppsala experience:

- 13 / 372 (3.5%) complex EVAR developed AGI (MAGIC)
- fEVAR (n=5), bEVAR (n=6), Arch (n=2)
- 4 fistula (oesophageal, bronchial, ureteral) with bleeding
- Treatment:
  - OSR attempt, died intraoperatively (n=1)
  - Semi-conservative (drainage + ABx) (n=6)
  - Sonservative (Abx) (n=6)
- Outcome after mean 25 months FU (0.5-73 months):
  - 1 lost to FU
  - 7 died after mean 17 months
  - 5 still alive after mean 36 months
  - 1 patient ABx fee >12 months with no signs of recurrence

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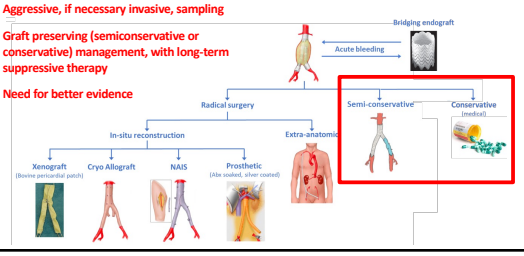
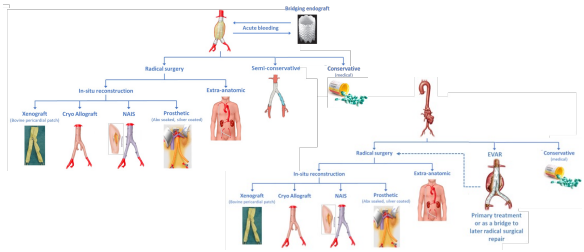
Future trends

- Aggressive, if necessary invasive, sampling
- Graft preserving (semiconservative or conservative) management, with long-term suppressive therapy
- Need for better evidence



Global aoRtic grAft iNfection aDaptive Platform triAl
GRANDPA



Primary Radical surgEry vs. conSERVative thErapy in uncomplicated abdominal aortic endograft infections (**PRESERVE**) RRCT trial