stand-alone therapy (A-F), while the right side
were inserted to the aneurysm (B), over which en-
teration (C). A fill catheter was inserted next to the
neck cavity in the aneurysm sac and obliterates
the aneurysm has cured (< 5 minutes), the endovascular
adjunct therapy (G-I), the process is very similar,
and elastomer (J, K), fixing the graft in an elastomer
CHAPTER 9

Aortic Customize: an in-vivo feasibility study of a percutaneous technique for the repair of aortic aneurysms using injectable elastomer

Eur J Vasc Endovasc Surg; 2010; Volume 40; Issue 1; 65-70

W.M.P.F. Bosman, J. Vlot, T.J. van der Steenhoven, O. van den Berg,
J.F. Hamming, A.C. de Vries, H.L.F. Brom, M.J. Jacobs
ABSTRACT

Objective: The purpose of this study was to test a percutaneous technique for aneurysm sac-filling by means of in-situ polymerization in an in-vivo model.

Design: Aortic Customize is a new endovascular treatment concept for aortic aneurysms: a non-cross-linked liquid elastomer is injected to fill the aneurysm sac around a balloon-catheter. With this method a compliant elastomer mould with a patent lumen is created.

Material: The formulation used in the experiments, consisted of a two-component addition-cure liquid silicone formulation, based on Vinyl terminated polydimethylsiloxane (PDMS).

Methods: The concept of aneurysm sac filling was tested in-vivo in porcine experiments (n=3).

Results: In-vivo porcine experiments with the sac-filling application showed successful exclusion of the created aneurysms with patent lumens and absence of endoleaks. The aneurysms were excluded successfully in the in-vivo model, injecting elastomer through a 7 French catheter, filling up the entire aneurysm sac.

Conclusions: These in-vivo experiments demonstrate that the principle of aneurysm sac filling by means of in-situ curing is feasible, excluding the aneurysm and creating a new lumen. Further long-term animal experiments must be done before clinical application can be considered.
INTRODUCTION

Endovascular repair of aortic aneurysms has evolved into a widely used technique. Large multicentre studies have shown clear advantages of this less invasive technique over conventional open repair. However, with the more widespread use, disadvantages also become more evident. Complications and re-interventions caused mainly by endoleaks, endotension, stent-graft migration and device failure are of major concern.

Due to anatomical restrictions, EVAR is not available for each patient with an AAA. Manufacturers of commercially available EVAR-grafts state that an infrarenal aneurysm neck of at least 15 mm is needed to ensure a strong proximal seal, and that a tortuous anatomy is a (relative) contra-indication. A study from Timaran et al has shown that with 27% of AAAs the anatomy of the aneurysm makes it unsuitable for EVAR because of insufficient neck length, large neck diameter or severe angulation. These problems are less outspoken with fenestrated or branched EVAR grafts, although the use of these grafts is not always possible.

Often, arterial cutdown of the femoral arteries is necessary, as bulky delivery devices with an external diameter of 12–16 French (Fr) have difficulties passing the stent through arteriosclerotic, stenotic and often elongated iliac vessels. The inguinal incisions can cause seroma, haematoma or wound infection, adding morbidity to the procedure.

To overcome these disadvantages Aortic Customize was devised: a method of excluding the aortic aneurysm using endovascular techniques to inject a biocompatible elastomer into the aneurysm sac (Fig. 9.1). The non-cross-linked liquid elastomer is used to fill the aneurysm sac around a balloon-catheter. An endoluminal mould fills up the aneurysm sac after in-situ polymerisation. With this method an elastomer mould with a patent lumen is created.

An earlier study in an in-vitro circulation model by our group has shown that filling an aneurysm sac with an injectable biocompatible elastomer realizes a reduction in the wall stress. With this reduction in wall stress, a reduction in rupture risk is achieved, since aneurysm rupture occurs when the local wall stress exceeds the local wall strength.

The purpose of this study was to test the treatment concept of aneurysm sac-filling in an in-vivo porcine model.

MATERIALS AND METHODS

The elastomer

The formulation used in the experiments, consisted of a two-component room temperature addition-cure liquid silicone formulation, obtained from Viazym BV [ViaZym BV; Delft, The Netherlands]. The two components consist of:
- A platinum containing Vinyl terminated polydimethylsiloxane (PDMS) with an optimized molecular weight with regard to viscosity versus mechanical properties of the cured end-product (elongation to break, modulus). This component further contains surface-treated amorphous silica and a sesquisiloxane-like material known as Vinyl Q, which is known to increase tear-strength of the final cured elastomer without much increase in viscosity.

- A methylhydro-dimethyl-siloxane copolymer containing vinyl terminated polydimethylsiloxane (PDMS). This component further contains surface-treated amorphous silica and Vinyl Q.

Silicone-based elastomers meet the requirements of blood compatibility and have been successfully used intra-vascular by others.\textsuperscript{11–16} The material is non-toxic and cross-links isothermically in the presence of blood, without the release of toxic by-products. Viscosity of the compound allowed infusion-rates of up to 2 ml per second using a standard angiographic pump with an injection-pressure up to 1200 pounds per square inch. The substance has an average polymerisation time of approximately 5 minutes. After curing, the material had a yield-stress of approximately 400 kiloPascal (kPa), failing at more than 20% elongation. The density of the cured elastomer is 1.0167 g/cm\textsuperscript{3}.

A cast of the material with the added crosslinker and filler has been subjected to fatigue tests at 21 cycles per second with stresses comparable to the stresses in the human aorta. No signs of material failure or tear have been observed after one month, which is comparable to an exposure of 18 years in a circulation with a mean frequency of 70 beats per minute.

**In-vivo porcine experiments**

After selection of the ideal composition of the elastomer, the concept of sac-filling through a small calibre catheter was tested. Earlier experiments in a circulation set-up had shown the feasibility of the treatment concept in a dynamic in-vitro set-up.\textsuperscript{8} To investigate the in-vivo feasibility of the treatment concept, 3 in-vivo porcine experiments were conducted. The animal experiment has been approved with the animal ethical committee of the Maastricht University Medical Centre. Three separate aneurysms were created by stitching ellipse-formed polyester patches in longitudinal incisions in polyester tube grafts. The aneurysms were 75 mm long and had a neck and sac diameter of 8 mm and 25 mm, respectively. In the adult pigs (45–55 kg) general anaesthesia was induced where after the abdomen was prepared in a sterile manner and opened through a midline incision. The aorta was exposed from the renal arteries to the trifurcation. Heparin was not administered. Non-traumatic vascular clamps were used to clamp the aorta below the renal arteries and above the trifurcation. The aorta was transected and a 7 cm segment was excised. The polyester aneurysm was sewn end-to-end into the defect with 4–0 running prolene sutures [Ethicon;
In-vivo Porcine Experiments

Somerville; USA] (Fig. 9.2A-B). Circulation was restored and haemostasis was achieved. The abdomen was not closed, allowing direct observation of the treatment concept (Fig. 9.2C). Following, bilateral incisions were made in the groin and the femoral arteries were exposed. Through an arteriotomy in the left femoral artery, a 7 Fr catheter [Boston Scientific; Natick; USA] was placed in the aneurysm sac and a control angiogram was made with standard radiographic contrast [Omnipaque; GE Healthcare; Fairfield; USA], showing no leakages from the sac or the attachment sites. Through the contralateral femoral artery a 7 Fr catheter with an 8 × 100 mm endovascular balloon [Cordis Corporation; New Brunswick; USA] was inserted.
and placed in the aneurysm, just below the renal arteries. The balloon was inflated with a mixture of saline solution and radiographic contrast (Omnipaque; GE Healthcare; Fairfield; USA), thereby excluding the aneurysm from the circulation. A standard angiographic pump, containing a cassette with the elastomer, was connected to the catheter in the left femoral artery (Fig 9.2D). The excluded aneurysm sac was filled with the elastomer, replacing the contrast in the aneurysm. The aneurysms were filled with ±6.1ml of elastomer [= (volume aneurysm sac minus volume of the balloon) + 5%]. The elastomer was given 5 minutes to cure, after which the balloon was deflated and the circulation was restored. We considered the treatment successful if the sac was excluded from the circulation, while the peripheral arteries were still perfused. Control angiograms were made to see that the aneurysms were treated successfully and were free from contrast. After the experiments, the pigs were observed for 30 minutes, after which they were sacrificed and the aneurysms were retrieved and inspected.

Fig. 9.2 The porcine experiments: a porcine aorta was ligated (A) and replaced by a hand made polyester aneurysm (B). After placing the aneurysm, a fill catheter and an endovascular balloon were inserted through an entrance in the femoral arteries (C). The aneurysm sac was excluded from the circulation by pumping up the endovascular balloon. The two components were loaded in an angiographic pump (D), which was attached to the 7Fr fill catheter. The excluded aneurysm sac was filled with the elastomer, which cured in less then 5 minutes (E). After the successful exclusion the specimen was terminated and the excluded aneurysm was harvested (F). From the polyester aneurysm sac a perfect elastomer mould was harvested (G), with a patent lumen at the place of the endovascular balloon (H).
RESULTS

The polyester aneurysms were inserted successfully in the porcine aortae (Fig. 9.2A-B). Pre-treatment angiograms showed no leakages from the aneurysm (Fig. 9.3) or its anastomoses. The aneurysms were successfully excluded from the circulation with the balloon, after which the sacs were filled with the elastomer through the 7 Fr catheter (Fig. 9.2 & 9.3).

After 5 minutes the elastomer had cured and the balloon was deflated, leaving a patent lumen. Control angiograms showed a straight, patent lumen. The aneurysm sac was excluded as there were no contrast or palpable pulsations in the former aneurysm sac. Pulsations were present in the pigs’ hind legs.

Fig. 9.3 Angiographic recordings of the porcine experiment. Adding contrast to the circulation shows the successfully inserted polyester aneurysm (A). After placing a 7Fr fill catheter, the aneurysm was excluded by a 8 mm ø, contrast filled endovascular balloon. Through the 7Fr catheter (arrow), the viscose elastomer was pumped in the aneurysm sac, pushing away the present contrast (dotted arrows) (B). When the aneurysm sac was entirely filled and the elastomer had cured, the endovascular balloon was deflated and extracted (C). Control angiography showed an excluded aneurysm sac with a patent straight lumen (D). No endoleaks or elastomer embolisms were detected.
Dissection of the aneurysms, after euthanisation of the animals, showed that the sac was completely filled by the elastomer, with a patent lumen at the site of the balloon (Fig. 9.2E-H).

DISCUSSION

The concept of filling the sac of an abdominal aneurysm with a biocompatible elastomer is a new treatment option, offering several advantages over conventional and endovascular techniques. These in-vivo experiments show that it is feasible to achieve complete exclusion of the aneurysm with this new technique, using only a 7 Fr catheter and sheath.

In a recent in-vitro study, Barnett et al also described a treatment concept in which the aneurysm sac is filled with a liquid polymer. In their in-vitro study they use hydrogels such as EmboGel and UltraGel to fill the aneurysm sac around an endovascular stent. EmboGel is a mixture of iohexol and alginate, while UltraGel consists of Irgacure, iohexol and polyethylene glycol diacrylate. In the search for a polymer solution for aneurysm sac-filling, we considered the use of alginate and acrylates. However these substances did not meet our specification with regard to durability; both materials are applied in the form of a bio-degradable hydrogel, which is undesirable as the implant is expected to stay in place for many years. In addition to the unfavourable bio-stability of the hydrogel-based solutions, these materials possess insufficient inherent strength and therefore need an additional endovascular stent to stabilize the aneurysm wall when used as sac-filling. This will still necessitate a bulky device in order to insert the graft in the aneurysm sac, thereby losing the advantage of a percutaneous approach.

Low elastic modulus of the implant, preferably matching that of a healthy aorta (1.18±0.21 MPa), is only possible with a small number of elastomers. PDMS being among the most versatile, the most biocompatible, non-biodegradable and most documented examples used in (bio-) medical applications.

Benefits of new technique

Although the results are quite preliminary, the concept of aneurysm sac filling has a number of hypothetical advantages compared to the current EVAR-techniques. The major complication of EVAR is endoleak after the placement of the EVAR graft. We expect that the sac-filling technique is free of type II endoleaks (branch-vessel leakage) because, like the aneurysm sac, branch-vessels will be occluded by the elastomer. Type III endoleaks are not likely to occur as the mould is cast in one piece and there is no graft material in which tears can occur. As the material is non-porous, type IV endoleak is not likely to occur.
With the current generation of EVAR grafts, angulation of the AAA neck is an important excluding factor for treatment. When endovascular balloons will be available in different kinds of form and configuration, in theory, any AAA with a deviant anatomy may become treatable. With current EVAR-techniques, severe angulation may lead to endoleaks\textsuperscript{21–23} and to kinking of the graft material and eventually to migration of the graft.\textsuperscript{23–25} The fluidity of the non-polymerized elastomer inherently causes adjustment to the geometry of the aneurysm, not only by filling the large aneurysm sac but also by diffusing into all irregularities and sideholes. The elastomer mould will fixate itself as it customizes itself to the form of the AAA sac.

Another important exclusion criterium for the current EVAR therapy is strong tortuosity or occlusive disease of the iliac arteries. Many stent grafts need a minimal diameter of 12–16 Fr for access of the bulky delivery sheath. To fill the sac with the biocompatible elastomer a fill catheter with diameter of minimal 7 Fr needs to be introduced to the aneurysm sac through the femoral or brachial artery.

Beside the treatment concept as depicted in Fig. 9.1, the elastomer and injection-technique are more broadly applicable. The elastomer can already be used as an adjuvant with current stent-grafts when problems of endoleak or migration occur. In these cases, the elastomer can be used to fill-up the aneurysm-sac and secure the endovascular stentgraft.\textsuperscript{26}

**Potential limitations of technique**

Despite the potential benefits, the treatment option might have other shortcomings. Although not observed by us in our in-vivo and in-vitro experiments, type I endoleaks may still occur at the junction-sites of the elastomer mould and the native vessel-wall. However addition of conventional stents might still be an option to repair this. Furthermore it is not desirable to have leakage of the fluid elastomer (before the cross-linking) to the peripheral vessels (e.g. renal arteries), as this might act as an arterial embolus. During the filling procedure, the aneurysm sac is excluded from the circulation, below the renal arteries. In the various in-vitro and in-vivo experiments we conducted, there was no visible sign of leakage of the elastomer to distal areas, along the side of the balloon.\textsuperscript{8} However it could still be possible that small invisible fragments indeed leaked away. Intensive in-vivo animal experiments will have to be done to exclude this potential disadvantage. The amount of elastomer that has to be used can be calculated from pre-operative CT-volume measurements, thereby preventing potential “overfilling” of the sac, which may lead to leakage.

Another theoretical disadvantage is that during the filling of the sac, the pressure may increase in such a way, that the AAA sac is at risk of rupture. If indeed such a rupture does occur, it will in all probability directly be sealed by the curing elastomer.
The potential rupture might then not be relevant anymore, as it is directly treated and excluded from the circulation.

Animal experiments are necessary to prove the long-term success of the treatment concept. At this moment we do not yet know how the aneurysm sac will react to the elastomer filling in-vivo. It is not clear if the sac will continue to dilate after elastomer filling or that present thrombus will break down, creating new open spaces in the aneurysm sac. Experiments will have to prove if this might lead to clinically relevant problems.

All these hypothetical benefits and potential shortcoming will have to be investigated before clinical application can be considered.

**Perspective**

In earlier in-vitro research we have shown that filling the aneurysm sac with elastomer clearly decreases the amount of wall-stress. In a circulation model a latex aneurysm was successfully treated with elastomer, reducing the wall-stress from 15.6 N/cm² before sac-filling to 1.1 N/cm² after sac-filling.8

Before its clinical application, the focus will have to be on the long-term results of the aneurysm exclusion and on the development of new endovascular balloons. For example, to treat aneurysms all different morphologies, it will be necessary to be able to place kissing balloons with a perfect seal between each other.

Following these successful in-vivo experiments, we will conduct further animal and in-vitro experiments, testing this novel treatment concept, eventually leading to its clinical use in treating aortic aneurysms.

**CONCLUSION**

The technique of aortic customizing offers a whole new approach to treating aneurysmatic disease of the abdominal aorta. Advantages are the percutaneous approach, absence of (type II-IV) endoleaks and impossibility of kinking or migration of the graft. Therefore it circumvents most major problems associated with currently available stent-grafts. This in-vivo study shows that treatment concept is feasible and it potentially offers a custom-made treatment for the majority of arterial aneurysms. However, clinical application of this sac-filling technique is still an unproven modality and long-term animal research must be done.
ACKNOWLEDGEMENTS

We would like to acknowledge the help of the following persons: J. van Turnhout MSc PhD, J. van Dieten and L. Allili, Department Polymer Materials & Engineering, Technical University Delft, for their assistance with developing the elastomer; G.W. Schurink MD PhD, Department of Surgery, Maastricht University Medical Center and M. de Haan MD PhD, Department of Radiology, Maastricht University Medical Center for their assistance in conducting the porcine experiments.
Chapter 9

REFERENCE LIST


