I. POLICY

Endovascular stent grafts using devices approved by the U.S. Food and Drug Administration may be considered medically necessary in the following situations: (see policy guidelines)

- Treatment of descending thoracic aortic aneurysms without dissection
- Treatment of acute, complicated (organ or limb ischemia or rupture) Type B thoracic aortic dissection.

Endovascular stent grafts may be considered medically necessary for the treatment of rupture of the descending thoracic aorta.

Endovascular stent grafts are considered investigational for the treatment of thoracic aortic lesions that do not meet the above criteria, including but not limited to thoracic aortic arch aneurysms as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Policy Guidelines

Endograft placement relies on non-aneurysmal aortic segments proximal and distal to the aneurysm and/or dissection for anchoring, and a maximal graft diameter that varies by device. The GORE TAG® endoprosthesis is approved by the U.S. Food and Drug Administration (FDA) for “≥2 cm non-aneurysmal aorta proximal and distal to the aneurysm” and an “aortic inner diameter of 23–37 mm.” The Talent™ Thoracic Stent Graft System is approved by the FDA for “non-aneurysmal aortic proximal and distal neck lengths ≥20 mm” and “non-aneurysmal aortic diameter in the range of 18–42 mm.” The Zenith TX2® device is approved by the FDA for non-aneurysmal aortic segments “of at least 25 mm in length” and “diameter measured outer wall to outer wall of no greater than 38 mm and no less than 24 mm.”

Cross-reference:
MP-1.090 Endovascular Grafts for Abdominal Aortic Aneurysms
II. PRODUCT VARIATIONS

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO*

III. DESCRIPTION/BACKGROUND

Thoracic endovascular aneurysm repair (TEVAR) involves the percutaneous placement of a stent graft in the descending thoracic or thoracoabdominal aorta. It is a less invasive alternative to open surgery for the treatment of thoracic aortic aneurysms, dissections, or rupture, and thus has the potential to reduce the morbidity and mortality of open surgery.

Thoracic Aortic Aneurysms

Aortic aneurysms are arterial dilations that are associated with age, atherosclerosis, and hypertension, as well as some congenital connective tissue disorders. The likelihood of significant sequelae of aortic aneurysm is dependent on location, size, and underlying disease state. Left untreated, these aneurysms tend to enlarge over time, increasing the risk of rupture or dissection. Of greatest concern is the tendency for aortic aneurysms to rupture, with severe consequences including death. Another significant adverse occurrence of aortic aneurysm is aortic dissection, in which an intimal tear permits blood to enter the potential space between the intima and the muscular wall of the aorta. Stable dissections may be managed medically; however, dissections which impinge on the true lumen of the aorta, or occlude branching vessels are a surgical emergency.

Indications for the elective surgical repair of aortic aneurysms are based on estimates of the prognosis of the untreated aneurysm balanced against the morbidity and mortality of the intervention. The prognosis of thoracic aortic aneurysm (TAA) is typically reported in terms of the risk of rupture according to size and location, i.e., the ascending or descending or thoracoabdominal aorta. While several studies have estimated the risk of rupture of untreated aneurysms, these studies have excluded patients who underwent surgical repair; therefore, the true natural history of thoracic aneurysms is unknown. Clouse et al performed a population-based study of TAA diagnosed in Olmstead County, Minnesota, between 1980 and 1994.1 A total of 133 patients were identified; the primary clinical end points were cumulative rupture
risk, rupture risk as a function of aneurysm size, and survival. The cumulative risk of rupture was 20% after 5 years. The 5-year risk of rupture as a function of aneurysm size at recognition was 0% for aneurysms less than 4 cm in diameter, 16% for those 4 to 5.9 cm, and 31% for aneurysms 6 cm or more. Interestingly, 79% of the ruptures occurred in women. Davies et al reported on the yearly rupture or dissection rates in 721 patients with TAA. A total of 304 patients were dissection-free at presentation; their natural history was followed up for rupture, dissection, and death. Patients were excluded from analysis once the operation occurred. Not surprisingly, the authors reported that aneurysm size had a profound impact on outcomes. For example, based on their modeling, a patient with an aneurysm exceeding 6 cm in diameter can expect a yearly rate of rupture or dissection of at least 6.9% and a death rate of 11.8%. In a previous report, the authors suggested surgical intervention of a descending aorta aneurysm if its diameter measured 6.5 cm.

Surgical morbidity and mortality are typically subdivided into elective versus emergency repair with a focus on the incidence and risk of spinal cord ischemia, considered of the most devastating complications, resulting in paraparesis or paraplegia. The operative mortality of surgical repair of aneurysm of the descending and thoracoabdominal aorta is estimated at 6% to 12% and 10% to 15%, respectively, while mortality associated with emergent repair is considerably higher. In elective cases, predictors of operative mortality include renal insufficiency, increasing age, symptomatic aneurysm, presence of dissection, and other comorbidities, such as cardiopulmonary or cerebrovascular disease. The risk of paraparesis or paraplegia is estimated at 3% to 15%. Thoracoabdominal aneurysms, larger aneurysms, presence of dissection, and diabetes are predictors of paraplegia. A number of surgical adjuncts have been explored over the years to reduce the incidence of spinal cord ischemia, including distal aortic perfusion, cerebrospinal fluid drainage, hypothermia with circulatory arrest, and evoked potential monitoring. However, the optimal protective strategy is still uncertain. This significant morbidity and mortality makes definitive patient selection criteria for repair of thoracic aneurysms difficult. Several authors have recommended an individual approach based on balancing the patients' calculated risk of rupture with their anticipated risk of postoperative death or paraplegia. However, in general, surgical repair is considered in patients with adequate physiologic reserve when the thoracic aneurysm measures from 5.5 to 6 cm in diameter or in patients with smaller symptomatic aneurysms.

**Thoracic Aortic Dissection**

Aortic dissection can be subdivided into type A, which involves the aortic arch, and type B, which is confined to the descending aorta. Type A dissections are usually treated surgically, while type B dissections are usually treated medically, with surgery indicated for serious complications, such as visceral ischemia, impending rupture, intractable pain, or sudden reduction in aortic size. Dissections associated with obstruction and ischemia can also be subdivided into an obstruction caused by an intimal tear at branch vessel orifices, or by compression of the true lumen by the pressurized false lumen. It has been proposed that endovascular therapy can repair the latter group of dissections by redirecting flow into the true
lumen. The success of endovascular stent grafts of abdominal aortic aneurysms has created interest in applying the same technology to the aneurysms and dissections of the descending or thoracoabdominal aorta.

As noted, type A dissections (involving the ascending aorta) are treated surgically. There is more controversy regarding the optimal treatment of type B dissections (i.e., limited to the descending aorta). In general, chronic, stable type B dissections are managed medically, although some surgeons recommend a more aggressive approach for younger patients in otherwise good health. When serious complications arise from a type B dissection (i.e., shock or visceral ischemia), surgical intervention is usually indicated. However, although there is an estimated 50% one-year survival rate in those treated with an open surgical procedure, it is not clear whether that rate is any better or worse for those treated medically. The advent of stent grafting, with the potential of reducing the morbidity and mortality of an open surgical procedure, may further expand the number of patients considered for surgical intervention.

**Thoracic Aortic Rupture**

Rupture of the thoracic aorta is a life-threatening emergency that is nearly always fatal if untreated. Thoracic artery rupture can result from a number of factors. Aneurysms can rupture due to progressive dilatation and pressure of the aortic wall. Rupture can also result from traumatic injury to the aorta, such as occurs with blunt chest trauma. Penetrating injuries that involve the aorta can also lead to rupture. Penetrating ulcers can occur in widespread atherosclerotic disease and lead to aortic rupture.

Emergent repair of thoracic artery rupture is indicated in many cases in which there is free bleeding into the mediastinum and/or complete transection of the aortic wall. In some cases of aortic rupture, where the aortic media and adventitia are intact, watchful waiting with delayed surgical intervention is a treatment option. With the advent of thoracic endovascular aneurysm repair (TEVAR), the decision making for intervention may be altered, as there may be a greater tendency to intervene in borderline cases due to the potential for fewer adverse events with TEVAR.

**Thoracic Endovascular Aneurysm Repair**

TEVAR is an alternative to open surgery. TEVAR has been proposed for prophylactic treatment of aneurysms that meet criteria for surgical intervention, as well as for patients in need of emergency surgery for rupture or complications related to dissection. The standard open surgery technique for TAA is open operative repair with graft replacement of the diseased segment. This procedure requires lateral thoracotomy, use of cardiopulmonary bypass, lengthy surgical procedures, and is associated with a variety of peri- and postoperative complications, with spinal cord ischemia considered the most devastating.

TEVAR is performed through a small groin incision to access the femoral artery, followed by delivery of catheters across the diseased portion of the aorta. A tubular stent graft composed of fabric and metal is then deployed under fluoroscopic guidance. The stent graft is then fixed to the
proximal and distal portions of the aorta. Approximately 15% of patients do not have adequate femoral access; for them, the procedure can be performed using a retroperitoneal approach.

Potential complications of TEVAR are bleeding, vascular access site complications, spinal cord injury with paraplegia, renal insufficiency, stroke, and cardiopulmonary complications. Some of these complications are similar to those encountered with open repair (e.g., paraplegia, cardiopulmonary events), and others are unique to TEVAR (e.g., access site complications).

**Regulatory Status**

A number of endovascular grafts are approved for use in TAAs (FDA product code: MIH).

In March 2005, the Gore TAG® Thoracic Endoprosthesis (W.L. Gore and Associates, Flagstaff, AZ) was approved by FDA through the premarket approval (PMA) process for endovascular repair of aneurysms of the descending thoracic aorta. Use of this device requires patients to have adequate iliac/femoral access, aortic inner diameter in the range of 23 to 37 mm, and 2 cm or more nonaneurysmal aorta proximal and distal to the aneurysm. In January 2012, FDA granted an expanded indication for the Gore TAG® system to include isolated lesions of the thoracic aorta. Isolated lesions refer to aneurysms, ruptures, tears, penetrating ulcers, and/or isolated hematomas, but do not include dissections. Indicated aortic inner diameter is 16 to 42 mm, with 20 mm or more of nonaneurysmal aortic distal and proximal to the lesion.

In May 2008, the Zenith TX2® TAA Endovascular Graft (Cook Inc., Bloomington, IN) was approved by FDA through the PMA process for the endovascular treatment of patients with aneurysms or ulcers of the descending thoracic aorta. Indicated aortic inner diameter is in the range of 24 to 38 mm.

In June 2008, the Talent™ Thoracic Stent Graft System (Medtronic Vascular, Santa Rosa, CA) was approved by FDA through the PMA process for the endovascular repair of fusiform and saccular aneurysms/penetrating ulcers of the descending thoracic aorta. Indicated aortic inner diameter is in the range of 18 to 42 mm.

In September 2012, FDA approved the Relay® Thoracic Stent-Graft with Plus Delivery System (Bolton Medical, Sunrise, FL) for the endovascular repair of fusiform aneurysms and saccular aneurysms/penetrating atherosclerotic ulcers in the descending thoracic aorta in patients having appropriate anatomy, including:

- Iliac or femoral access vessel morphology that is compatible with vascular access techniques, devices, and/or accessories
- Nonaneurysmal aortic neck diameter in the range of 19 to 42 mm
- Nonaneurysmal proximal aortic neck length between 15 and 25 mm and nonaneurysmal distal aortic neck length between 25 and 30 mm depending on the diameter stent graft required.

In 2012, the Valiant™ Thoracic Stent Graft with the Captivia® Delivery System (Medtronic Vascular, Santa Rosa, CA) was approved by FDA through the PMA process for isolated lesions of the thoracic aorta. Isolated lesions refer to aneurysms, ruptures, tears, penetrating ulcers,
and/or isolated hematomas, but not including dissections. Indicated aortic diameter is 18 to 42
mm for aneurysms and penetrating ulcers, and 18 to 44 mm for blunt traumatic injuries. In
January 2014, FDA-approved indications for the Valiant™ Thoracic Stent Graft with the
Captivia® Delivery System were expanded to include all lesions of the descending thoracic
aorta, including type B dissections. The Valiant graft is intended for the endovascular repair of
all lesions of the descending aorta in patients having appropriate anatomy including:

- Iliac/femoral access vessel morphology that is compatible with vascular access
techniques, devices, and/or accessories;
- Nonaneurysmal aortic diameter in the range of 18 to 42 mm (fusiform and saccular
aneurysms/penetrating ulcers), 18 to 44 mm (blunt traumatic aortic injuries [BTAI]), or
20 to 44 mm (dissections) and;
- Nonaneurysmal aortic proximal and distal neck lengths 20 mm or more (fusiform and
saccular aneurysms/penetrating ulcers), and landing zone 20 mm or more proximal to the
primary entry tear (BTAI, dissection). The proximal extent of the landing zone must not
be dissected.

The expanded approval was based on the Medtronic Dissection Trial (NCT01114724), a
prospective, nonrandomized study to evaluate the performance of the Valiant stent graft for
acute, complicated type B dissection, which included 50 patients enrolled at 16 sites.

Other devices are under development and, in some situations, physicians have adapted other
commercially available stent grafts for use in the thoracic aorta.

IV. RATIONALE

Controlled trials of specific patient groups treated with specific procedures are required to
determine if endovascular approaches are associated with equivalent or improved outcomes
compared with surgical repair. For patients who are candidates for surgery, open surgical
resection of the aneurysm with graft replacement is considered the criterion standard for
treatment of aneurysms or dissections. Some patients who would not be considered candidates
for surgical therapy due to unacceptable risks might be considered candidates for an
endovascular graft. In this situation, the outcomes of endovascular grafting should be compared
with optimal medical management. Comparative mortality rates are of high concern, as are the
rates of serious complications such as the incidence of spinal cord ischemia.

Randomization to treatment groups is also very important in the evaluation of endovascular
repair of thoracic aortic disorders. This is due to the numerous patient factors (e.g., age,
comorbidities, location and size of the aneurysm, presence or absence of dissection) and
procedure variables involved in surgical repair that are potential confounders of outcome.
Selection for either open or endovascular repair involves a complex set of patient and anatomic
considerations. As a result, studies are highly prone to selection bias if there is no randomized
assignment.
Aneurysms of the Descending Thoracic Aorta

There are no randomized controlled trials (RCTs) of endovascular repair versus open surgery for thoracic aneurysms. The best evidence consists of nonrandomized comparative studies and systematic reviews of these studies. The following review includes representative prospective, nonrandomized studies, and selected systematic reviews.

Systematic Reviews
A systematic review of the evidence for endovascular repair of thoracic aneurysms was published by the Cochrane Peripheral Vascular Diseases Group in January 2009 and was based on the literature to October 2008. No RCTs comparing endovascular repair to open surgical interventions for thoracic aneurysms were found in the medical literature. Reports from nonrandomized studies suggest that endovascular repair is technically feasible and may reduce early negative outcomes, including death and paraplegia. However, endovascular repair is associated with late complications not often seen in open surgery, such as the development of leaks, graft migration, and need for reintervention. Patients receiving endovascular grafts also require more frequent surveillance with computed tomography scans and have increased radiation exposure.

In 2016, Biancari et al published a meta-analysis of thoracic endovascular aneurysm repair (TEVAR) for aneurysms of the descending thoracic aorta in the elderly (mean, 72.6 years; 95% confidence interval [CI], 71.3 to 73.9 years). No RCTs were identified, and the review did not compare TEVAR with open surgical repair in this more fragile population. The 11 observational studies (673 patients, 6 retrospective) reported technical success in 91.0% of procedures with vascular access complications requiring repair in 9.7% of cases. Endoleak was observed in 10.5% of patients. Survival rates were 96.0% at 30 days, 80.3% at 1 year, 77.3% at 2 years, and 74.0% at 3 years. TEVAR as an emergency procedure was performed in about one-third of the population, and had a significantly higher 30-day mortality rate than elective TEVAR (17.1% vs 1.8; relative risk [RR], 3.83; 95% CI, 1.18 to 12.40; p=0.025). By 3 years, reintervention was needed in 9.7% of patients, with death secondary to aneurysm rupture and/or fistula in 3.2% of patients. Interpretation of these results is difficult due to the lack of comparison with open repair.

Nonrandomized Comparative Studies

TAG 99-01 Study
The TAG 99-01 study was a controlled trial of patients with aneurysms of the descending thoracic aorta treated with either surgical repair (n=94; 50 historical, 44 concurrent) or stent grafting (n=140) at 17 sites in the United States. Patients for both the graft group and the control group were selected using the same inclusion and exclusion criteria. After fractures in the wire frame of the TAG endoprosthesis were discovered in TAG 99-01, 51 patients underwent stent grafting with a modified TAG endoprosthesis at 11 sites in the subsequent TAG 03-03 study. The primary outcomes assessed in both TAG 99-01 and TAG 03-03 were the number of patients who had 1 or more major adverse events and the number of patients who did not experience device-related events 12 months post device deployment. The number of patients in the TAG 99-
01 device group who experienced 1 or more major adverse event (42%) was significantly lower (p<0.001) than the surgical repair control group (77%) at 1-year follow-up. Major adverse events included major bleeding, neurologic, pulmonary, renal function, and vascular complications. In the TAG 99-01 device group, 4 (3%) of 140 patients experienced paraplegia or paraparesis versus 13 (14%) of 94 patients in the control group.

In the 12-month follow-up of TAG 99-01, 8 (3%) patients had 1 or more major adverse device-related events, while the 12- to 24-month follow-up in this group only noted 1 major adverse device-related event. No major adverse device-related events occurred in the 30-day follow-up of the TAG 03-03 group. Information on 142 patients from the TAG 99-01 trial was published by Makaroun et al; however, the authors did not report on comparative data with the surgical control group, citing regulatory requirements pending U.S. Food and Drug Administration (FDA) review. The Makaroun report of the TAG 99-01 study reported favorable aneurysm-related (97%) and overall survival (OS) (75%) rates, and concluded that the Gore TAG device was a safe alternative treatment for descending thoracic aortic aneurysms.

The same authors also reported 5-year outcomes of the TAG 99-01 trial. In this follow-up of 140 endograft patients and 96 noncontemporaneous controls, the authors concluded that endovascular treatment was superior to surgical repair at 5 years in anatomically suitable patients. At 5 years, aneurysm-related mortality was lower for TAG patients at 2.8% compared with open controls at 11.7% (p=0.008). No differences in all-cause mortality were noted, with 68% of TAG patients and 67% of open controls surviving to 5 years. Endoleaks in the TAG group decreased from 8.1% at 1 month to 4.3% at 5 years. Five TAG patients had undergone major aneurysm-related reinterventions at 5 years (3.6%). For this study, significant sac size change was defined as a 5 mm or greater increase or decrease from the 1-month baseline measurement. Migration was defined as 10 mm or more cranial or caudal movement of the device inside the aorta. Compared with the 1-month baseline, sac size at 60 months decreased in 50% and increased in 19% of TAG patients. At 5 years, no ruptures, 1 migration, no collapse, and 20 instances of fracture in 19 patients were reported, all before the revision of the TAG graft. Trialists also noted that, although sac enlargement was concerning, the modified device may help resolve this issue.

**VALOR and VALOR II Trials**

The Evaluation of the Medtronic Vascular Talent Thoracic Stent Graft System for the Treatment of Thoracic Aortic Aneurysms (VALOR) trial was a nonrandomized study conducted at 38 sites within the United States to assess the Talent stent graft. The VALOR trial enrolled patients who were candidates for open surgical repair and compared 195 thoracic aortic aneurysm (TAA) patients (age, 70.2 years; male, 59%) with 189 retrospective open surgical repair controls (age, 69.6 years; male, 52.4%). Patients in the Talent endovascular graft group had smaller TAA size and were less likely to have a previous aortic aneurysm (37/195 vs 70/189 in the surgery group). Talent subjects were also less likely to have comorbid conditions including angina (pooled RR=1.6; 95% CI, 1.0 to 2.6), coronary artery disease (pooled RR=1.2; 95% CI, 1.0 to 1.5), or previous myocardial infarction (MI; pooled RR=1.3; 95% CI, 1.0 to 1.6). Thirty-day (Talent
group, 4/195 vs surgery group, 15/189; p<0.1) and 12-month mortality (Talent group, 31/192 vs surgery group, 39/189; p<0.01) were lower in the endovascular graft group than the open surgery group. Fewer endovascular graft patients required blood transfusions (Talent, 22% vs surgery, 93%). Endovascular graft patients had a shorter intensive care unit stay (Talent, 2±5.5 days vs surgery, 8±8.5 days) and overall hospital stay (Talent, 6±11.5 days vs surgery, 17±15 days).

The Evaluation of the Clinical Performance of the Valiant Thoracic Stent Graft in the Treatment of Descending Thoracic of Degenerative Etiology in Subjects Who Are Candidates for Endovascular Repair (VALOR II) was a prospective nonrandomized study at 24 sites designed to evaluate the Valiant thoracic stent graft. VALOR II enrolled 160 patients who underwent stent grafting with the Valiant device, using similar enrollment criteria to VALOR. Outcomes were compared with those from the VALOR study. Stent-graft delivery was technically successful in 154 patients. Hundred fifty-one patients were evaluated at 12 months postprocedure; all-cause mortality at 12 months associated with the Valiant stent graft (12.6%) was statistically noninferior to the Talent stent graft (16.1%) and exceeded the primary effectiveness goal of 12-month successful aneurysm treatment (defined as absence of aneurysm growth >5 mm and of secondary procedures for type I/III endoleak).

In 2014, Matsumoto et al reported rates of secondary procedures over 3-year follow-up for patients enrolled in the VALOR and VALOR II trials. Three-year follow-up evaluations were available for 127 (65.5%) patients in the TEVAR arm of VALOR and 96 (61.8%) in VALOR II. Freedom from secondary procedures at 3 years was 85.1% (95% CI, 78.5% to 89.8%) in the TEVAR arm of VALOR and 94.9% (95% CI, 88.8% to 97.7%) in VALOR II (p<0.001). The overall 3-year difference between groups in secondary procedure rates was driven by differences in early (within 1 year) reintervention rates. This comparison suggests that the newer-generation stent-graft device may be associated with fewer reinterventions; however, the nonrandomized comparison and potential differences between patients in VALOR and VALOR II makes it difficult to draw firm conclusions about the relative efficacy of different devices.

**Goodney et al**

Goodney et al used Medicare claims data from 1998 to 2007 to compare TEVAR with open surgery in patients with aneurysms of the descending aorta. This study included both intact and ruptured aneurysms. A total of 13,998 patients with intact aneurysms were identified; 11,565 were treated with open surgery and 2433 with TEVAR. There were baseline differences between the 2 groups, with the TEVAR group being older and more likely to have a variety of medical comorbidities. The authors performed 2 comparisons, an unadjusted comparison of outcomes in all patients and a propensity-matched comparison in a subset of 1100 patients.

Thirty-day mortality was slightly lower among TEVAR (6.1%) patients than open surgery patients (7.1%), but this difference was not statistically significant (p=0.07). In the propensity-matched comparison, there was no difference in 30-day mortality between the TEVAR group (4.5%) and open surgery group (4.2%; p=0.78). Long-term survival was reported using Cox proportional hazards analysis. At 5 years, survival in the TEVAR group (62%) was lower than in
the open surgery group (72%; p=0.001). In the propensity-matched comparison, the TEVAR group (73%) also had lower OS at 5 years than the open surgery group (81%; p=0.007).

Matsumara et al
The Zenith TX2 device received premarketing approval from FDA based on results of Matsumara et al. This prospective cohort study compared 160 thoracic endovascular aneurysm repair patients (age, 72 years; male, 72%) with 70 open surgery patients (age, 68 years; male, 60%). The study arms were comparable in previous history of cardiovascular and other vascular disease. The TEVAR patients had a lower American Society of Anesthesiologist classification (p<0.01) and higher Society of Vascular Surgery/International Society of Cardiovascular Surgery risk score (p=0.03).

The 30-day survival rate for the endovascular group was noninferior (p<0.01) to the control group (98.1% vs 94.3%, respectively). The 30-day severe morbidity composite index (cumulative mean number of events per patient) was significantly lower in the endovascular group (0.2) than in the control group (0.7; p<0.01). At 12 months, aneurysm growth was identified in 7.1% of the endovascular patients, endoleak occurred in 3.9% (4/103), and migration in 2.8% (3/107). At 12 months, aneurysm growth was identified in 7.1% of the endovascular patients, endoleak occurred in 3.9% (4/103 patients), and migration in 2.8% (3/107 patients).

In 2014, Matsumara et al published 5-year follow-up from the Zenith TX2 prospective cohort trial. The 70 patients in the open surgical control group underwent clinical evaluation before discharge or at 1 month and then at 12 months and yearly thereafter up to 5 years. Follow-up beyond 1 year was unavailable for 24 patients due to institutional review board restrictions and for 4 other patients who were lost to follow-up. TEVAR patients had follow-up at 1, 6, and 12 months postprocedure and yearly thereafter. Of the 160 TEVAR patients, 2 did not have successful device deployment and only had follow-up to 30 days; an additional 32 were lost to follow-up. Five-year survival was 62.9% for the TEVAR group and 62.8% for the open surgical group (nonsignificant difference between groups). Kaplan-Meier estimates of freedom from severe morbidity composite index was significantly higher in the TEVAR group than the open surgical control group (87.3% vs 64.3% at 1 year and 79.1% vs 61.2% at 5 years; log-rank test, p<0.001). Secondary interventions occurred at similar rates between the endovascular and open surgical control patient groups during follow-up through 5 years. While this study is limited by some loss to follow-up, it suggests that the early morbidity benefit associated with TEVAR persists over time and that rates of secondary interventions may be comparable with open surgical repair.

Other Studies
In addition to the prospective studies described above, other studies have compared open and endovascular repair using either large administrative databases or retrospective comparative designs. Orandi et al published a comparative analysis of 1030 patients undergoing open surgery and 267 undergoing endovascular repair using the Nationwide Inpatient Sample database. In-hospital mortality was similar between open and endovascular patients (adjusted odds ratio [OR],

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1.2; 95% CI, 0.73 to 2.12). Dick et al reported a post hoc analysis of prospectively collected data for clinical and quality-of-life outcomes in 52 patients undergoing endovascular repair with 70 patients undergoing open surgical repair, with no significant differences in perioperative mortality rates or overall quality-of-life scores. Other representative retrospective studies of TEVAR for aortic aneurysms are those by Cazavet et al., Iba et al., and Arnaoutakis et al.

Section Summary: Aneurysms of the Descending Thoracic Aorta

There are no RCTs of TEVAR versus open surgery for elective repair of thoracic aortic aneurysms, with the best evidence on this question consisting of nonrandomized, comparative studies. The main limitation of these studies is noncomparability of groups, with group differences demonstrated between endovascular and surgical patients in nearly all cases. In some instances, TEVAR patients appear to be less severely ill than open surgery patients, but in other instances, the TEVAR population appears to be more severely ill. These group differences preclude definitive conclusions about the comparative efficacy of endovascular versus open surgery for repair of thoracic aneurysms.

The results of these studies are consistent in showing equivalent or reduced short-term mortality and fewer early complications for TEVAR. The consistency of this finding across populations with different characteristics lends support to the conclusion that TEVAR is a safer procedure in the short term. The likely short-term benefits of TEVAR are mitigated by longer term outcomes that are less favorable for TEVAR. Longer term mortality appears to be roughly similar for patients undergoing TEVAR or open surgery, and some studies report that long-term survival is better following open surgery. TEVAR patients have a higher rate of long-term complications, primarily from endoleaks, and a higher reintervention rate. TEVAR patients also require closer monitoring after intervention, with more frequent imaging studies.

Type B (Descending) Aortic Dissections

Acute, Uncomplicated Type B Aortic Dissections

Randomized Controlled Trials

One RCT (the ADSORB trial) compared TEVAR with best medical therapy for patients with acute, uncomplicated dissections. In 2014, initial results of the ADSORB trial, which randomized 61 patients with uncomplicated acute type B aortic dissection to best medical therapy (n=31) or best medical therapy plus endovascular repair with the Gore TAG stent graft (n=30), were published. Eligible patients had acute (randomized within 14 days of symptom onset), uncomplicated type B dissection without evidence of connective tissue disease. The median time from onset of symptoms to randomization was 4.8 and 4.6 days for the best medical therapy and the TEVAR group, respectively. Treatment crossovers occurred in 3 patients from the best medical therapy group to the TEVAR group. Fourteen subjects failed due to inadequate/no imaging, and were counted in the 1-year efficacy end point calculations as failures. The study’s primary end point was a composite of (1) incomplete or no false lumen thrombosis at 1 year, (2) aortic dilation at 1 year, or (3) aortic rupture through the 1-year follow-
up period. At 1 year, 15 (50.0%) of the 30 TEVAR patients had at least 1 end point event and all 31 best medical therapy patients had at least 1 end point event (p<0.001). In the control group, 30 patients had no false lumen thrombosis and 14 had aortic dilatation; there were no cases of aortic rupture in either group. There were no deaths within 30 days postprocedure; during follow-up, 1 death (cardiac arrest) occurred in the TEVAR group.

Nonrandomized Comparative Studies
One retrospective study compared outcomes of endovascular repair with medical therapy for acute type B aortic dissections. Of 88 patients presenting with acute dissection over a 12-year period, 50 were treated medically and 38 were treated with endovascular repair. Overall mortality was reported for a mean follow-up of 33 to 36 months and did not differ between the medical therapy group (24%) and the endovascular group (23.7%; p=NS).

Section Summary: Acute, Uncomplicated Type B Aortic Dissections
One RCT reported short-term improvements in aortic remodeling and risk of aortic dilation and rupture in patients with acute, uncomplicated aortic dissections treated with TEVAR, compared with those treated with best medical management. However, this trial was underpowered to evaluate mortality differences, and limitations include a high rate of failure of imaging follow-up. Single-arm series report relatively high success rates and favorable long-term results compared with historical controls undergoing open surgery.

Acute, Complicated Type B Aorta Dissections

Systematic Reviews
In 2014, Moulakakis et al reported results of a systematic review and meta-analysis of studies on the management of complicated and uncomplicated type B aortic dissection, including medical management, open surgical repair, and endovascular repair. “Complicated dissections” were defined as those with aortic rupture, visceral and renal ischemia, lower extremities ischemia, or spinal cord ischemia, or with expansion to the aortic arch or proximal descending aorta with a total diameter of 4.5 cm or more. The review included 30 studies on TEVAR, 15 studies on best medical therapy, and 9 studies on surgical repair. For the 2531 patients with acute complicated type B aortic dissection treated with TEVAR, the pooled 30-day/in-hospital mortality rate was 7.3% (95% CI, 5.3 to 9.6%). Survival rates ranged from 62% to 100% at 1 year and from 61% to 87% at 5 years. For the 1276 patients with acute complicated type B aortic dissection treated with open repair, the pooled 30-day/in-hospital mortality rate was 19.0% (95% CI, 16.8% to 21.1%). Survival rates ranged from 74.1% to 86.0% at 1 year and from 44.0% to 82.6% at 5 years. Direct comparisons between treatment groups are not reported, and the study does not account for between-group differences (other than treatment modality), which limits conclusions that may be drawn.

Randomized Controlled Trials
There are no RCTs for treatment of acute, complicated type B dissections, which is the group for which endovascular repair is often targeted.
Nonrandomized Controlled Trials
Fattori et al compared long-term survival between TEVAR and best medical therapy for type B acute aortic dissections among 1129 patients enrolled in an international registry of acute aortic dissections. The multinational registry included 24 referral centers in 12 countries; the registry was designed to provide an unbiased representative population of patients with acute aortic dissection. A total of 3865 patients were enrolled from December 26, 1995, to January 20, 2012. The present study included 1129 patients with type B acute aortic dissections, who underwent either medical therapy (n=853) or endovascular stent-graft placement (n=276). Patients who underwent TEVAR were matched in a 2:1 manner to medical therapy patients based on a propensity score created from a multivariable binary logistic regression model for the conditional probability for endovascular treatment versus medical treatment. The groups differed significantly at baseline: patients receiving endovascular treatment were more likely to present with clinical signs of malperfusion, such as leg pain (21.7% vs 8.4%, p<0.001) and limb ischemia (20.6% vs 4.8%, p<0.001), were more likely to have preoperative acute renal failure (21.4% vs 12.4%, p<0.001), any pulse deficit on presentation (28.3% vs 13.4%, p<0.001), and complicated dissections (defined by the presence of shock, periaortic hematoma, signs of malperfusion, stroke, spinal cord ischemia, mesenteric ischemia/infarction, and/or acute renal failure (61.7% vs 37.2%, p<0.001). Kaplan-Meier survival estimates at 5 years showed that patients who underwent TEVAR (15.5%) had a lower death rate than best medical therapy patients (29.0%; p=0.018).

Observational Studies
A number of case series have been reported, and some have reported long-term results for use of TEVAR in complicated type B aortic dissection.

White et al analyzed 1-year outcome after TEVAR in patients with complicated type B aortic dissection who had rupture or malperfusion and symptom onset 14 days or less (acute), 15 to 30 days (subacute), and 31 to 90 days (chronic) until required intervention. Their report focused on the acute cohort. Clinical data were systematically collected from 5 physician-sponsored investigational device exemption clinical trials between 2000 and 2008. Adverse events were reported early (≤30 days) and late (>30 days). In this study, there were 99 complicated type B aortic dissection patients: 85 were acute, 11 were subacute, and 3 were chronic. Among the acute patients, 31.8% had rupture and 71.8% had malperfusion, including 55.7% lower extremity, 36.1% renal, 19.7% visceral, 8.2% other, and 3.3% spinal cord (patients may have had >1 source). Rupture and malperfusion were both reported for 3 acute patients. Early major adverse events occurred in 37.6% of patients, including death (10.6%), stroke (9.4%), renal failure (9.4%), and paralysis (9.4%); late adverse events included vascular (15.8%), cardiac (10.5%), gastrointestinal (6.6%), and hemorrhage (5.3%). The point-estimate mortality rate was 10.8 (95% CI, 4.1 to 17.5) at 30 days and 29.4 (95% CI, 18.4 to 40.4) at 1 year, when 34 patients remained at risk. The authors concluded that emergency TEVAR for patients with complicated type B aortic dissection (malperfusion or rupture) provides acceptable mortality and morbidity results out to 1 year.
Steuer et al published a retrospective, single-center, consecutive case series from Europe. In this study, during the period 1999 to 2009, TEVAR was carried out in 50 patients with nontraumatic acute complicated type B dissection and in another 10 patients with acute complications, including rupture, end-organ ischemia, and acute dilatation during the primary hospitalization but more than 14 days after onset of symptoms. Within 30 days, 2 (3%) deaths, 1 (2%) paraplegia, and 3 (5%) strokes were observed. Five-year survival was 87% and freedom from reintervention at 5 years was 65%. The authors concluded that, in patients with acute complicated type B aortic dissection, TEVAR can be performed with excellent early and long-term survival.

Hanna et al published a retrospective case series of long-term follow-up (median follow-up, 33.8 months) of 50 patients who underwent TEVAR for management of acute complicated type B aortic dissection. At 30 days, no deaths were reported. OS at 5 and 7 years was 84%. No deaths were attributable to aortic pathology, but a high proportion of patients (26%) required reintervention over the follow-up period.

Ruan et al evaluated predictors of early and late mortality among 63 patients who underwent TEVAR for complicated type B aortic dissection. The 30-day mortality rate was 9.68%; in multivariable modeling, significant periprocedural predictors of early mortality included type I endoleak and cardiac tamponade. Follow-up was available for all 56 survivors at a median 52.8 months, during which time 9 deaths (16.07%) occurred, 4 of which were aorta-related. Independent periprocedural predictors of late mortality included rupture of false lumen, postoperative MI, and acute renal failure. The authors suggested that careful evaluation for type I endoleaks during the TEVAR procedure may help reduce early mortality.

Section Summary: Type B Aorta Dissections
For patients with acute, complicated type B dissections, there is limited evidence from a systematic review of case series and a propensity-matched study which reported a significant early survival advantage for patients treated with TEVAR. This evidence is limited by the noncomparability of treatment groups. The single-arm series have reported relatively high success rates and short-term survival that is possibly better than expected with open surgery.

Chronic Type B Aortic Dissections

Systematic Reviews
Thrumurthy et al performed a systematic review of endovascular repair for chronic type B dissections, defined as dissections that present with symptoms for more than 14 days. There were 17 publications included in this review, consisting of 1 RCT (the INSTEAD trial, discussed next) and 16 single-arm series. Of the 16 single-arm series, 2 were prospective and 14 were retrospective. At a median of 24 months of follow-up, mortality was 9.2% for patients treated with TEVAR, with a range of 0% to 41% across studies. A total of 8.1% of patients had endoleaks at this follow-up, and there was an increasing rate of endoleaks with longer follow-up times. Delayed aortic rupture occurred in 3.0% of patients. Freedom from reintervention occurred in a range of 40% to 100% at 24-month follow-up.
Randomized Controlled Trials
One RCT, the Investigation of Stent Grafts in Patients with type B Aortic Dissection (INSTEAD) trial has compared stents to best medical therapy for patients with chronic, stable dissections. The INSTEAD trial was reported in 2010. This trial compared endovascular stenting with medical management for stable thoracic aortic dissections. Stable or uncomplicated type B dissections differ from acute lesions in that there is no evidence of ischemia or extension over the time of observation that would necessitate emergency surgery. Patients were randomly assigned to elective stent-graft placement in addition to optimal medical management (n=72) or to optimal medical management alone (n=68) to maintain arterial pressure below 120/80 mm Hg. The primary end point of all-cause mortality at 1 year was not statistically significant between the 2 groups: cumulative survival was 91.3% in the endovascular group and 97.0% in the medical-only group (p=0.16). In addition, aorta-related mortality did not differ (5.7% and 3.0%, respectively; p=0.42). There were 2 cases of ischemic spinal cord injury with stent grafting and in the medical group. Seven (10.6%) patients in the medical group did cross over to the stent-graft group due to deterioration in condition, and 1 patient from each group required open surgical intervention within the 12-month study period. An additional stent graft for false lumen expansion was required in 6 patients. A secondary measure of aortic remodeling did occur more frequently in the endovascular repair group (91.3% vs 19.4%, respectively; p<0.001), but the clinical significance is unknown. Three adverse neurologic events occurred in the endovascular group compared with in the medical-only arm. The authors concluded that elective stent-graft placement does not improve survival at 1 year and called for larger studies with extended follow-up.

In 2013, Nienaber et al published long-term follow-up results from the INSTEAD trial (INSTEAD-XL). Patients were followed for a minimum 5 years (maximum, 8 years); the median interval until death or latest follow-up was 69 months (interquartile range, 62-83 months); there was no loss to follow-up. Twenty-one additional TEVAR procedures were performed in the 5-year follow-up period, 14 in the optimal medical therapy group (5 emergency cases), with conversion to open repair in 4 cases, and 7 in the TEVAR group, with conversion to open repair in 3 cases. The risk of all-cause mortality was not statistically significantly different between groups at 5 years postrandomization (11.1% in the endovascular repair group vs 19.3% in the optimal medical therapy group, p=0.13). However, Kaplan-Meier curves demonstrated a survival benefit in the endovascular repair group between 2 and 5 years postrandomization (100% in the endovascular group vs 83.1% in the optimal medical therapy group, p<0.001). Patients randomized to endovascular repair had lower aorta-specific mortality (6.9% vs 19.3%, p=0.04) and progression of aortic pathology (27.05% vs 46.1%, p=0.04). For the combined end point of disease progression (aorta-specific death, crossover/conversion, secondary procedures) and aorta-specific events at 5 years of follow-up, freedom from the combined end point was 53.9% with medical therapy alone and 73.0% with TEVAR. Landmark analysis was performed to compare hazard ratios (HRs) for events occurring from randomization until 24 months postrandomization with events occurring beyond 24 months postrandomization to assess for a time-dependent response to treatment. In landmark analysis, groups had similar patterns of freedom from progression of aortic disease from randomization until 2 years of follow-up.
(76.1% vs 75.5%; HR=0.997; 95% CI, 0.51 to 1.95; p=0.994). However, from 2 to 5 years of follow-up, the TEVAR group was more likely to have freedom from progression than the medical therapy group (95.9% vs 71.9%; HR=0.112; 95% CI, 0.03 to 0.49; p=0.004).

The INSTEAD-XL findings suggest that, in stable patients with type B aortic dissection, preemptive endovascular repair may be associated with an excess risk of morbidity and mortality in the immediate postprocedural period, which is outweighed by a longer term survival benefit. The authors noted that best medical management did not prevent late complications of aortic dissections, including expansion, rupture, and late crossover/conversion to emergent TEVAR.

**Nonrandomized Comparative Trials**

A number of studies have compared outcomes for open and endovascular repair or endovascular repair and best medical therapy using prospective or retrospective nonrandomized cohort studies. Some of these studies use propensity score matching to attempt to adjust for factors other than repair strategy that may have differed between groups.

Andersen et al compared open and endovascular repair for chronic type B aortic dissection in a retrospective review of 107 patients treated at a single center. The study included 75 (70%) patients who underwent endovascular procedures, 44 of which were TEVAR, 27 of which were hybrid aortic arch, and 4 of which were hybrid thoracoabdominal aortic aneurysm repair; this group was compared with 32 (30%) patients who underwent open procedures. The institutional preference was to perform an endovascular repair for chronic type B aortic dissection in all non–connective tissue disease patients with suitable anatomy. Twenty-one (n=18) patients underwent nonelective repair, most commonly due to impending aneurysm rupture. Rates of stroke, paraplegia, and operative mortality were 0%, 0%, and 4%, respectively, following endovascular-based repairs, and were 16%, 9%, and 6%, respectively, following open repair. Cumulative 1- and 5-year survival rates were 86% (95% CI, 78% to 95%) and 65% (95% CI, 52% to 80%), respectively, following endovascular-based repairs, and were 88% (95% CI, 77% to 100%) and 79% (95% CI, 65% to 96%), respectively, following open repair. However, the heterogeneity among endovascular and open repair groups in terms of dissection location and repair type precludes direct comparisons between open and endovascular repair specifically for chronic type B thoracic aortic dissections without concomitant abdominal aortic pathology.

Van Bogerijen et al reported results of a retrospective, single-center study comparing TEVAR and open repair among 122 patients with chronic type B aortic dissection who were treated between 1993 and 2013. Compared with the 90 patients who had open repairs, the 30 patients who underwent TEVAR were older, more likely to be female, have chronic obstructive pulmonary disease or prior abdominal aortic aneurysm repair, have only intramural hematoma, and were less likely to have aortic arch involvement. For the study’s primary outcome of late mortality, the 5-year survival was 78.1% in the TEVAR group compared with 86.7% in the open repair group (p=0.232). In multivariable analysis after propensity score adjustment for patient-related and treatment-related factors, the repair type was not significantly associated with late mortality. The open repair group had higher 3-year treatment efficacy (96.7% vs 87.5%, p=0.02).
a result that remained significant after in multivariable analysis with propensity score
adjustment.

Jia et al performed a prospective, multicenter, nonrandomized comparative study of TEVAR
versus optimal medical therapy (OMT) for chronic type B thoracic aortic dissections. A total of
208 patients were treated with TEVAR and 95 patients were treated with OMT. In the TEVAR
group, there were no periprocedural deaths, and serious complications (retrograde type A
dissection, brachial artery pseudoaneurysm, paraplegia, MI) occurred in 12 (5.8%) patients.
Estimated survival at 2 and 4 years was 87.5% and 82.7% with TEVAR, compared with 77.5%
and 69.1% with OMT, both respectively, but this difference in survival was not statistically
significant (p=0.068). The estimated freedom from aorta-related death at 2 and 4 years was
91.6% and 88.1% for the TEVAR group compared with 82.8% and 73.8% with OMT, both
respectively, a difference that was statistically significant (p=0.039).

**Section Summary: Chronic Type B Aortic Dissections**

For patients with chronic, stable dissections of the thoracic aorta, 1 RCT reported that short-term
outcomes do not differ significantly between TEVAR and best medical management. However,
over 5 years of follow up, patients who undergo preemptive endovascular repair may
demonstrate reduced morbidity and mortality.

**Tears and Rupture of the Descending Aorta**

**Systematic Reviews**

In 2010, Jonker et al published a meta-analysis of studies published between 1996 and 2009 to
evaluate outcomes of open surgical repair (n=81) versus endovascular repair (n=143) for
ruptured descending TAA. The 30-day mortality was 19% for patients treated with
endovascular repair compared with 33% for patients treated with open repair (p=0.016). The 30-
day incidence of MI was 3.5% for those treated with endovascular repair versus 11.1% in
patients treated with open repair (p<0.05). Rates of stroke and paraplegia were also increased in
the surgically treated patients, but were not statistically significant. Additional vascular
interventions were performed in 9.1% of endovascular patients versus 2.3% of surgical patients
(p=0.169). Regarding safety, during a median follow-up of 17 months, 5 additional patients in
the endovascular group died of aneurysm-related causes, endoleak was reported in 11.1% of
patients, and endograft migration was reported in 1 patient. The authors noted that the durability
and development of endovascular-related complications remain concerns and that further
surveillance of the endografts is required. These data need to be interpreted with caution given
the nonrandom treatment assignment.

Lee et al summarized data on use of TEVAR for repair of traumatic thoracic aortic injuries to aid
development of practice guidelines. The systematic review included 7768 patients from 139
studies. This review found significantly lower mortality rates in patients who underwent
endovascular repair, followed by open repair, and nonoperative management (9%, 19%, 46%,
respectively, p<0.01). Based on the overall very low quality of evidence, the committee suggests
that endovascular repair of thoracic aortic transection is associated with better survival and
decreased risk of spinal cord ischemia, renal injury, graft, and systemic infections, compared with open repair or nonoperative management. In addition to the low quality of the evidence, the authors also noted that these conclusions should be tempered by the lack of suitable (anatomic fit) devices, which can lead to severe complications, and to the lack of follow-up data.

A 2015 Cochrane review searched for published or unpublished RCTs to determine whether TEVAR for blunt traumatic thoracic aortic rupture would reduce mortality and morbidity compared with open surgical repair. The authors did not identify any RCTs meeting their selection criteria.

**Nonrandomized Comparative Studies**

The nonrandomized study by Azizzadeh et al compared outcomes of TEVAR and open surgery using prospectively collected data in 106 consecutive patients between 2002 and 2010 at 1 institution. This time interval covered the period of adoption for TEVAR at this institution, in which the proportion of patients treated with TEVAR increased from 0% to 100%. As a result, the number of procedures done in each group varied over time; 56 patients underwent open surgery and 50 underwent TEVAR. Primary outcomes were in-hospital death and complications. Death occurred in 5 (8.9%) of 56 patients undergoing open surgery, compared with 2 (4.0%) of 50 patients undergoing TEVAR. The overall likelihood of complications, including death, was significantly lower in the TEVAR group (OR=0.33; 95% CI, 0.11 to 0.97). Also, the number of patients with at least 1 complication was greater in the open surgery group (69.6%) than in the TEVAR group (48%).

Canaud et al compared outcomes of endovascular and open surgical repair in 75 patients with acute traumatic rupture of the thoracic aorta at 1 tertiary care center. Open surgery was performed on 35 patients during the period 1990 to 2000, and endovascular repair was performed on 40 patients between 2001 and 2010. Early mortality was lower in the endovascular group (2.5%) than in the open surgery group (11.4%), but this difference was not statistically significant. Serious adverse events occurred in 20% of patients in the endovascular group compared with 14.2% in the open surgery group, which also was not a significant difference. There were no cases of paraplegia or stroke in either group.

Goodney et al used Medicare claims data from 1998 to 2007 to compare TEVAR with open surgery in patients with aneurysms of the descending aorta. This study included both intact and ruptured aneurysms. A total of 1307 patients with ruptured aneurysms were identified, 1008 were treated with open surgery and 299 with TEVAR. There were baseline differences between the 2 groups, with the TEVAR group being older and more likely to have a variety of medical comorbidities. Thirty-day mortality was significantly lower among TEVAR patients (28.4%) than open surgery patients (45.6%; p<0.001). Long-term survival was reported by Cox proportional hazards analysis. At 5 years, survival was low in both groups, with no significant difference between the TEVAR group (23%) and open surgery group (26%; p=0.37).

Gopaldas et al used the U.S. Nationwide Inpatient Sample database to identify patients who underwent procedures to repair a thoracic artery rupture. A total of 923 patients were identified between 2006 and 2008, 364 (39.4%) who underwent TEVAR and 559 (60.6%) who underwent...
open repair. Patients undergoing TEVAR were older and had a significantly higher burden of comorbidities than patients undergoing open repair. Overall mortality was 23.4% for TEVAR and 28.6% for open repair, which was not significantly different. There were also no differences in complication rates. TEVAR patients were more likely to have routine discharge from the hospital to home compared with open surgery patients (OR=3.3, p<0.001).

In 2013, Klima et al retrospectively compared outcomes and complications associated with open repair with endovascular repair for blunt aortic trauma for 49 patients treated at a single nonuniversity hospital from 2004 to 2011. Twenty-one patients underwent open repair, while 28 patients were managed with TEVAR; groups did not differ at baseline with regard to age, sex, or injury severity. Hospital length of stay, intensive care unit length of stay, and ventilator time were similar between groups, but patients in the open repair group (33%) had higher in-hospital mortality than patients in the TEVAR group (7%; p=0.028).

**Observational Studies**

**FDA-Approval Studies (Single-Arm)**

Data from 2 uncontrolled clinical series of patients with isolated thoracic artery lesions were reviewed by FDA as part of the expanded approval for thoracic endografts in 2012. The TAG 08-02 study used the Gore TAG endograft to treat 51 patients with aortic transection due to blunt aortic injury. All 51 patients had successful implantation of the Gore TAG endograft, although 6 (11.8%) patients required deployment of 2 stent grafts for adequate coverage. There were 4 deaths within 30 days of treatment (7.8%; 95% CI, 3.1% to 18.5%). Serious adverse events with reported in 39.2% of subjects at 30 days, with the most common events being pleural effusion (5.9%) and respiratory failure (5.9%). The primary effectiveness outcome was the number of patients with major device-related events in the first 30 days requiring reintervention. There were no patients who had such an event requiring reintervention. patients were identified with type II endoleaks, but neither patient required reintervention.

A similar study (RESCUE) was submitted to FDA using the Valiant Thoracic stent graft in 50 patients with blunt aortic trauma. All patients had successful deployment of the stent, with 2 patients requiring 2 devices. There were 4 deaths within 30 days of the procedure for a perioperative mortality of 8.0%. Serious adverse events occurred in 12.0% of patients, most of which were procedure-related events (e.g., femoral artery dissection, localized hematoma, hemothorax). Three patients required left subclavian artery revascularization to treat arm ischemia.

**Other Single-Arm Studies**

Since FDA’s approval of thoracic endografts for traumatic aortic rupture, a number of single-arm studies have reported outcomes for TEVAR for this indication. Martinelli et al reported an in-hospital mortality rate of 7.4% in a cohort of 27 patients who underwent TEVAR for blunt aortic trauma. Piffaretti et al reported an in-hospital mortality rate of 6.5% in a cohort of 35 patients who underwent TEVAR for blunt aortic trauma, with no subsequent mortality over a median follow-up of 72 months. Steuer et al reported that in patients who underwent TEVAR and
survived the concomitant injuries from the initial trauma, 5-year survival was 81%, with reintervention needed in 16%.

**Section Summary: Tears and Rupture of the Descending Aorta**

FDA approval was granted for endovascular stent-graft treatment of thoracic artery ruptures in 2012. The evidence on TEVAR for treatment of thoracic artery rupture consists of single-arm series and nonrandomized comparative studies. There are no RCTs, but RCTs are likely difficult to complete for this indication because of the emergent nature. The available evidence suggests that there are fewer early deaths and complications with TEVAR than with open surgery, but these data are limited by noncomparability of groups. The longer term outcomes are uncertain, with no discernible differences between TEVAR and open surgery.

**Pathology of the Ascending Aorta**

Compared with its use for descending aortic pathologies, TEVAR has been less widely studied for management of ascending aortic pathologies. Only small case series for use of TEVAR for ascending aortic pathologies were identified. For example, Vallabhajosyula et al retrospectively reported outcomes for 6 patients who underwent endovascular repair for ascending aorta pseudoaneurysm (n=4) or acute type A aortic dissection (n=2). Roselli et al described a series of 22 patients who underwent TEVAR of the ascending aorta for acute type A aortic dissection (n=9), intramural hematoma (n=2), pseudoaneurysm (n=9), chronic dissection (n=2), or aortocardiac fistula (n=2). Appoo et al reported imaging-related outcomes for 16 patients who underwent TEVAR for aortic arch or ascending aorta.

**Section Summary: Pathology of the Ascending Aorta**

The evidence related to the use of TEVAR for ascending aortic pathologies is limited to small case studies that include heterogeneous patient populations.

**Mixed Populations**

Several studies have evaluated outcomes after TEVAR in heterogeneous groups of patients.

In 2005, the National Institute of Clinical Excellence conducted a systematic review of 27 case series and 2 comparative observational studies of endovascular repair in the treatment of thoracic aortic disease. Data from the included studies demonstrated technical success in approximately 93% of cases. The short-term (30-day) mortality rate was 5% (range, 0%-14%), and with a mean follow-up period of 14 months; overall mortality rate was 12% (range, 3%-24%) across studies. The most frequent technical complications were endoleaks (13%), injury to the access site (6%), and stent fracture (6%). Stroke occurred in 6% and paraplegia in 2% of patients. The evidence base primarily consists of case series that include heterogeneous groups of patients with incomplete outcome data. However, the review concluded that the safety of the procedure must be weighed against the fact that mortality is very high if patients with thoracic aortic aneurysm are untreated and that endovascular stent placement is a suitable alternative to open surgery in appropriately selected patients with aneurysm or dissection.
In 2009, Cambria et al reported on 59 patients who received TEVAR for emergent repair of thoracic aorta pathology due to acute complicated type B dissection, traumatic aortic tear, and ruptured degenerative aneurysm. The authors’ own literature review prospectively postulated a combined mortality/paraplegia rate of 12.6% for TEVAR compared with 29.6% for open surgery for each of the 3 diagnostic conditions, or arms, of the study. Based on presurgery power analysis, it was estimated that 52 test subjects would be required overall to detect a difference of 17% in the composite outcome; 20 subjects were enrolled in each arm, subject to anatomic considerations; at the time of presentation, the final number of subjects drafted was 59 due to a solitary patient reclassification. The combined 30-day mortality/paraplegia end point was observed in 13.6% of study participants (7 deaths, 1 paraplegia), significantly lower than the literature-based rate for open surgery (29.6%) previously stated (p=0.008). Not surprisingly, 30-day complications in addition to the composite end point were high: 48 (81%) patients experienced at least 1 major complication. Of these, 11 (18.6%) were attributable to device failure or complication. During mean follow-up of 409±309 days, an additional 12 patients had died, 1 patient was converted to open surgery, and 2 patients had major, device-related events. For the entire study group, survival at 1 year was 66% (n=40). Regression analysis revealed that age and concurrent chronic obstructive pulmonary disease were predictive of death at 1 year.

Naughton et al reported on 100 patients with “acute thoracic aortic catastrophes” treated with either TEVAR (n=76) or open surgery (n=24). Conditions included ruptured aneurysms (n=41), traumatic transection (n=27), complicated acute type B dissections (n=20), penetrating ulcers (n=4), intramural hematoma (n=3), penetrating injury (n=3), and embolizing lesions (n=2). Patients in the open surgery group were older and had more prior episodes of aortic surgery. Overall mortality at 30 days was lower for the TEVAR group (8%) than the open surgery group (29%; p=0.007). Respiratory complications were also lower in the TEVAR group (16% vs 48%, p<0.05). There were no significant differences in postoperative adverse events or mean length of stay.

In 2013, Alsac et al reported outcomes from for 48 patients treated with TEVAR for a “descending thoracic acute aortic syndrome,” including 19 ruptured aneurysms, 12 acute dissections, and 17 traumatic ruptures. Ten patients died during the periprocedural hospitalization (mortality rate, 20.8%), but no deaths were reported later in the 33 patients for whom longer term follow-up was available. Reintervention in the first month postprocedure was required in 8 (16.7%) patients, and late reintervention was required in 5 (10.4%) patients.

In 2014, Sood et al published a comparison of open repair, hybrid repair, and TEVAR for a mixed population of patients with thoracic aorta aneurysms (n=83) or dissections (n=15) treated at a single institution from 1993 to 2013. Patients treated with TEVAR were older and more likely to have a history of tobacco use. For the study’s primary outcome of all-cause late mortality, Kaplan-Meier analysis showed no significant difference in 5-year survival between TEVAR patients and open/hybrid repair patients.

Botsios et al reported outcomes for 21 patients who underwent emergency TEVAR for nontraumatic rupture of the descending thoracic aorta, due to underlying degenerative aneurysms
Thirty-day mortality was 9.5%; over a median follow-up of 65.6 months (range, 1.5-44 months), 10 additional patients died, leading to a late mortality rate of 52.6%. Late mortality was more likely to be related to nonaortic causes, with 2 aorta-related deaths and 8 non-aorta-related deaths.

Wiedemann et al reported short- and medium-term outcomes for 300 patients who underwent TEVAR at a single institution for a range of thoracic aortic conditions, including 137 descending thoracic aneurysms, 80 type B dissections (60 acute, 20 chronic), 59 perforating aortic ulcer, and 24 traumatic aortic transections. Thirty-day mortality was 5% (15 patients) with no statistically significant differences between the 4 groups. Median follow-up was reported as 44 years, although this may be a typographic error. In Kaplan-Meier analysis, OS at 1, 5, and 10 years was 86%, 63%, and 44%, respectively, with significant differences between groups and the lowest survival for descending thoracic aneurysms.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 1.

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NCT: national clinical trial.
* Denotes industry-sponsored or cosponsored trial.

Summary of Evidence
For individuals who have type B (descending) thoracic aortic aneurysms who receive endovascular repair, the evidence includes nonrandomized comparative studies and systematic reviews. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity and mortality. The available nonrandomized comparative studies have consistently reported reduced short-term morbidity and mortality compared with surgical repair. Although these types of studies are subject to selection bias and other methodologic limitations, the consistency of the findings of equivalent or reduced short-term mortality and fewer early complications across
populations with different characteristics supports the conclusion that thoracic endovascular aneurysm repair (TEVAR) is a safer procedure in the short term. The likely short-term benefits of TEVAR are mitigated by less favorable longer term outcomes, but longer term mortality appears to be roughly similar for patients undergoing TEVAR or open surgery. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals who have type B (descending) aortic dissections who receive endovascular repair, the evidence includes randomized controlled trials (RCTs), systematic reviews, and nonrandomized comparative studies. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity and mortality. For acute uncomplicated type B dissections, 1 RCT has reported short-term improvements in aortic remodeling and a decreased risk of aortic dilation and rupture in patients treated with TEVAR compared with best medical management. However, this trial was underpowered to evaluate mortality differences, and limitations include a high TEVAR failure rate based on imaging follow-up. For acute complicated type B dissections, there are no RCTs. Short- and intermediate-term results from a systematic review of observational studies that compared TEVAR with open surgery suggest a benefit for TEVAR in complicated (organ or limb ischemia or rupture) type B dissection. However, this evidence is limited by selection bias and baseline differences between groups, and therefore is not definitive on the efficacy of TEVAR versus open surgery. For chronic type B dissections, the evidence from 1 RCT did not demonstrate short-term outcome benefits associated with TEVAR; however, after more than 5 years of follow-up, TEVAR was associated with a survival benefit beginning 2 years post-procedure. Additional evidence from high-quality trials is needed to determine whether TEVAR improves outcomes for patients having type B aortic dissections The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have traumatic descending aortic tears or rupture who receive endovascular repair, the evidence includes nonrandomized comparative studies and systematic reviews. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity and mortality. For traumatic thoracic aortic injury and rupture, nonrandomized comparative data has suggested a benefit for TEVAR in reducing periprocedural morbidity and mortality. Although it is expected that RCTs will be difficult to conduct for this indication due to its emergent nature, the risks of bias in the available nonrandomized studies is high. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have ascending aortic disorders who receive endovascular repair, the evidence includes small case series. Relevant outcomes are overall survival, morbid events, and treatment-related morbidity and mortality. For patients with ascending aortic pathologies, including dissections, aneurysms, and other disorders, the evidence on use of TEVAR is limited to small series that assess heterogeneous patient populations. The evidence is insufficient to determine the effects of the technology on health outcomes.
Clinical Input Received From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 4 academic medical centers (5 reviewers) and 1 physician specialty society while this policy was under review in 2011. Most of those providing input supported use of TEVAR in complicated type B aortic dissections and, in certain cases, in traumatic thoracic aortic injury.

Practice Guidelines and Position Statements

European Association for Cardio-Thoracic Surgery, European Society of Cardiology, et al
The European Association for Cardio-Thoracic Surgery, the European Society of Cardiology, and the European Association of Percutaneous Cardiovascular Interventions published a position statement on TEVAR in 2012.65 This document made the following statements concerning the use of TEVAR:

- Thoracic aortic aneurysms
  - TEVAR is indicated for asymptomatic patients when the maximum diameter of the aneurysm exceeds 5.5 cm or if rapid expansion occurs (>5 mm in 6 months)
  - It may be appropriate to select a larger aortic diameter threshold in patients with increased operative risk.
- Type B aortic dissections
  - For acute, complicated type B dissections, TEVAR is the treatment of choice.
  - For chronic, complicated type B dissections, the treatment approach should be discussed by an interdisciplinary team, considering the risks and benefits of open surgery versus TEVAR
  - For uncomplicated type B dissections, a primary conservative approach with close surveillance for complications is justified.
- Traumatic aortic injury
  - Immediate endovascular treatment is indicated for patients with complete transection of the aortic wall and free bleeding into the mediastinum, or the presence of pseudocoarctation syndrome.
  - Delayed endovascular treatment can be considered when there is limited disruption of the aorta with intact media and adventitia.

American College of Cardiology Foundation, American Heart Association, et al
In 2010, a joint task force published guidelines on the diagnosis and management of descending thoracic and thoracoabdominal aortic aneurysms.66 The task force consisted of the American College of Cardiology Foundation, American Heart Association, American Association for Thoracic Surgery, American College of Radiology, American Stroke Association, Society of Cardiovascular Anesthesiologists, Society for Cardiovascular Angiography and Interventions,
The task force offered the following class I recommendations:

- For patients with chronic dissection, particularly if associated with a connective tissue disorder, but without significant comorbid disease, and a descending thoracic aortic diameter exceeding 5.5 cm, open repair is recommended. *(Level of Evidence: B)*

- For patients with degenerative or traumatic aneurysms of the descending thoracic aorta exceeding 5.5 cm, saccular aneurysms, or postoperative pseudoaneurysms, endovascular stent grafting should be strongly considered when feasible. *(Level of Evidence: B)*

- For patients with thoracoabdominal aneurysms, in whom endovascular stent graft options are limited and surgical morbidity is elevated, elective surgery is recommended if the aortic diameter exceeds 6.0 cm, or less if a connective tissue disorder such as Marfan or Loeys-Dietz syndrome is present. *(Level of Evidence: C)*

- For patients with thoracoabdominal aneurysms and with end-organ ischemia or significant stenosis from atherosclerotic visceral artery disease, an additional revascularization procedure is recommended. *(Level of Evidence: B).*

U.S. Preventive Services Task Force Recommendations

Not applicable.

V. DEFINITIONS

**AORTA** is the largest artery in the body, originating from the left ventricle of the heart and extending down to the abdomen, where it branches off into two smaller arteries (the common iliacs). The aorta distributes oxygenated blood to all parts of the body through the systemic circulation. It is usually divided into five segments/sections:

- Ascending aorta—the section between the heart and the arch of aorta
- Arch of aorta—the peak part that looks somewhat like an inverted "U"
- Descending aorta—the section from the arch of aorta to the point where it divides into the common iliac arteries
  - Thoracic aorta—the half of the descending aorta above the diaphragm
  - Abdominal aorta—the half of the descending aorta below the diaphragm

**STENT** refers to any material or device used to hold tissue in place, to maintain open blood vessels, or to provide support for a graft or anastomoses while healing is taking place.

**THORACIC** refers to the chest or thorax.
VI. BENEFIT VARIATIONS

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

VII. DISCLAIMER

Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

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<td>I71.03</td>
<td>Dissection of thoracoabdominal aorta</td>
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<td>I71.1</td>
<td>Thoracic aortic aneurysm, ruptured</td>
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<tr>
<td>I71.2</td>
<td>Thoracic aortic aneurysm, without rupture</td>
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### IX. REFERENCES


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<th>Endovascular Stent Grafts for Disorders of the Thoracic Aorta</th>
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### MEDICAL POLICY

**Policy Title**: Endovascular Stent Grafts for Disorders of the Thoracic Aorta  
**Policy Number**: MP-1.132

### MEDICAL POLICY

#### POLICY TITLE
Endovascular Stent Grafts for Disorders of the Thoracic Aorta

#### POLICY NUMBER
MP-1.132


Other Sources:
Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD) 20.23 Fabric Wrapping of Abdominal Aneurysms CMS [Website]:

Novitas Solutions. Local Coverage Article (LCA) A53124. Endovascular Repair of Aortic Aneurysms. Effective 10/1/15. [Website]:

X. POLICY HISTORY

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<td>CAC 2/28/2012</td>
<td>Adopt BCBSA. Information related to endovascular stent grafts for thoracic aortic aneurysms was extracted from MP 1.090 Endovascular Repair of Aortic Aneurysms and this separate policy created. Added medically necessary statement for use with acute, complicated (organ or limb ischemia or rupture) Type B thoracic dissections. Treatment of aortic dissections was previously considered investigational.</td>
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