

In the past we've been very comfortable saying, "oh a stable sac is fine". But I'm not sure that that's true and I think there's more data that's becoming apparent that really what we want is to mimic as close to possible open surgical repair and get complete exclusion of the aneurysm sac so we get shrinkage and we get a sac that regresses and a patient that has a reduced cardiovascular morbidity and mortality. When we talk about in endovascular repair and remodeling that we see there's multiple factors that are involved with the success of EVAR. Patient characteristics specifically looking at the anatomy, looking at patients' comorbidities, how the device works in vivo, medical management, statin therapy, the other things we do to try to make as effective as possible. And as well, we have to look at the device design and what makes a device allow you to have a successful aneurysm repair. We need it to be accurate. We need it to have both separately seal and fixation that allows us to depressurize the aneurysm sac. We want it to be both a conformable device that works well in vivo and has fabric material that will completely depressurize the sac and hopefully really minimize the risk of type II endoleaks. I think sac regression is a critical part of what were doing and I think we're starting to learn that although sac regression is a great marker for success of aneurysm repair it may even be a more overall more important marker of cardiovascular morbidity mortality and it really should be our goal to get as many of these patients to regress as possible.