Endovascular aneurysm repair (EVAR) is becoming the preferred treatment strategy for AAA worldwide.

Several large RCTs have demonstrated early survival benefits when compared to open surgical repair.

Anatomic suitability represents the main factor that can restrain endovascular repair.

Recent development in EVAR devices allows to accommodate more difficult anatomicies.

**Case 1**
Max Diameter: 10.2 cm  
Neck Diameter: 28 mm  
Neck length: 5 mm  
Neck Angle: 80°  
Iliac Diameter: 13 mm  
Iliac Angle: 105°

**Case 2**
Max Diameter: 12.1 cm  
Neck Diameter: 24 mm  
Neck length: 25 mm  
Neck Angle: 90°  
Iliac Diameter: 12 mm  
Iliac Angle: 115°

**Case 3**
Max Diameter: 11.5 cm  
Neck Diameter: 30 mm  
Neck length: 0 mm  
Neck Angle: 85°  
Iliac Diameter: 14 mm  
Iliac Angle: 95°

**Discussion**

**Huge aneurysms**
Absent screening programs in developing countries leads to delay in diagnosis, with larger aneurysm sizes at time of discovery.

Huge aneurysms (more than 10 cm) tend to have more difficult anatomy, as the aneurysm grows in 3 dimensions leading to increasing tortuosity and landing zone dilatation.

Even with successful EVAR outside the IFUs, aneurysms with hostile anatomy has more incidence of post operative endoleak, and late mortality.

**Conclusion**

Huge aneurysms tend to have hostile anatomy, not suitable for EVAR  
Screening programs for AAA are mandatory to decrease late diagnosis with more incidence of huge sized aneurysms.  
Open repair will continue to have an important role in the upcoming future, specially in developing countries, where more sophisticated techniques are still very costly.