Treatment Strategies for Catastrophic Failure

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Disclosures

- Abbott Vascular
- Bard Peripheral
- Boston Scientific
- Cardiovascular Systems, Inc.
- Cook Medical
- Medtronic
- Spectranetics
- Terumo Medical
Case Study 1

82 yr old male with history of Type II DM, CHF, CAD, HTN, PAD and obesity. Former smoker 39 pack-year history.

Presented with severe claudication and rest pain (Rutherford IV).
Case Study 2

76 yr old female with hx of PVD, HTN, hyperlipidemia, DOE, obesity, claudication (Rutherford 3)

Presents with recent unsuccessful long complex right SFA, popliteal and AT intervention. Foot is cool to the touch with some discoloration.
Case Study 3

• 61 year old male
• CLI – Rutherford V with LLE rest pain
• Type 2 DM, HTN, hyperlipidemia, CAD with 4 vessel CABG, carotid stenosis
• Smoker – 30 years x 2.5ppd
• BMI = 36
• Multiple previous revascularizations of LLE
  – 2 previous attempts with unsuccessful crossing of left SFA lesion
  – 2 failed left femoral- tibial bypass procedures

Patient presented with cold foot 2 weeks post last tibial bypass, what is next?
Limb Salvage Procedure

• USN-guided multiple access:
  – Left brachial artery
  – Right CFA retrograde
  – Left SFA retrograde
  – Left PTA retrograde

• Angiogram showed multiple CTOs located left:
  – proximal SFA at location of previously placed stent
  – PTA just above bifurcation of plantar arteries
  – AT
  – Peroneal
Rescue limb salvage revascularization

Initial right CFA access

Rerograde schmidt access

UO, 035 cath in the left PFA
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Schmidt retro wire
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4F Precision sheath/retro schmidt

Schmidt retro wire snared
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Always protecting PFA

Prep for access reversal
Telescoping catheter technique for complex CTO

Angio to evaluate CFA/PFA
Schmidt retro sheath removed with antegrade balloon PTA
Sequential balloon angioplasty after access reversal

Brachial access for PFA protection & tibial wire snaring
• After extensive CTO crossing, multiple access and balloon angioplasty there is NO FLOW...
• What is next?
Selective angiogram from tibio-pedal to CFA
Then repeat PVI at the NO FLOW sites
Is this sufficient inflow?
Is this sufficient outflow?
Treat the PFA?
Treat the CFA?
Endo vs open surg?
Final outflow runoff
Outcomes

• 1 month later presented for re-attempt of occluded graft to left PT. Stenosis reduced from 100% to 10%
• Gangrene developed with maggot infestation
• Underwent urgent guillotine amp at the ankle with left BTK amputation one week later.
• Delayed incision healing
Outcomes, cont.

- 20 months post amputation presented with non-healing wounds on left stump Wound A – left distal, medial amputation site. Wound B – left, proximal, medial amputation site.
- Underwent laser atherectomy and cutting balloon angioplasty of left profunda, followed with 2 self-expanding stents from the left profunda into the left CFA. PTA and self-expanding stents into the left external iliac into the common iliac reducing stenosis from 70% to 10%.
- 4 months out Wound B has healed and Wound A still under treatment.
Thank You

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