Retrograde recanalization after failed antegrade entry into flush SFA CTO, via pedal access, in a patient with previous SFA stenting and fem-tib bypass

Ashwani Kumar, MD, FACC
*Interventional Cardiologist*
Virginia Cardiovascular Specialists
Richmond, VA, USA
Disclosure

Speaker name: Ashwani Kumar, MD

I have the following potential conflicts of interest to report:

- Consulting
- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company
- Other(s)

☒ I do not have any potential conflict of interest
Case History

• 85 year old male who presented with right great toe non healing ulcer, resting leg pain, unable to sleep at night due to leg pain, for almost six months.

• PMHx:
  • PAD s/p SFA stenting, subsequent right Fem – Tib bypass 5 years ago
  • CAD, CABG
  • Ischemic cardiomyopathy, EF 20-25%
  • DM type 2, Hypertension, Hyperlipidemia
Clinical Examination

- Ulcer on right great toe dorsal aspect, foot is cold to feel. DP is detected with Doppler only.
- Dorsum of foot is erythematous, mild swelling
- Left foot is warm with DP 2+
Non-Invasive studies

- ABI: Right: .45; Left .91
- Duplex US:
  - Total occlusion of right SFA with proximal stump
  - Reconstituted at Popliteal level.
  - Below knee only one vessel flow via AT, PT is occluded and reconstitute distally.
Angiogram
Crossed the total occlusion with CTO crossing catheter: Viance
Pedal access via DP
Viance Catheter from DP into SFA
Access into CFA, contrast injection confirms intraluminal position
Wire from pedal access into CFA
PTA with 6.0x150 balloon
Post PTA
Take home Point/Follow up

- In flush SFA occlusion retrograde (popliteal or pedal) approach is helpful in gaining access into true lumen of proximal patent vessel.

- Resting pain relief

- Wound healed completely in 4 weeks
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