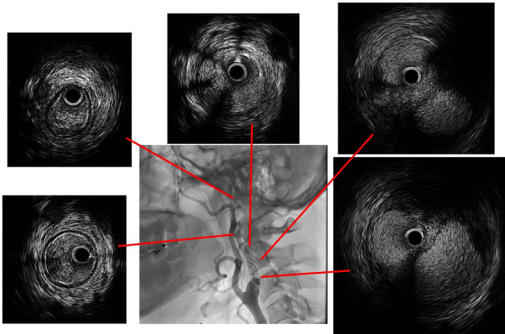
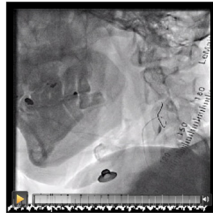


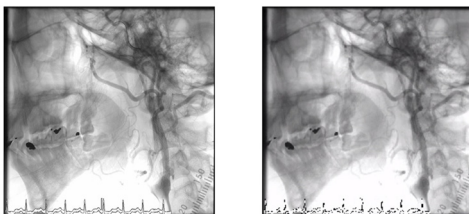
4. Failed to pass Stents. Repeated PTA. Stenting.
5. Post dilatation.
6. No reflow, thrombus aspiration. Removed Spider.
7. Repetitive PTA to residual lesions.
8. Final flow improved, the patient did not experience any discomfort. Bloodpressure was relatively stable.

Successful Wiring to Left ICA

- Guiding Catheter: Medtronic JR4 8F
- Guiding Wire: Asahi Fielder FC
- Micro-Guiding Catheter: Boston Scientific Excelsior micro-catheter
- 6 mm Spider Protection Device



FINAL



Case Summary. Why are there so many channels in LICA?
 All channels are true lumens?
 Any dissection exists? Role of IVUS.
 Which channel can be used for intervention?
 What can we do to facilitate advancing devices in such tortuous vessel?
 How to treat the vessel with much plaque burden?
 Furthermore, what should we do to prevent thrombogenesis and restore a good flow?

TCTAP C-187
Challenging Anatomy Carotid Artery Angioplasty Combined Femoral - Radial Route (CFRR)

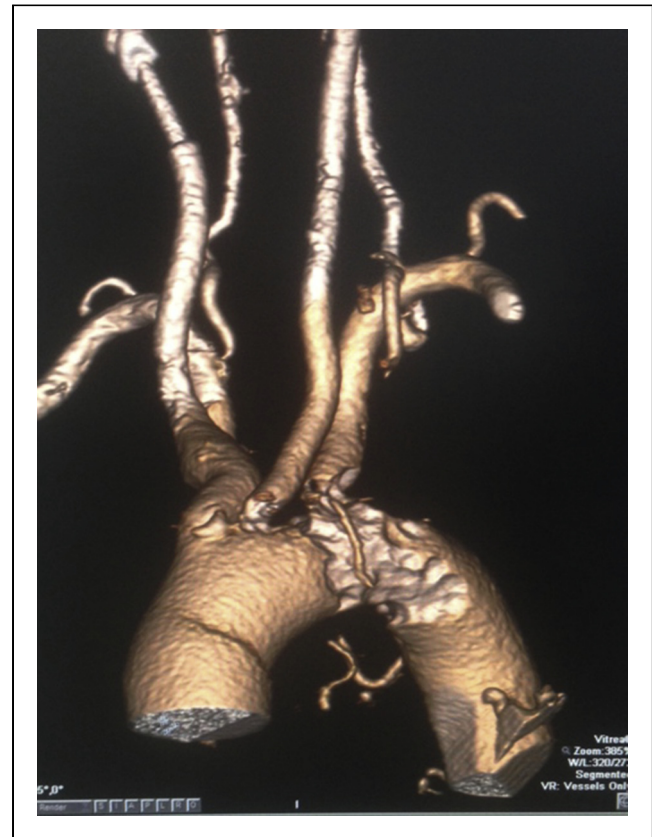
Igor V. Buzaev,¹ Vladimir V. Plechev,² Irina E. Nikolaeva,¹ Ilgiz Gayfullovich Zagitov¹
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[CLINICAL INFORMATION]

Patient initials or identifier number. M

Relevant clinical history and physical exam. A 75 years-old nonsmoking female with history of hypertension, chronic obstructive pulmonary disease presented to Republican Cardiac Center with severe dizziness, headaches and visual disturbances. Auscultation revealed systolic bruit above left carotid artery bifurcation. Neurologic exam was uneventful.

Relevant test results prior to catheterization. Workout with carotid ultrasound revealed right ICA stenosis 65-70% with bifurcation up to 50%, left ICA 55-60%. CT with contrast of aortic arch with main branches found type III aortic arch with erosive calcified atherosclerotic plaque, ostial stenosis of left subclavian and left CCA.



Relevant catheterization findings. Right ICA stenting via right femoral artery were scheduled. Bilateral carotid angiography was performed. 60-70% stenosis of right ICA and 50-60% of left ICA were confirmed as well as type III aortic arch with calcification.

[INTERVENTIONAL MANAGEMENT]

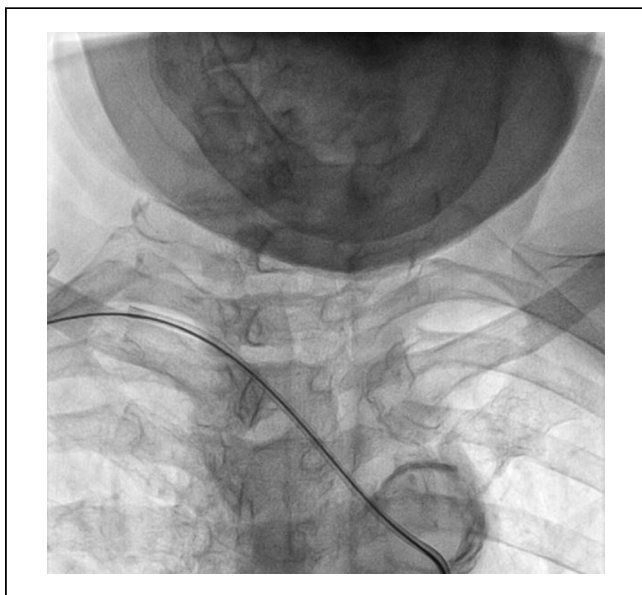
Procedural step. 6F sheath has been placed after right femoral artery puncture. We tried to pass to right ICA by the different types of guidewires, but without success. The wires could not pass because of the angle in the aortic arch and presence of calcification there. We tried different types of guidewires and catheters to solve the situation.

As a plan B, we decided to use right radial arterial approach. It was impossible to pass to right carotid artery from this route too because of sharp angle of brachiocephalic trunk bifurcation with right CCA.

Finally, 0.35” 260 cm hydrophilic wire had been passed through the radial artery to iliaca externa, where it had been captured by goose neck retriever from femoral introducer and had been withdrawn outside of the patient.

Other side of the wire (radial) had been fixated outside of the introducer by the clamp. As the result one side of the wire was clinched outside radial introducer. From femoral side of the wire guiding catheter had been inserted and passed to the right subclavian artery. After that guiding catheter had been gently withdrawn to ostium of right CCA. Right CCA had been wired by 0.35 Amplatzer Superstiff wire and guiding sheath had been placed to the right CCA.

Carotidstent 7.0x40.0 mm had been uneventfully placed at the level of stenosis. Patient was discharged 3 days after surgery without neurologic complications.



Case Summary. Carotid artery stenting is a treatment option for atherosclerotic disease of the cervical internal carotid artery in high-risk patients. The traditional transfemoral approach sometimes is not suitable for patients with challenging anatomy. Radial approach is available as a plan B.

We suggest combined femoral-radial route (CFRR) in difficult femoral or radial cases when angulations and calcifications are present.

TCTAP C-188
Bilateral Carotid Artery In-stent-restenosis in a Patient with Malignant Atherosclerosis

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¹Apollo Gleneagles Hospital, India

[CLINICAL INFORMATION]

Patient initials or identifier number. SKB

Relevant clinical history and physical exam. Mr. SKB 65 years male presented with recurrent syncope for 2 months and effort angina (CCS-Class-III) for 6 months. Bilateral lower limb claudication with nocturnal leg pain for 1 year.

Risk Factors: Diabetes Mellitus-5 years. Systemic hypertension- 10 years. Dyslipidaemia - 5 years. Ex-smoker.

Peripheral Pulses - Bilateral Radial-absent. Bilateral Carotid-feeble. Bilateral Femoral- palpable. Bilateral Dorsalis Pedis and Posterior tibial- absent. CVS- mild cardiomegaly. No murmur. Chest-clear.

Relevant test results prior to catheterization. Blood Parameters:: Hb-10gm %.

Serum Creatinine- 1.6mg%.

Lipid Profile: Total Cholesterol- 246mg/dl. Triglyceride- 178mg/dl.

LDL - 140mg/dl. HDL- 36mg/dl. Lp(a)-56 mg/dl.

Serum Vit-D3- 23ng/ml. SGPT - 88iu/L.

ECG- Normal sinus rhythm. Mild LVH. Normal Axis.

Echocardiography- Good LV systolic function. No RWMA. LVEF- 62%.

Duplex Doppler Study - severe in-stent-restenosis in both carotid artery stents.

Loss of triphasic flow pattern with parvus et tardus type flow in both femoral and popliteal arteries.