Management of long Flush SFA Occlusion with Ipsilateral Antegrade Common Femoral Artery Access

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Disclosure

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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
How flush SFA lesions start

- Plaque in the distal SFA (Adductor canal) becomes occluded, and the occlusion propagates retrograde to the next largest branch point, the profunda artery
- So flush SFA lesions are usually long lesions
Why flush SFA lesions are difficult?
Challenges of Treating Flush SFA Lesions

Absence of SFA stump can preclude successful wire access of the SFA.
Challenges of Treating Flush SFA Lesions

Finding the SFA CTO origin can be difficult
How to tackle the lesion

• Ipsilateral antegrade puncture of the common femoral artery.

• Contralateral cross-over access to the common femoral artery

• Retrograde Popliteal puncture
Contralateral approach

Jihad A. Mustapha, Larry J. Diaz-Sandoval
Endovascular Today May 2014
Retrograde approach
Ipsilateral approach
28 patients with flush SFA lesions with or without extension of the occlusion to the popliteal and/or tibial arteries.

<table>
<thead>
<tr>
<th>Extent of CTO</th>
<th>Number</th>
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<tbody>
<tr>
<td>Proximal 1/3 of the SFA</td>
<td>0</td>
</tr>
<tr>
<td>Proximal 1/3 extending into middle 1/3 of SFA</td>
<td>5</td>
</tr>
<tr>
<td>SFA total length till the adductor canal</td>
<td>13</td>
</tr>
<tr>
<td>SFA extending to popliteal artery</td>
<td>6</td>
</tr>
<tr>
<td>SFA extending to popliteal and tibial arteries</td>
<td>4</td>
</tr>
</tbody>
</table>

- This morphology of occlusive lesions corresponded to TASC C&D
• Technical success in 24 (85.7 %) cases
• Technical failure in 4 (14.3 %) cases
  ➢ obesity 2 cases
  ➢ inability to engage into the proximal SFA in 2 cases
• Complications in 4 cases
  ➢ 2 vessel perforation
  ➢ 2 intraoperative thrombosis.
Technique
Advantages

• Superior pushability, trackability, and torquing of the wire as the entire force applied to the wire and catheter is transmitted to the lesion
Disadvantages

• Its proximity to the lesion with no enough space to manipulate the wire through the occlusion.
• The position of partially inserted sheath is not secure with the possibility to slip outside the artery.
• Not suitable for lesions involving the CFA
• Difficult in obese patients with hanging abdomen.
Endovascular Management of Flush SFA with Ipsilateral Approach
“not easy but not impossible”
Thank You
Management of long Flush SFA Occlusion with Ipsilateral Antegrade Common Femoral Artery Access

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