Pre-recorded live case
Infrapopliteal & inframalleolar EVT

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Disclosure

Speaker name: Tatsuya Nakama MD.

I have the following potential conflicts of interest to report:

- **Consulting**: Abbot Vascular Japan, Boston Scientific Japan
- Employment in industry: None
- Stockholder of a healthcare company: None
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  Abbot Vascular, Asahi Intecc, Astellas, Boston Scientific, COOK, Cordis, DVX, Diaiichi-Sankyo, Goodman, Kaneka, Lifeline, Medikit, Medtronic, Otsuka, Orbus Neihi, Sanofi, Terumo,
Case overview

50s diabetic male, non-dialysis infectious wounds

WiFi CS 4
W(2), I(3), FI(2), composite: 7

SPP dorsal: 20 mmHg
SPP plantar: 18 mmHg
Case overview
Control angiogram
Discussion 1

How to decide Target Artery
Angiosome oriented revascularization

It’s good concept but it’s only a concept

Iida et al, CCI 75:830-836 (2010)
Discussion 2

Antegrade 1st

or

Retrograde 1st
PTA = flash occlusion

Retrograde 1\textsuperscript{st} strategy is acceptable
Appropriate puncture site
Novel retrograde puncture technique for infrapopliteal artery revascularization: transplantar retrograde access

Fig. 3 Appropriate and inappropriate puncture needle positions. The puncture needle should be advanced into the target plantar artery in contralateral oblique position, because it is easy to understand the position relationship of the puncture needle and the target plantar artery. Puncture needle should be kept “in-lined fashion” to the target artery for the successful puncture.

Common plantar puncture
Retro-cross & Rendezvous
Rendezvous & POBA

Rendezvous

Externalization

POBA with 2.5mm
Puncture site hemostasis
After PTA revascularization
Discussion 3

Is the additional revascularization necessary?
One-straight line vs. Multi-vessel revascularization

There is no evidence for multi strategy
Durability of balloon angioplasty for infrapopliteal lesion; very poor

Frequent EVT is required

Blood supply

Peak blood supply after EVT

60mmHg
(SPP \geq 40mmHg)

CLI high risk population

40mmHg

1^{st} EVT
2^{nd} EVT
3^{rd} EVT

Frequent EVT is required
To improve the blood supply

Blood supply

60 mmHg (SPP ≥ 40 mmHg)

CLI high risk population

40 mmHg

Time
In patients with ischemic ulceration

Nakama et al. will be present in LINC 2017
Trans-pedal and retro-knuckle
Additional antegrade approach
Wire rendezvous again
Final angiogram
Final angiogram (Frontal)
Debridement after revascularization
Clinical course
Clinical course
Conclusion

• Bi-directional approach, which are included distal site puncture technique and trans-pedal / collateral, is feasible and safe technique for BTK intervention.

• Nobody know the appropriate endpoint of BTK intervention.

• Aggressive revascularization sometimes necessary for limbs salvage and wound healing.
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