How should we follow patients with CLI treated with BTK recanalisation

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Disclosure

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I have the following potential conflicts of interest to report:

- Consulting Cook Medical, Medtronic
- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company
- Other(s)

- I do not have any potential conflict of interest
CLI patient post revascularization Follow-up

**Endovascular Team**
- Choose Vascular Access and strategy
- Optimal revascularization
- Angiosome concept
- Lesion blush
- Optimize pedal out-flow
- Optimize in-flow
- Duplex scan

**Foot clinic Team**
- Healing process surveillance
- Minor amputation timing
- Debridement
- Infection treatment
- Skin graft
- Major amputation

- Wound healing surveillance
- Vessel patency surveillance
- Cardiovascular protection
Wound Healing Surveillance

Follow-up schedules: 2 days/week for the first 2 months, once a week for the third month and then every two weeks until complete healing

- Ulcer Debridement
- Minor amputation timing
- Infection treatment
- Skin graft
- Regression of healing signs
- Indication for Patency assessment and TLR
Wound Healing Surveillance

Regression of local healing signs
- Granulation tissue reduction
- Increase fibrin deposition
- Recurrence of necrosis (black wound margin)
- Ischemia signs (yellow-black vs red-pink)
- Pain (supine position)

The most important indication to check vessel patency and re-intervention in a fast track strategy fashion
Rutherford 5: concomitant ATK and BTK disease: DCB angioplasty
Patency assessment before planned minor amputation

Bleeding from surgical incision confirm good patency

Minor amputation at 1 month after demarcation of necrotic tissue

Healing process completed at 5 months

Patency assessment before planned minor amputation
Minor amputation after 20 days from revascularization

Abscess drainage
Worsening of the wound at 2 months: necrotic margin, fibrin deposition, regression of granulation tissue

Restoration of healing process, red more than white, reduction of ulcer dimension
1 week after revascularization
4 months healing stops fibrin deposition and regression of granulating marginal tissue

Post occlusive flow in distal PTA

Post TLR healing goes faster

Completed at 10 months
Vessel patency surveillance in complex BTK recanalisation

Subintimal recanalization and early DCB reocclusion
Mechanically driven TLR (occurring the first 4 weeks)
Vessel patency surveillance in complex BTK recanalisation
Early reocclusion by dissection flap: indication to angio and mechanical TLR
Mechanical TLR: repeat revascularization due to early reocclusion caused by dissection-recoil or thrombosis not restenosis.

2 weeks post procedure

Stent in TPT  Post MTLR
Duplex and angiography at 6 months
Conclusion

CLI patients deserve meticulous follow-up

- Invest in human resources to grow up a CLI center
- Be confidential with healing process anatomical changes
- Apply major amputation protocol
- Build a multispecialty team
- Duplex Skill should be part of your training
- Fast track strategy for Duplex and re-intervention is a must for limb salvage
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