Stenting the carotid for left arm fatigue? An unusual case of subclavian steal syndrome

Eugen Ivan, MD
Interventional Cardiologist
Lawton, Oklahoma
Disclosure

Speaker name: Eugen Ivan, MD

I have the following potential conflicts of interest to report:

- Consulting:
  Abbott Vascular
  CSI Inc. (proctor)
Clinical background

64 yo male smoker, hypertension, dyslipidemia

Presented 4 years ago with angina class IV and severe bilateral claudication

On coronary angiography: severe left main and 2 vessel disease, SYNTAX score over 33

Also had left iliac and bilateral SFA disease
CABG was recommended with LIMA to LAD and SVG to LCx

Revascularization of left subclavian artery to be carried out first
Left subclavian 100% occluded proximally – mild subclavian steal symptoms

Attempted PTA via left brachial approach – wire went subintimal and couldn’t be redirected into aortic lumen; re-entry device with ultrasound guidance not available at that time

Femoral approach unsuccessful due to extremely short stump of proximal subclavian
Patient underwent left carotid-to-subclavian bypass -- successful

Subsequently, CABG with LIMA to LAD and SVG to LCx, with resolution of angina symptoms

Peripheral revascularization followed - stenting left iliac and endarterectomy right CFA

Thereafter lost to follow-up
Returns 3 years later with subclavian steal syndrome manifestations

Dizziness upon using left arm, and also effort fatigue of the arm

First suspicion is occlusion of left subclavian-to-carotid bypass – no palpable pulse
Bypass widely patent, but ostial left common carotid (CCA) has 99% near-occlusion.

Double-wired with 0.14 and 0.018 wires for support and predilated with 5 mm balloon.

Stented with 8x19 mm balloon-expandable stent under distal embolic filter protection (NAV-6).
Patient had complete resolution of dizziness and left arm ischemia

Subsequent SFA intervention due to recurrent claudication

At follow-up 8 months later, still doing well and has stopped smoking
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