Intraluminal Whenever possible! Catheter and wire choice to be successful.

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I have the following potential conflicts of interest to report:

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

I do not have any potential conflict of interest
Technique Choice

• Intraluminal when severly calcified

• Subintimal (should not be first choice) when poorly calcified

• trans-collateral and trans-pedal as bail out after antegrade failure attempt;
Limitations

- Risk of perforation or dissection;
- It is not easy, in long occlusions, to be intraluminal!
- Wire might cross lesion, balloons not;
- Balloons might rupture.
- Consider re-coiling
1. 11 cm 4-6F Sheath

2. 4F Ber catheter or short ballon

3. 0,18-0,14-0,35 wire

4. Hypoosmolar diluted mdc
Interventional Procedural Steps

Guide Placement

• A coronary guide catheter or long sheath may be advanced to the distal SFA or mid popliteal artery
Interventional Procedural Steps

Wire Selection

• BTK - atraumatic 0.014" / 0.018" guidewires should be used and 0.014" preferred due to vessel diameter

• Type selection (floppy, medium, stiff) will be determined by the type of disease
Balloon Angioplasty

Requirements of BTK balloons

- 0.014” wire compatibility
- Diameter 1.5 mm - 4.0 mm
- Length 8 - 21 cm to reduce procedure time and dissections
- Low profile balloon with high pushability and trackability
- Vessel Conformability
- Flexibility
The Right Tool for the Right Lesion

Above the ankle – When You Need Versatility

Anatomy Considerations:
• Relatively straight vessels
• Various types of lesions
• “Everyday” BTK cases

Diameters: 2.0-4.0 mm
Lengths: 14, 30, 60, 80, 120mm
Shaft lengths: 100, 150cm
Guidewire compatibility 0.014” or 0.018”

Below the ankle – When You Need Reachability

Anatomy Considerations:
• Tortuous anatomy
• Small diameter and low vessel wall thickness
• Key for those practicing the Angiosome concept

Diameter: 1.5-4.0
Lengths: 20,40, 80, 120, 150, 210mm
Shaft lengths 120, 150 cm
Guidewire compatibility: 0.014”
Il Buono!
Il Buono!
Il brutto!
Il brutto!
Il brutto!
Il brutto!
Il brutto!
Il brutto!
Il Cattivo!
Il Cattivo!

Paziente morto dopo 6 mesi di MIC!
Failed recanalization by antegrade way

Collateral circulation to plantar artery (injection through the balloon)
Passage of guidewire through collateral vessel in posterior tibial artery by retrograde way and dilatation of the occlusion
Passage of new guidewire by antegrade way and POBA
Conclusions

• When severe calcifications, intraluminal first choice: CTO wires can help in straight vessels above all; attention to perforations

• A combination of intraluminal and subintimal technique could be helpful;

• Use retrograde approach as last option!
Thank you
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