Addressing Complex BTK CLTI Disease: the Need for Innovative Tools to Access, Cross, and Treat

Moderator: Jay Mathews, MD

12:00 – 12:05 Introduction
Jay Mathews, MD

12:05 – 12:20 Accessing and Crossing Complex Lesions with Innovative Tools Makes the Difference
Ashwani Sastry, MD

12:20 – 12:35 Exploring Retrievable Scaffold Therapy for BTK Treatment of CLTI
Michael Siah, MD

12:35 – 12:50 DEEPER REVEAL BTK Trial: primary endpoint outcomes of the Spur Peripheral Retrievable Stent System
Kevin Herman, MD

12:50 – 13:00 Discussion & Close
All

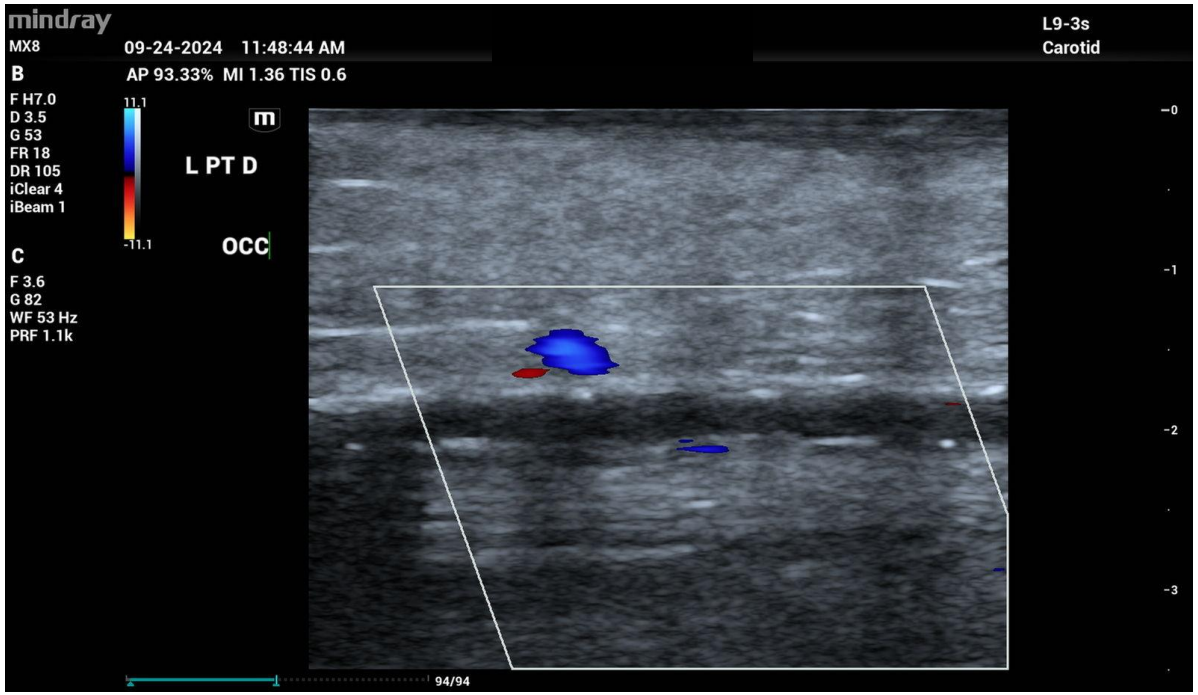
Accessing and Crossing Complex Lesions with Innovative Tools Makes the Difference

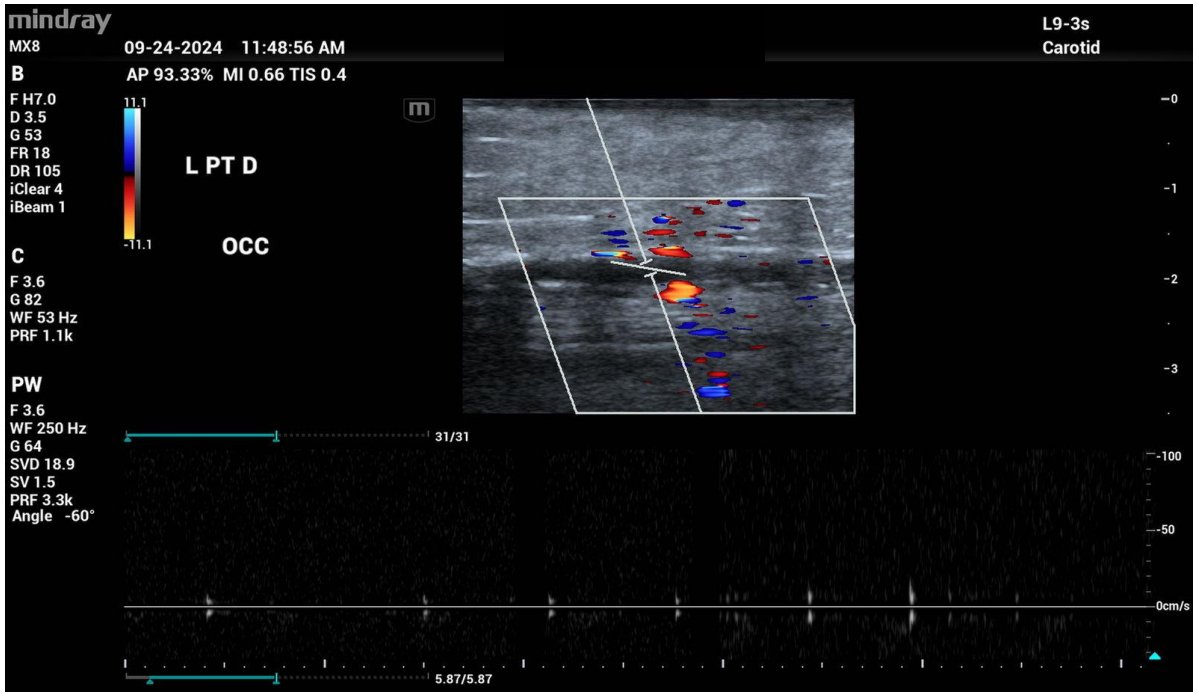
Ashwani Sastry, MD
Interventional Cardiologist
Sunrise Vascular
North Carolina

Disclosures

Reflow Medical, Aveera Medical

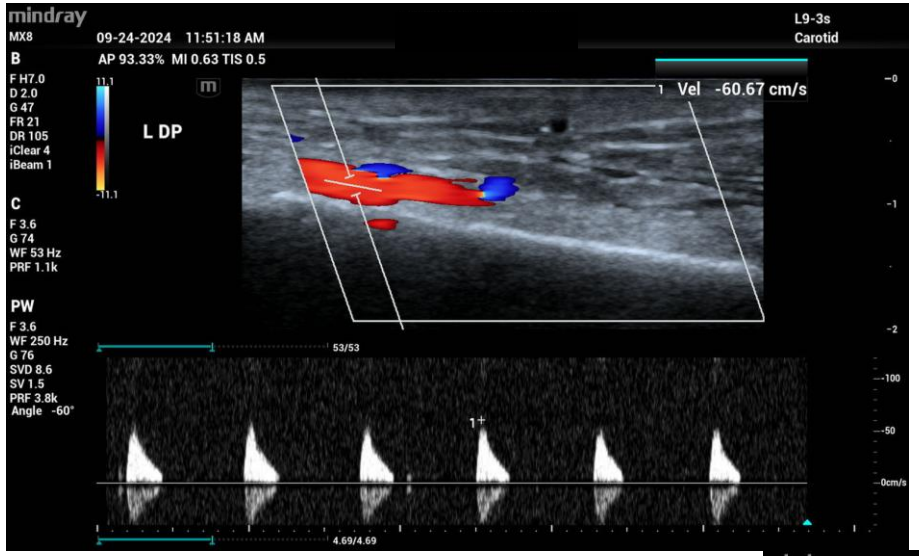
Case 1 – 85 y/o w/ plantar foot ulceration – posterior circulation



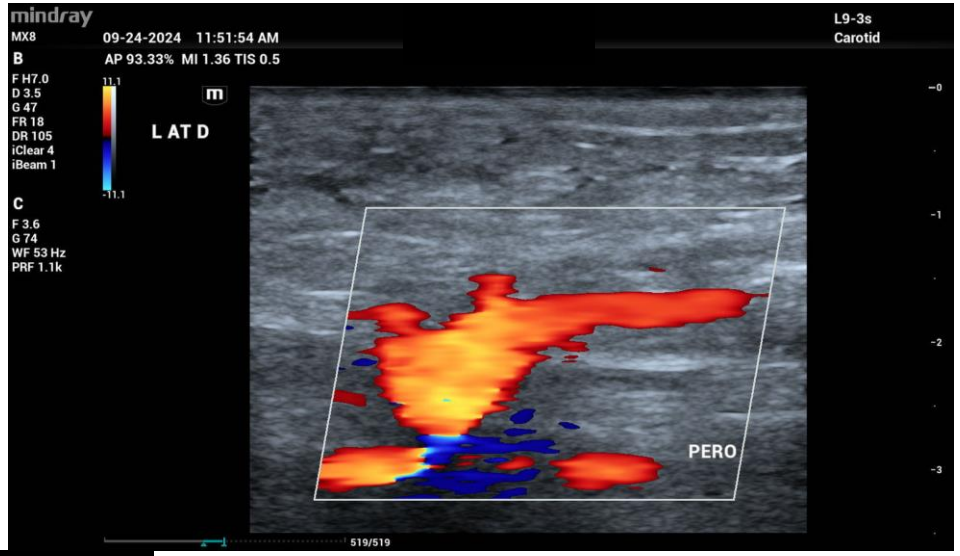


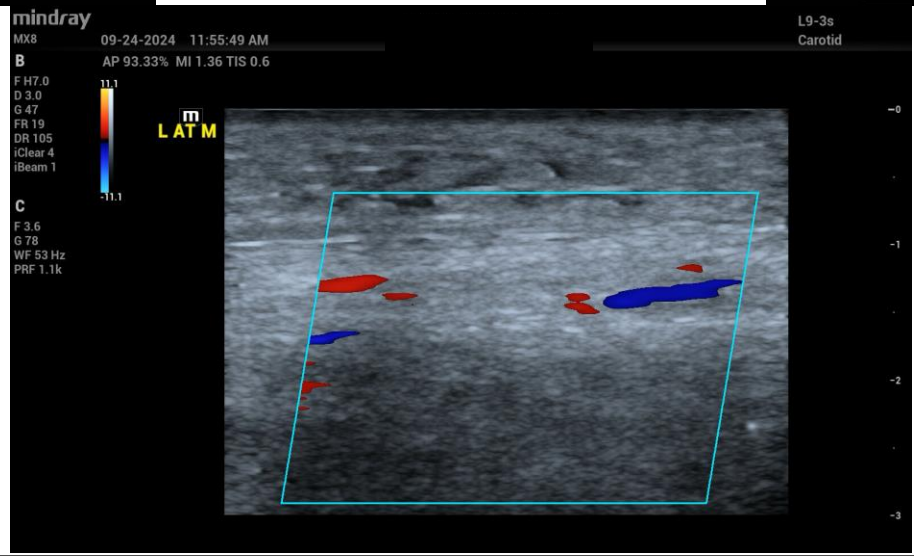
Calcific occlusion of posterior tibial artery

Case 1 – 85 y/o w/ plantar foot ulceration – anterior circulation

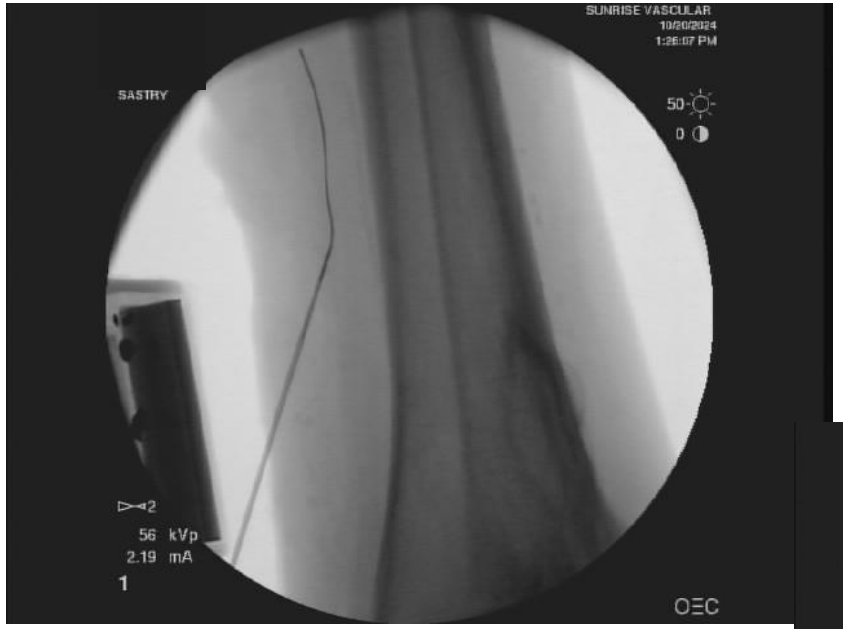


Suspected occlusion of ATA with peroneal reconstitution



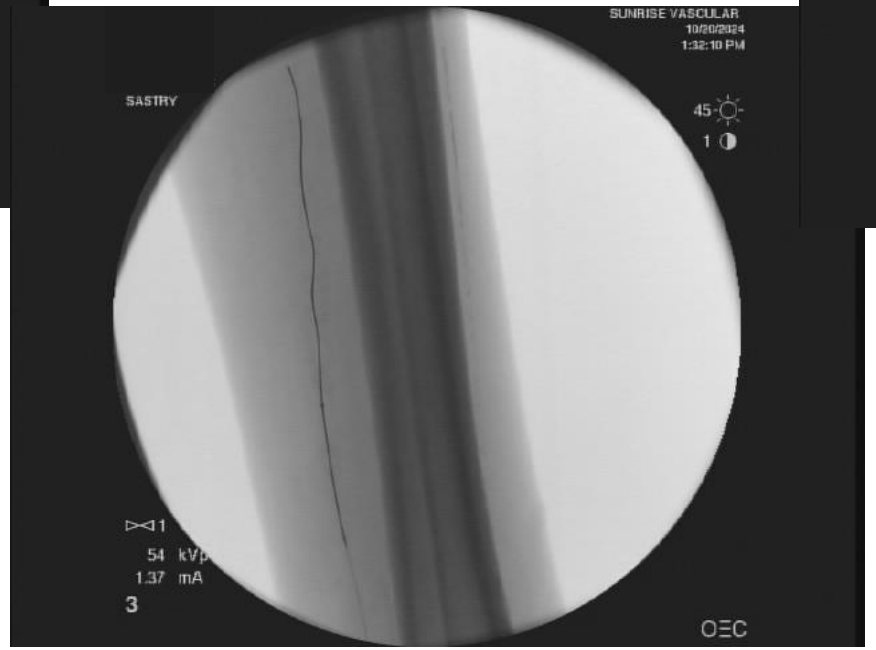


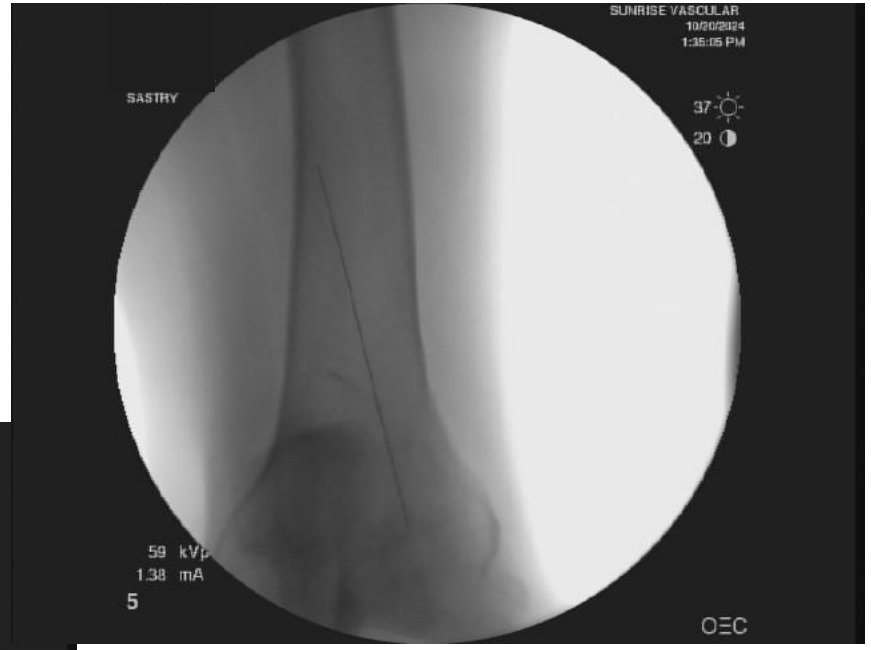
No prior angio – Occluded Vessel Access is Completely Safe



EVUS + Fluoro guidance, 018 wire

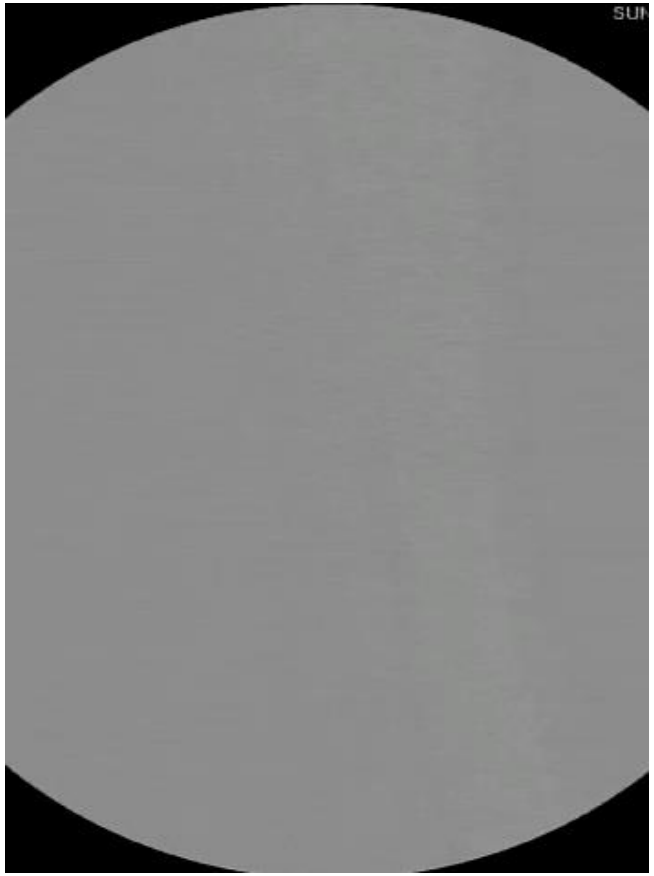
Easy crossing of long segment calcific occlusion

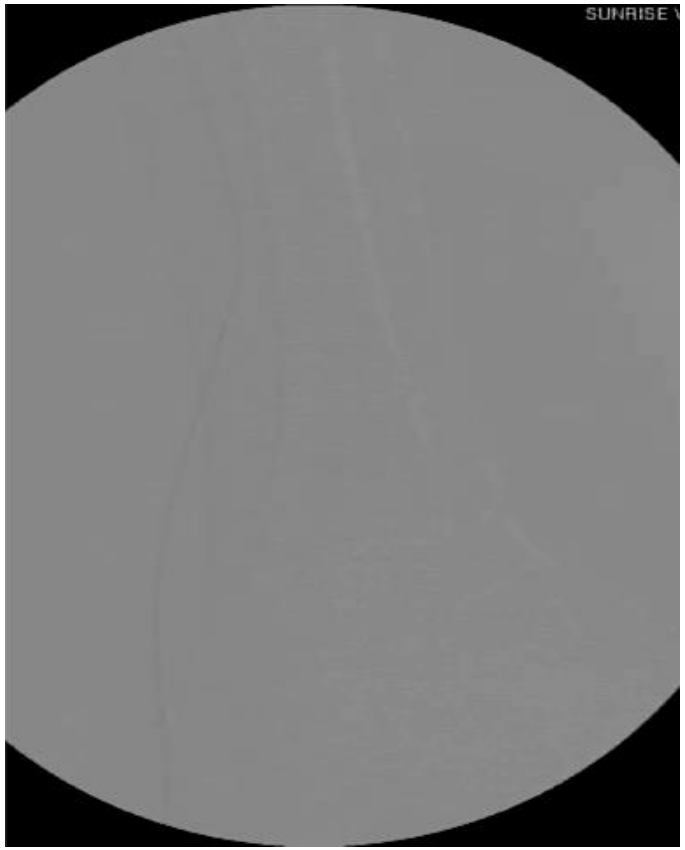


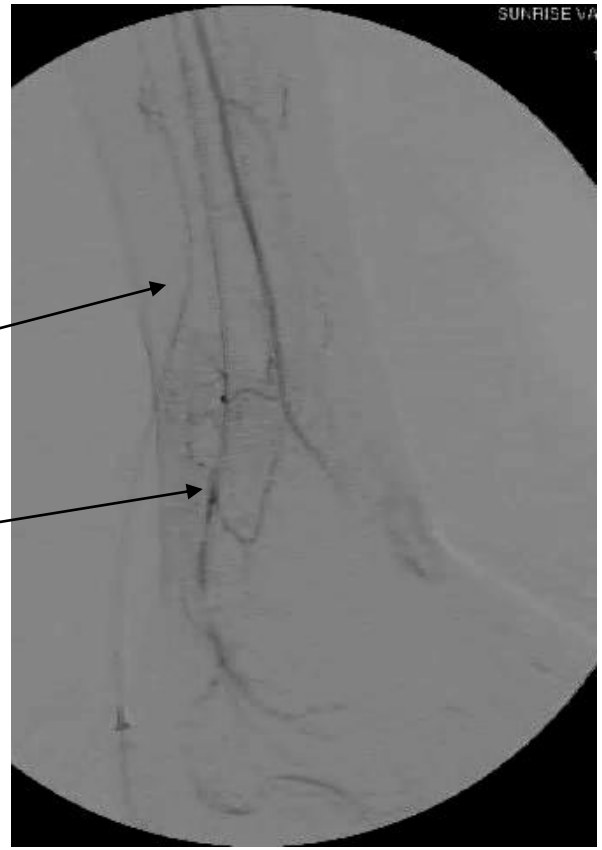


Crossing Devices for Complex Tibial Anatomy

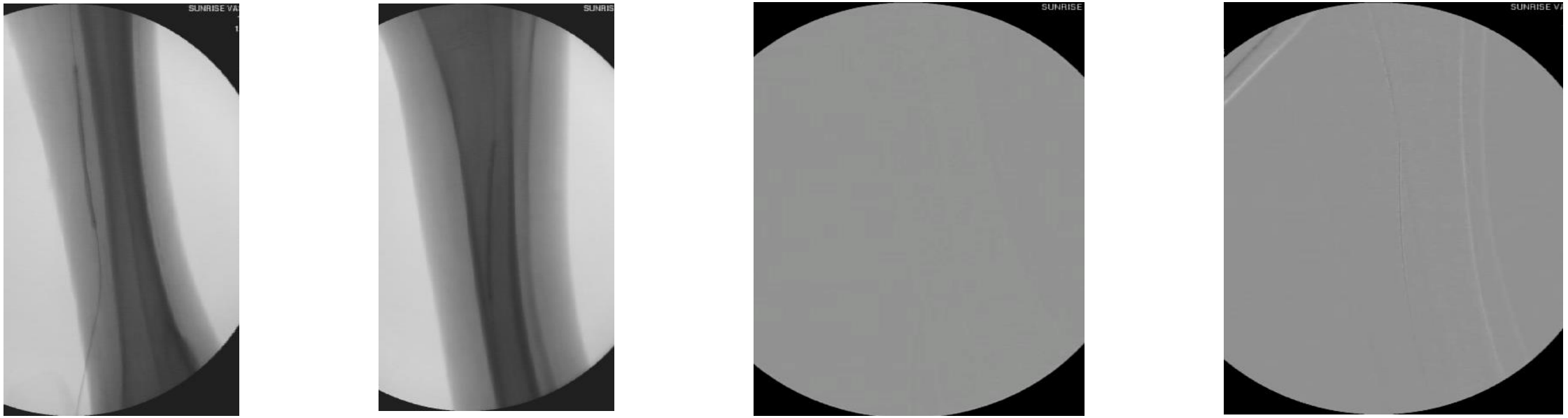
Selective Angiography via Spex LP 18 at Popliteal



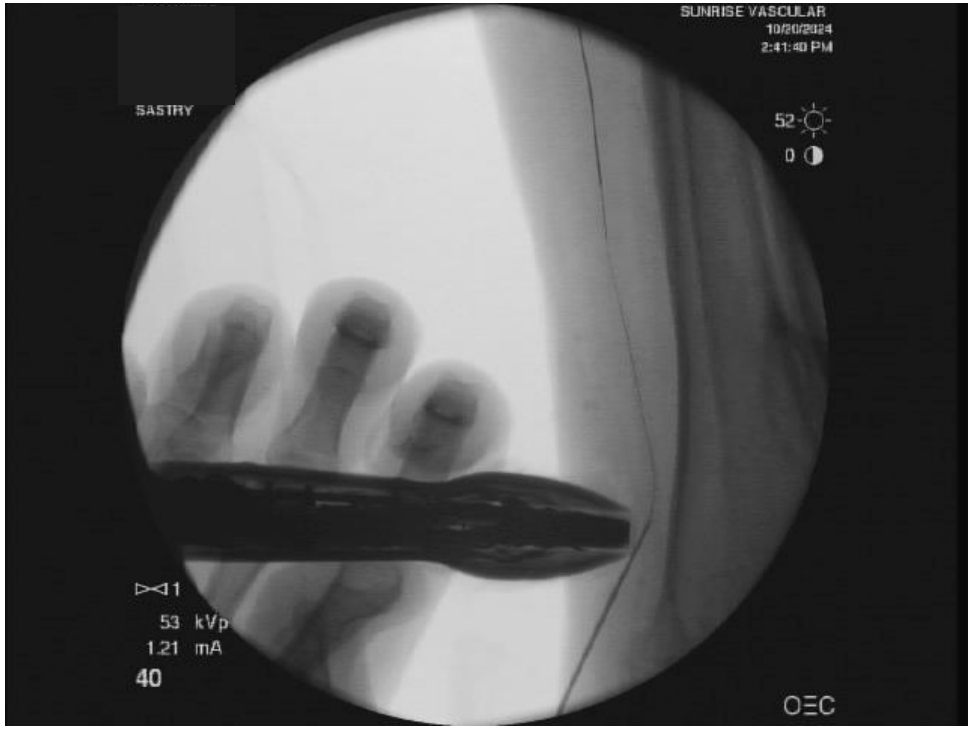




Angioplasty, Optimize Long Segment Occlusion



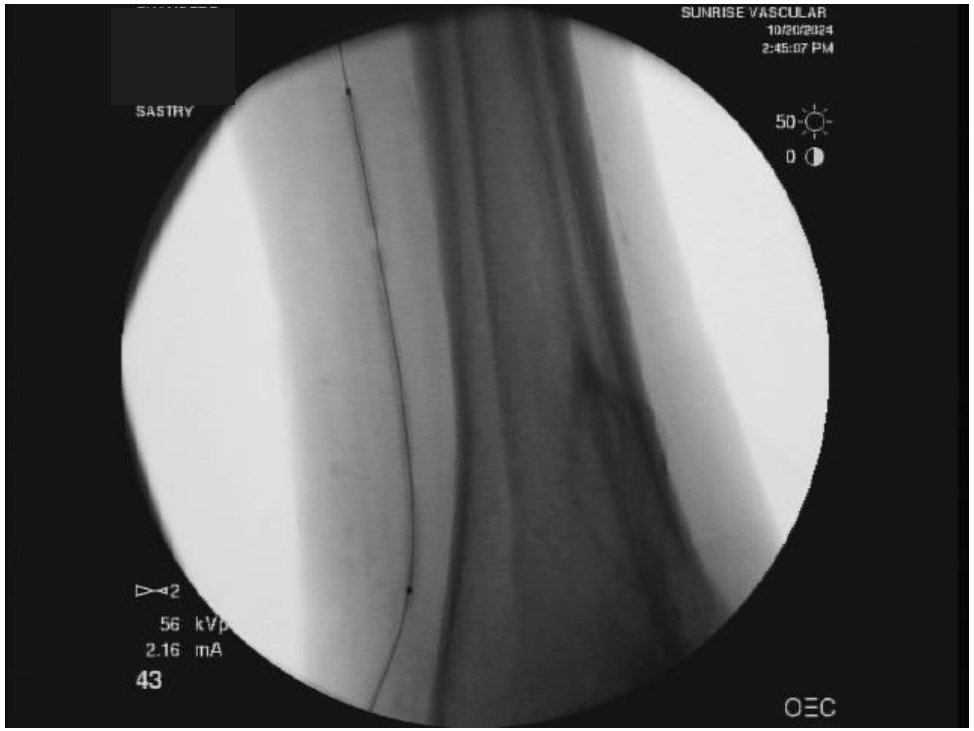
Second True Lumen Access to Complete Procedure



EVUS guided access of distal reconstituted segment

018 workhorse wire with good support easily traverses
Short segment occlusion

Stasis band or manual compression of proximal acccess

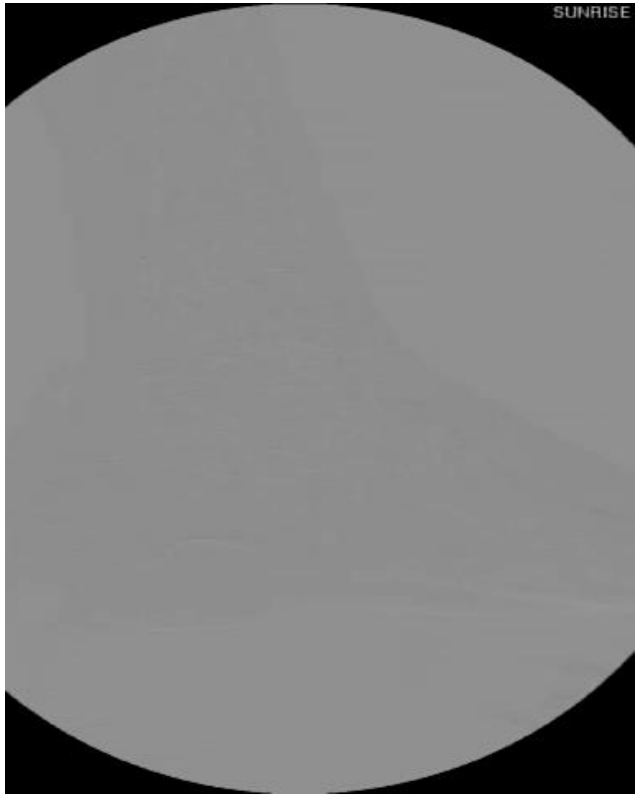


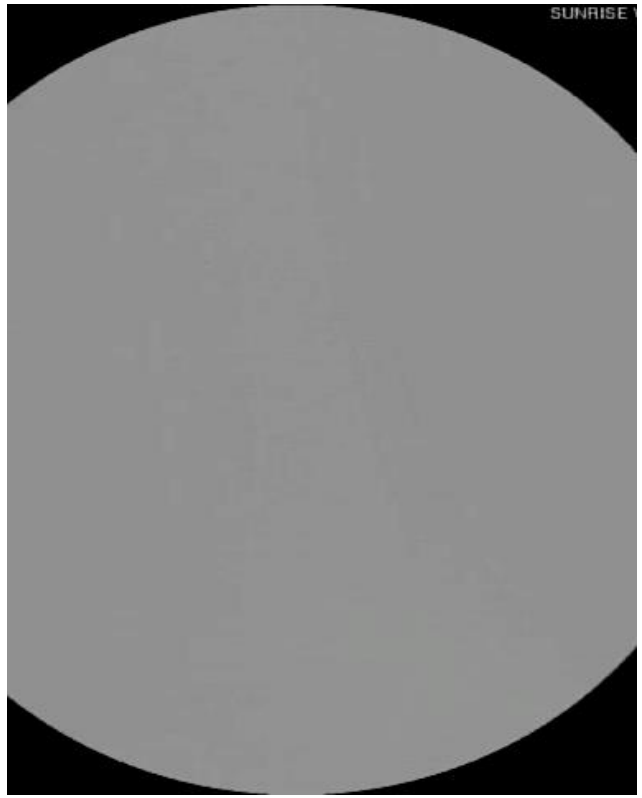
018 balloon (40 or 80 mm) over the wire sheathless compared to minimum Sheath O.D. 1.8 mm

Meticulous attention to marking access point to avoid ballooning arteriotomy

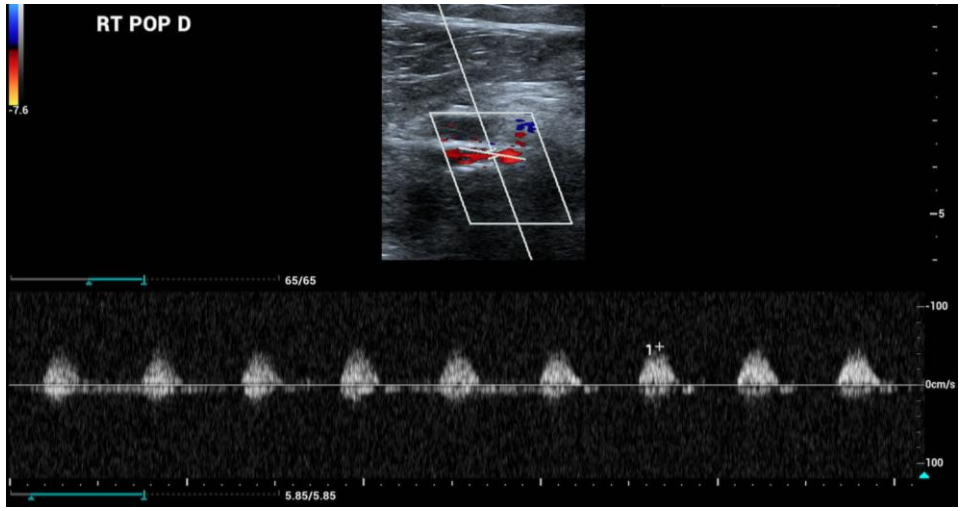
Prolonged inflation 3-4 min, additional heparin, deflate stasis band if used

High Dose Nitroglycerin and Final Angiogram via Balloon

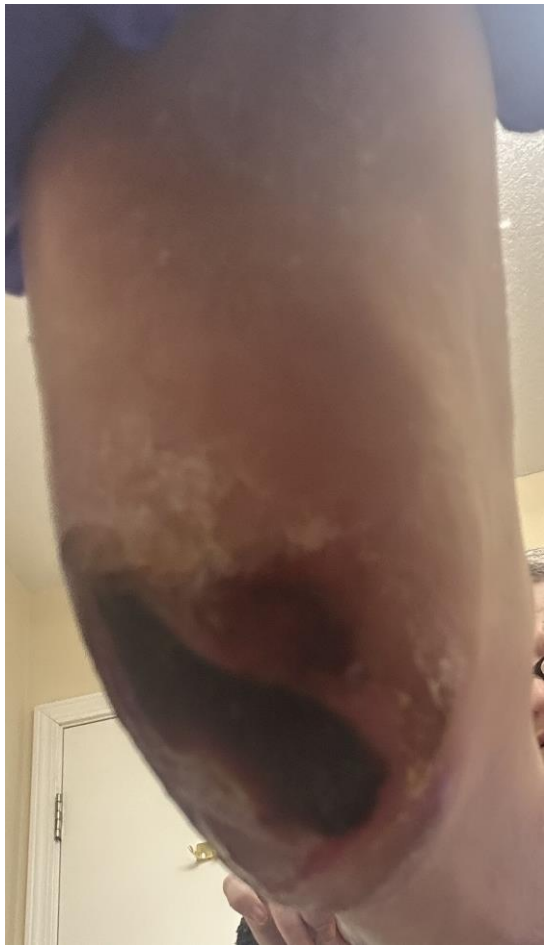


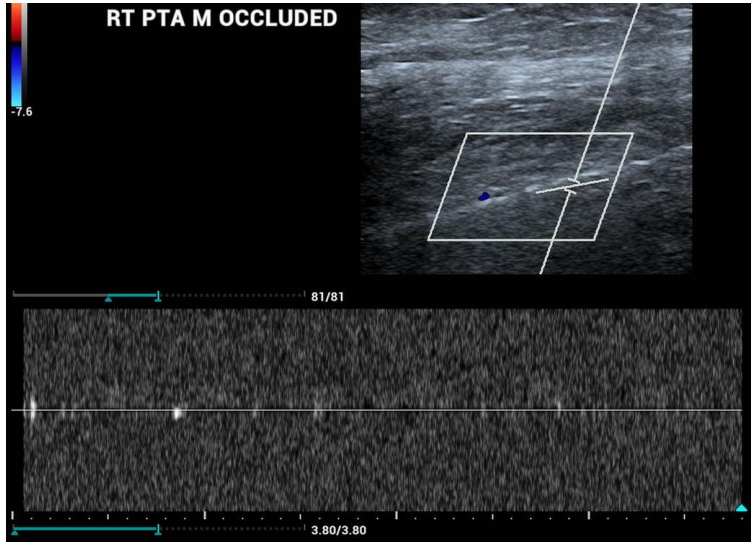


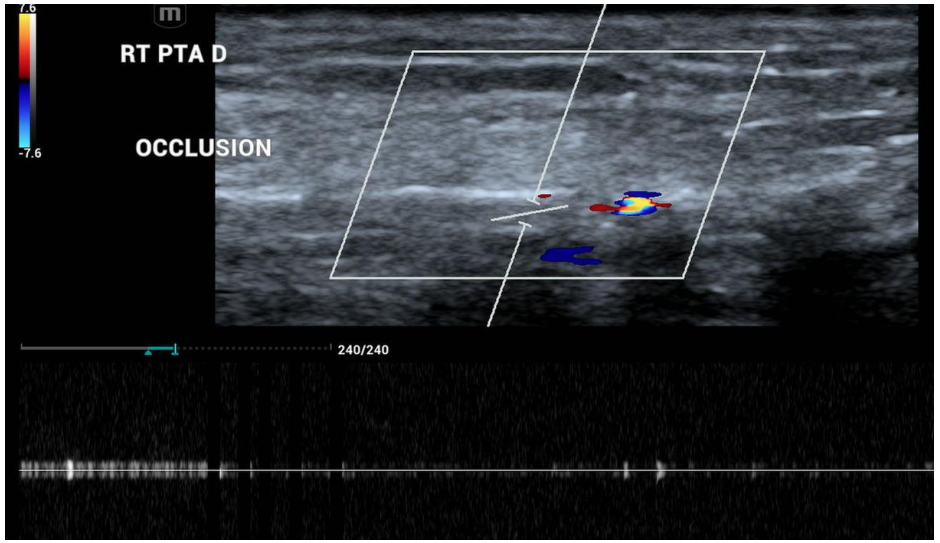
Case 2 – 63 y/o w/ large heel ulcer



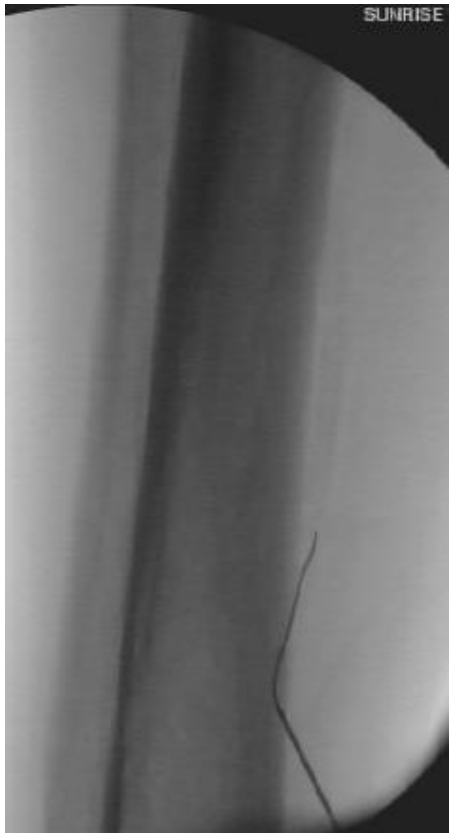
Suspected fem / pop disease and obliterated posterior tibial artery / plantar circulation



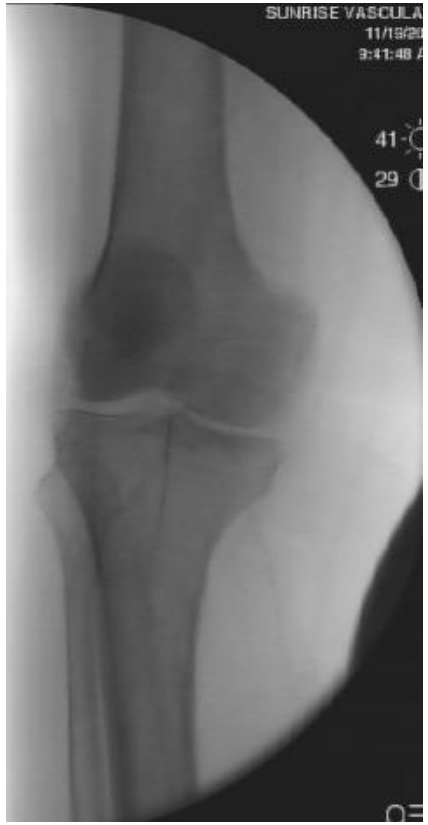




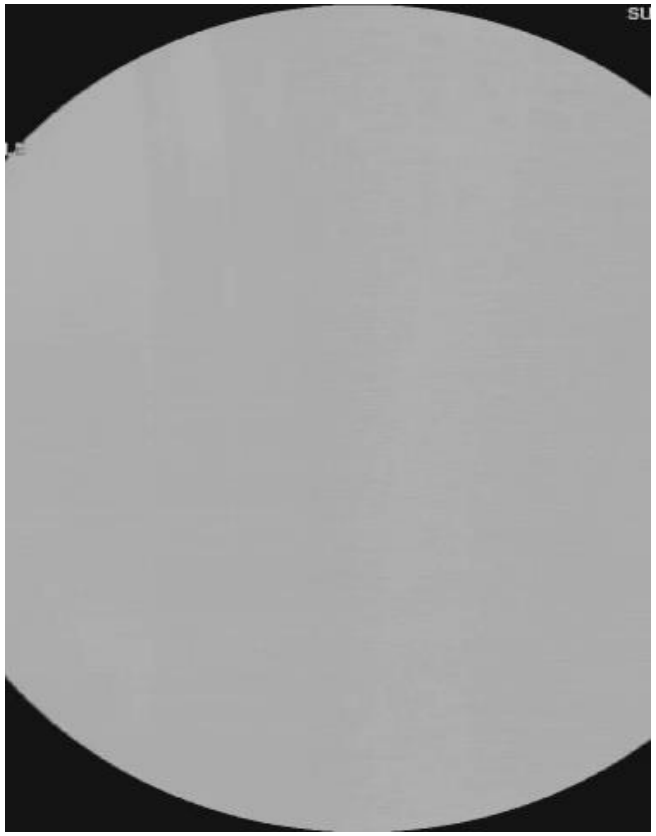
No Prior Angio – Occluded Vessel Access is Safe and Efficient



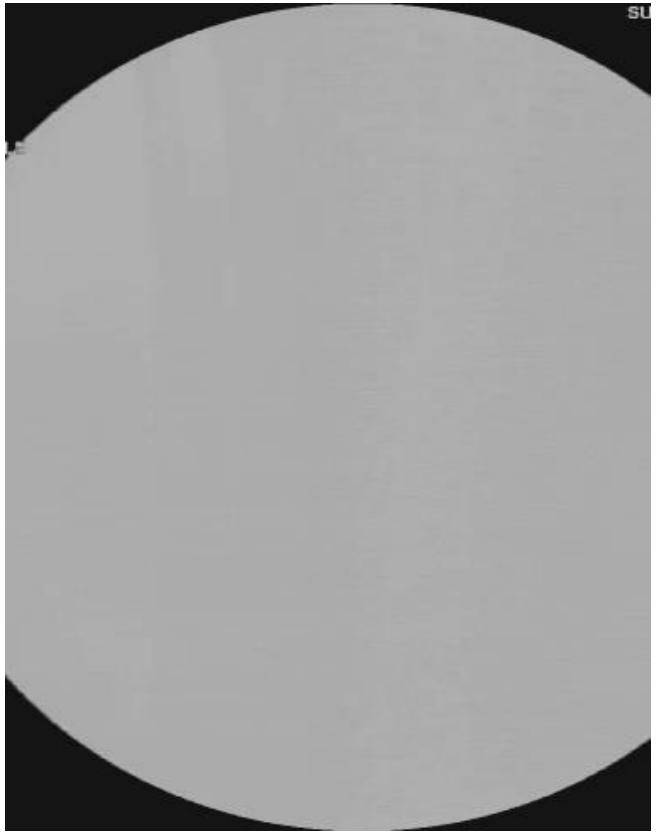
EVUS + Fluoro guidance, 018 wire



Easy crossing of long segment calcific occlusion

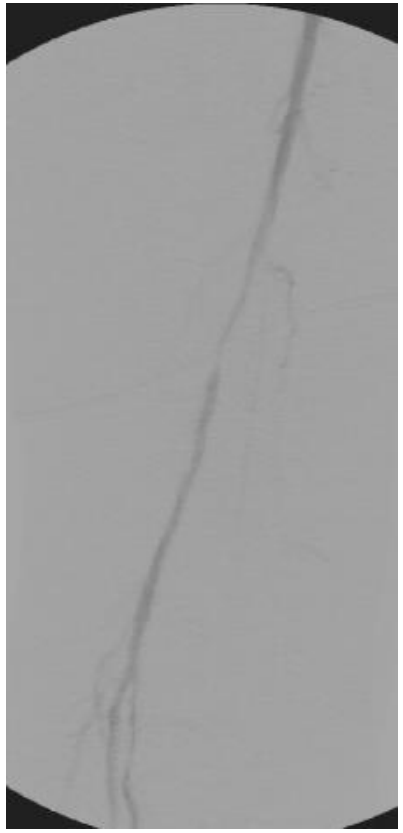
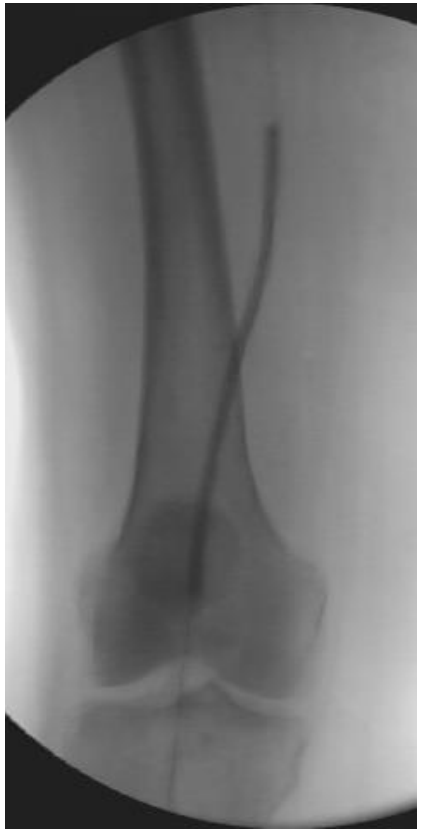
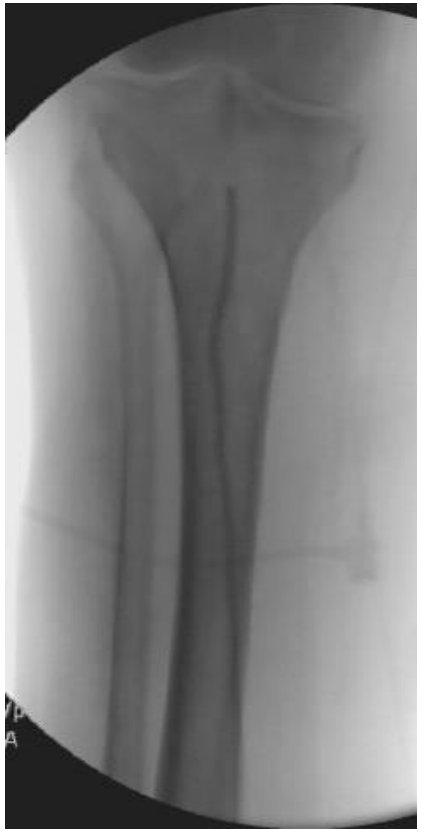
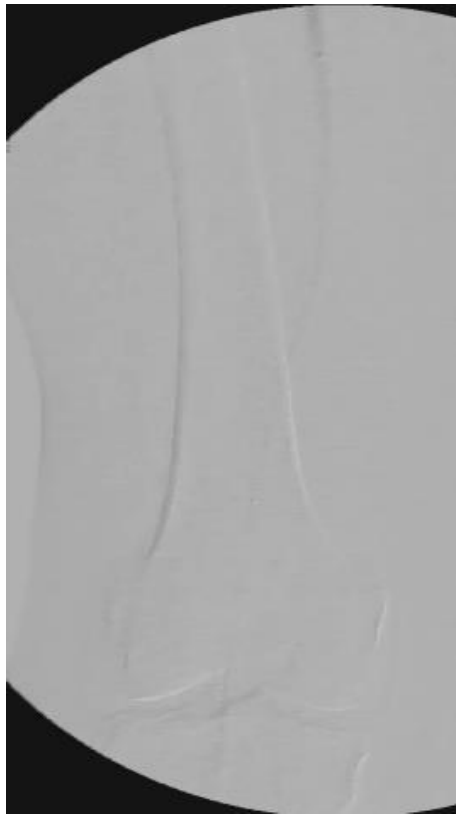


Hibernating PT lumen, long segment occlusion, severe TPT disease

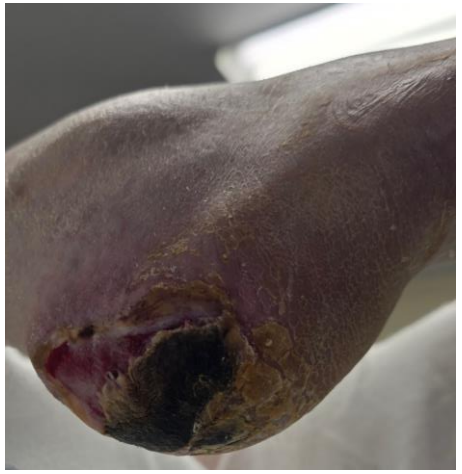


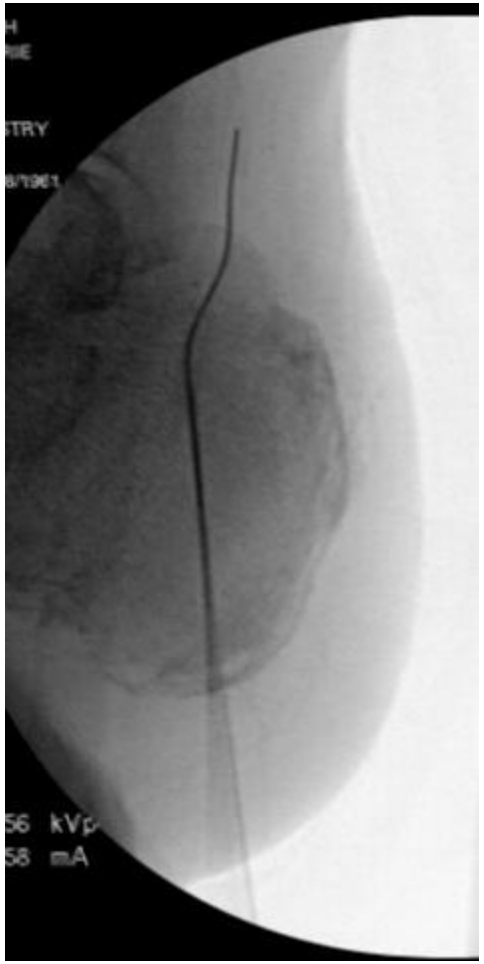
Faint blush to heel via peroneal

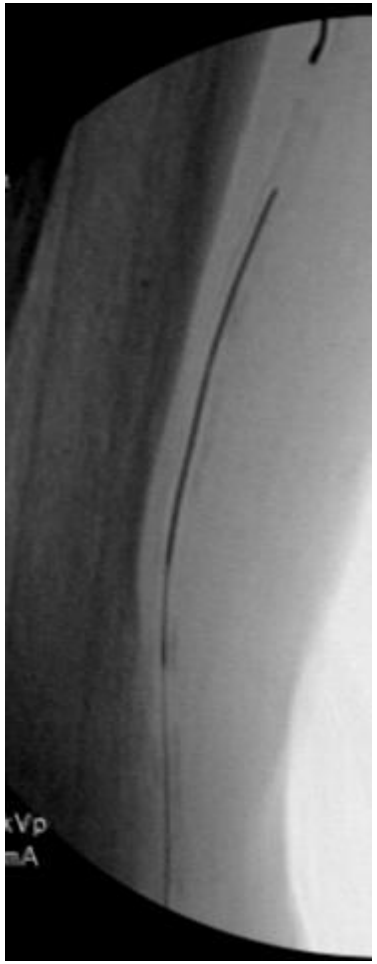
Atherectomy and DCB Angioplasty of Popliteal / TPT / PT

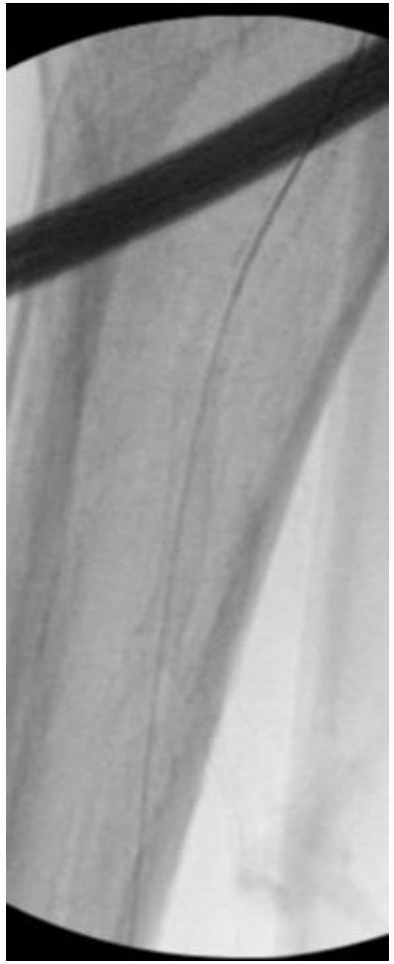






It Wasn’t Enough – Common Plantar Occluded Access

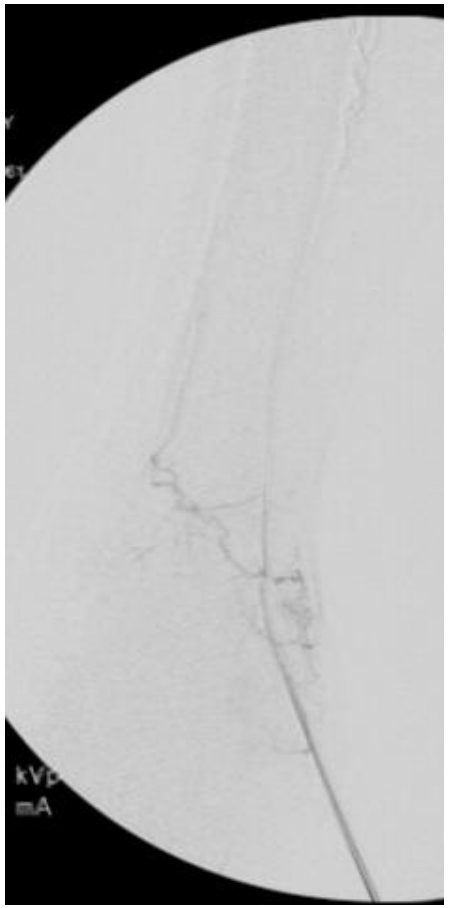


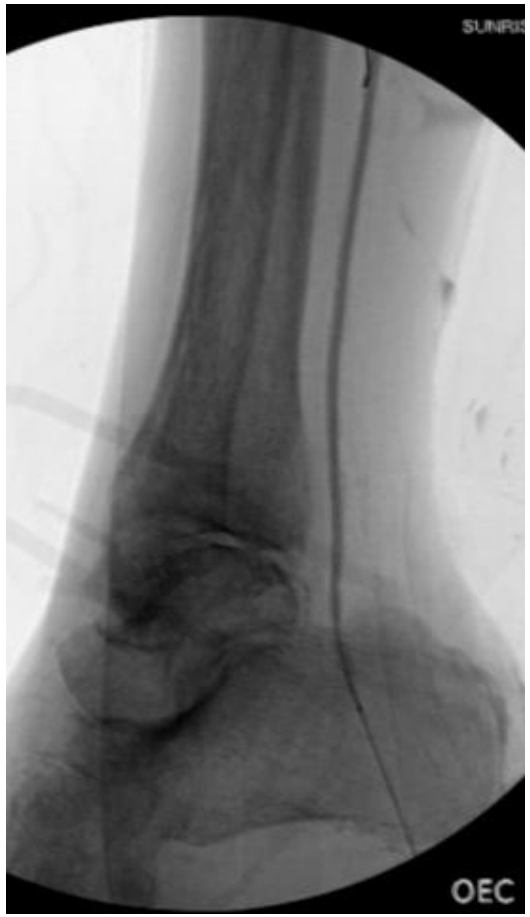




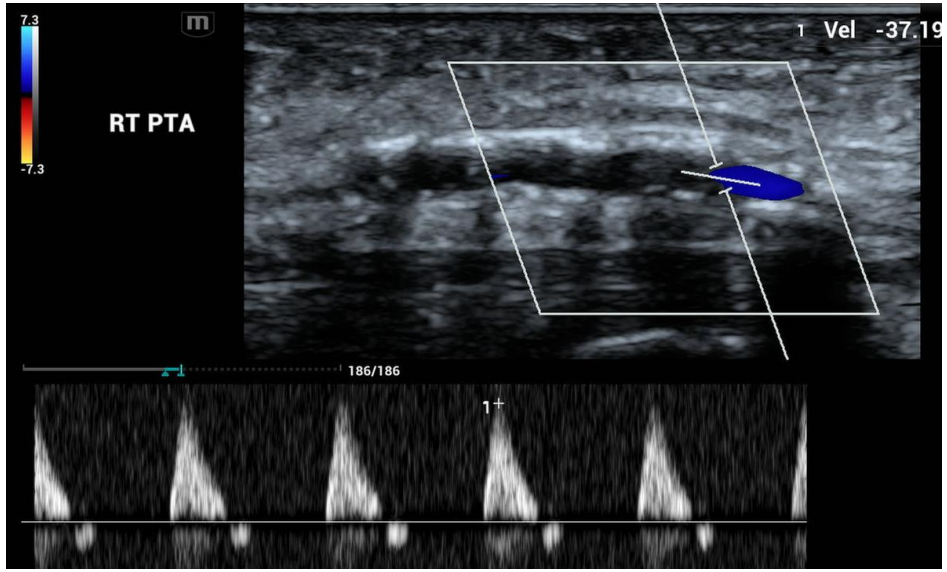


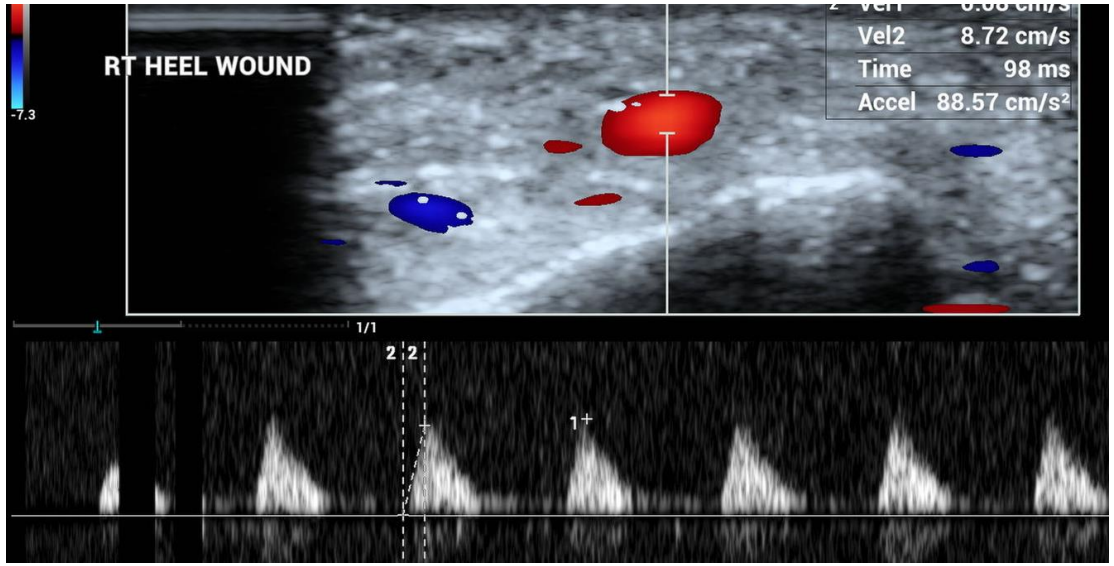
It Wasn’t Enough – Plantar Occluded Access

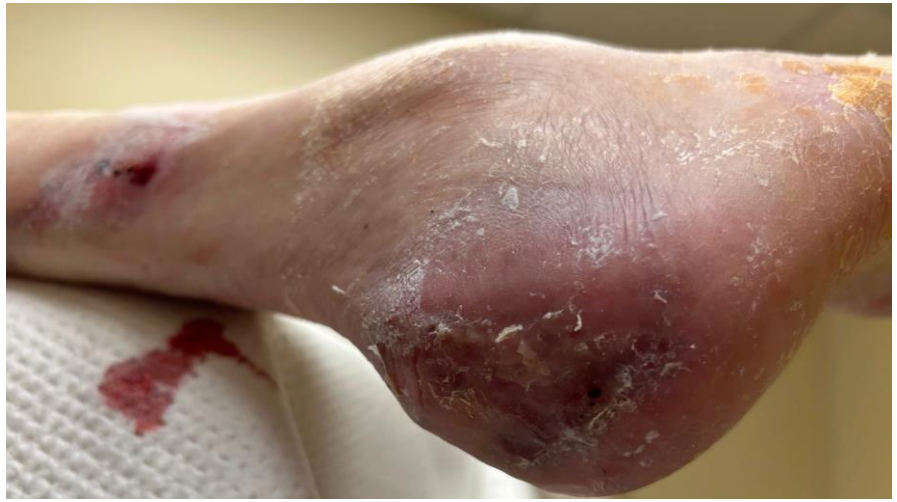




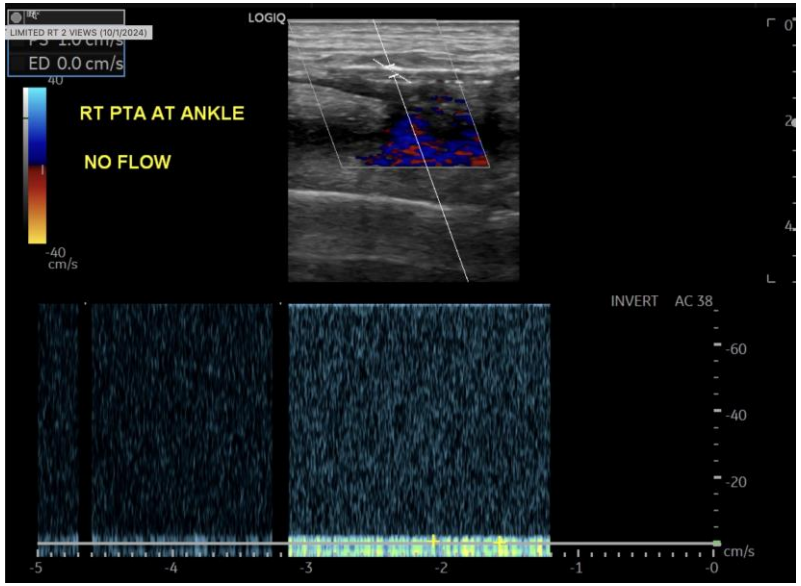
8 Weeks Later…. Full Healing

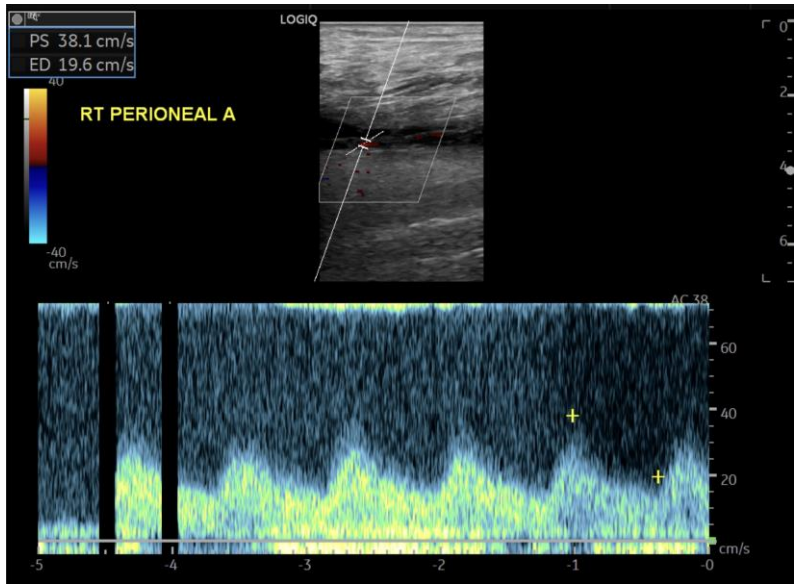


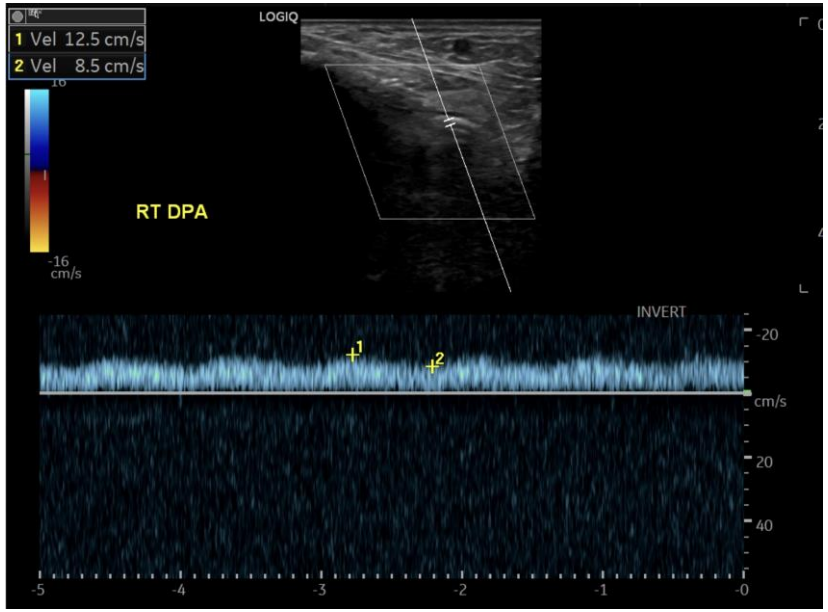




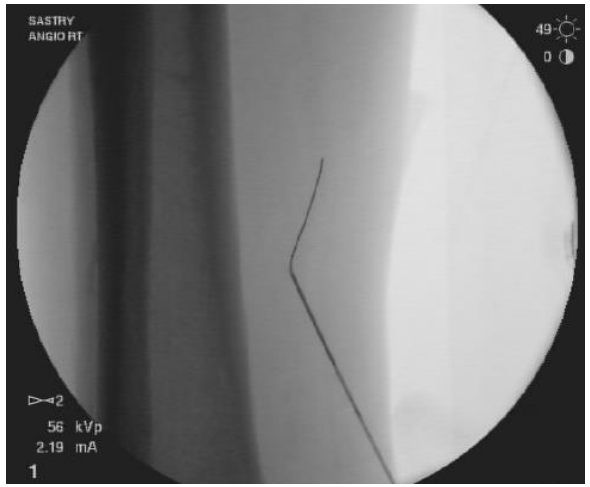
Case 3 – Three Vessel Tibial Occlusion Minimal Reconstitution

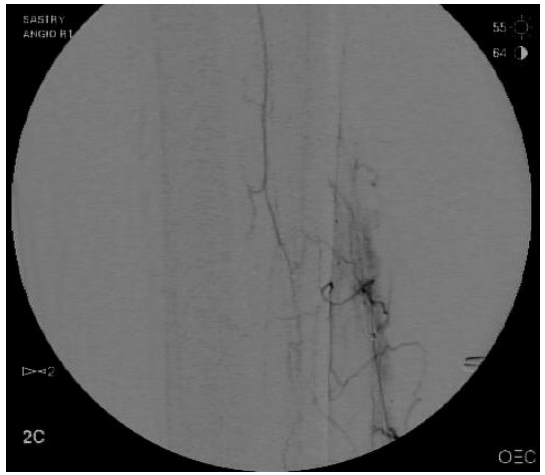


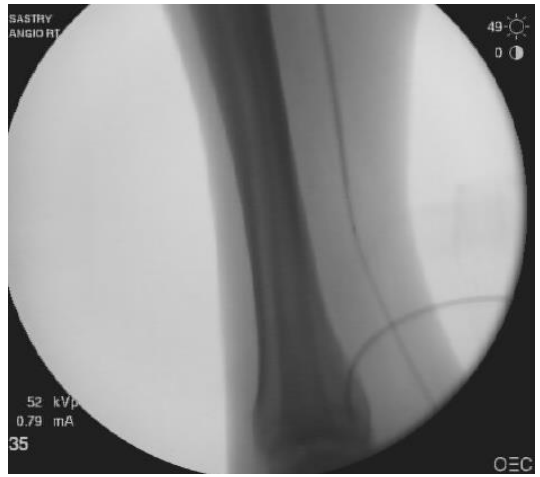


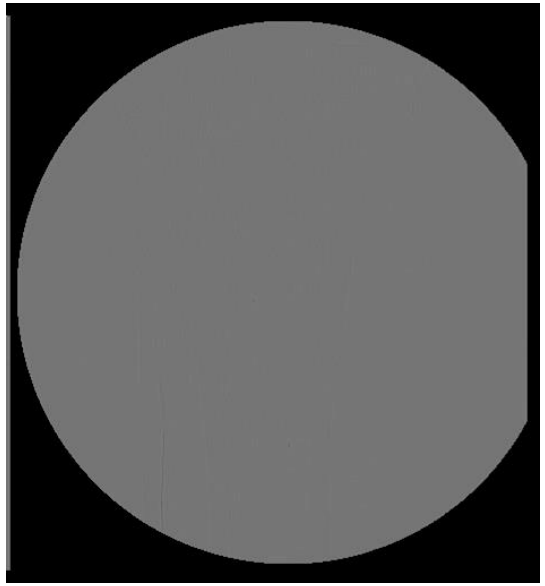


Initial Access – Occluded Vessel Access of Posterior Tibial

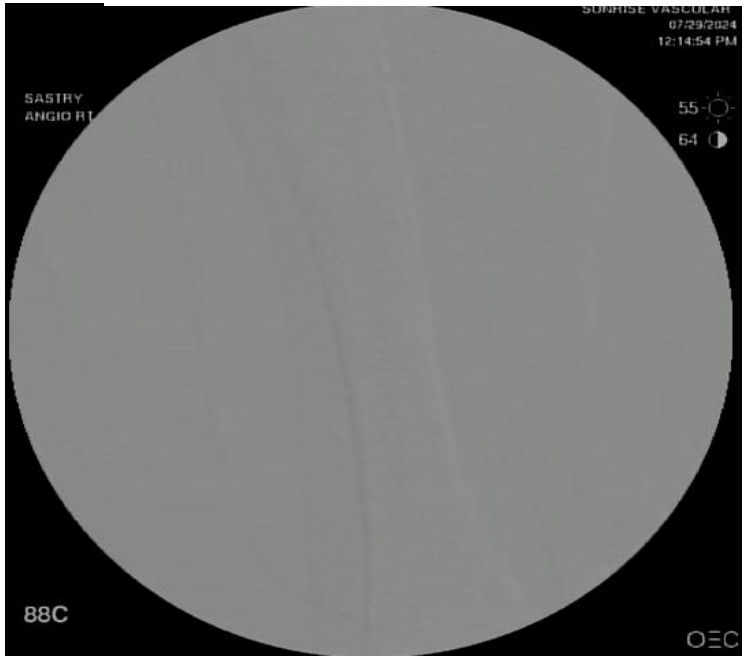


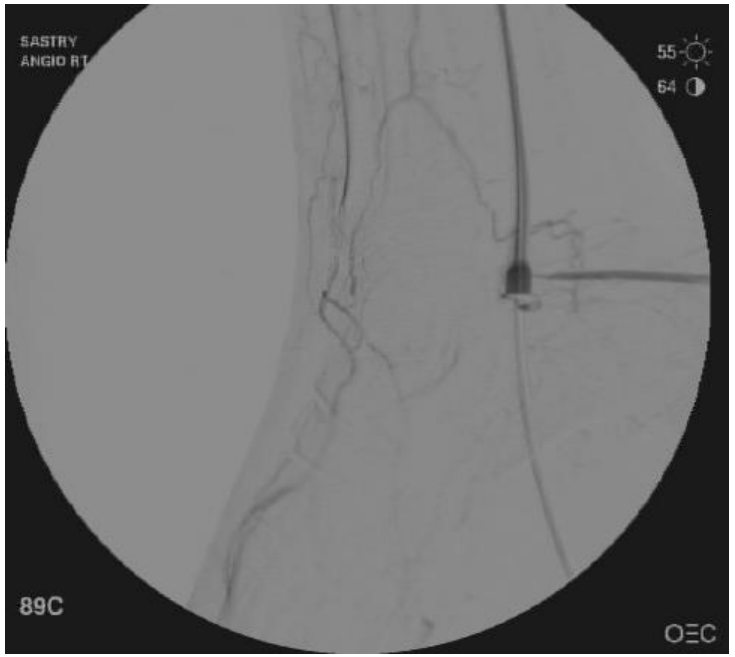


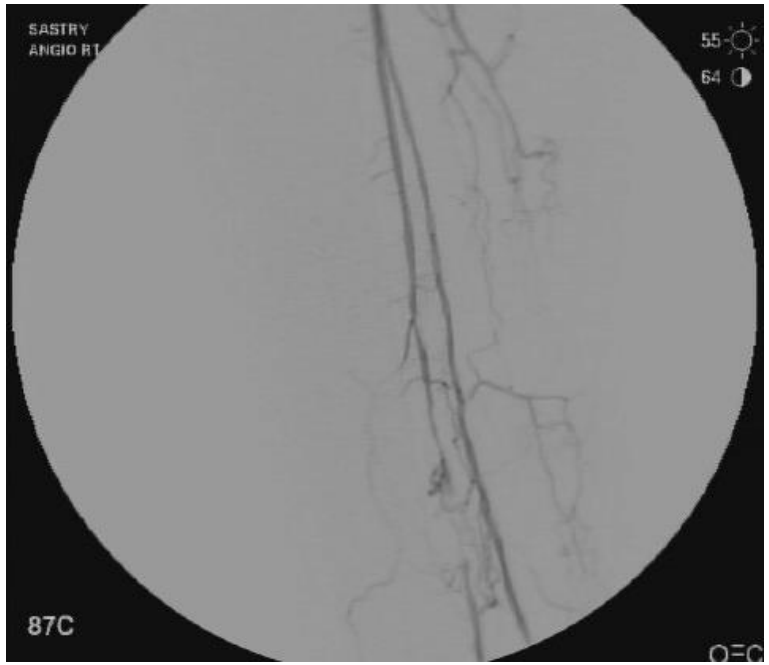




Spex LP 18 at Popliteal Level – Define Anatomy

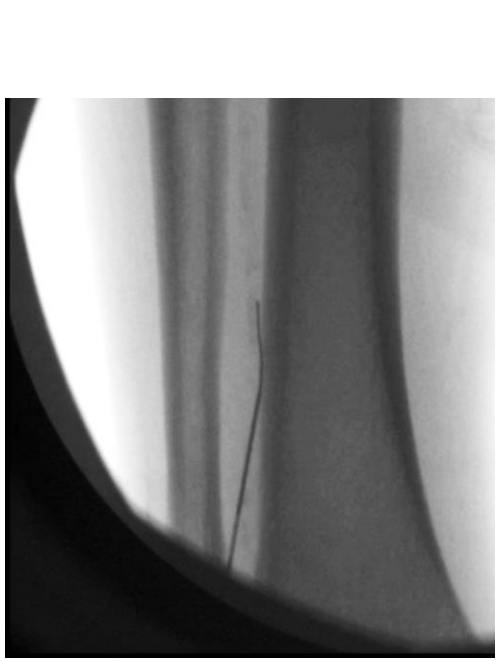
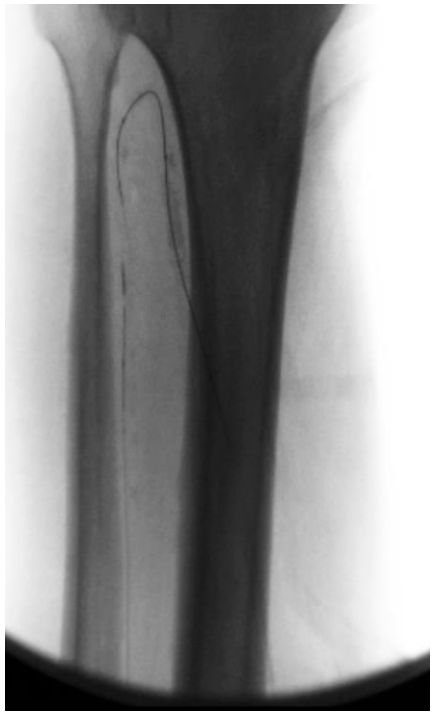
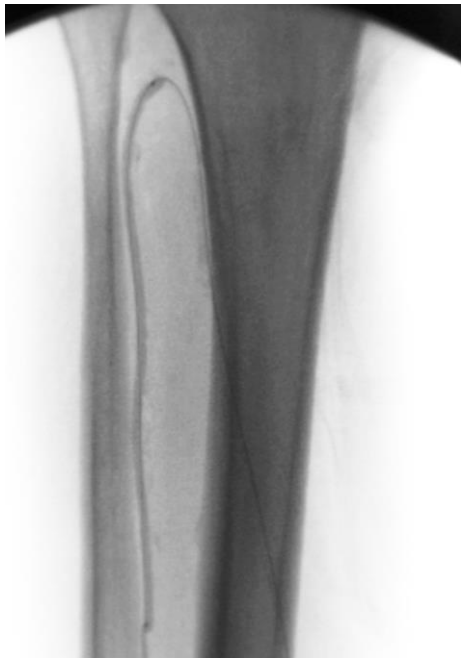
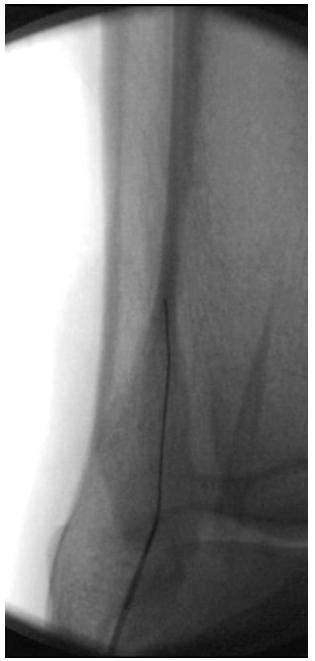
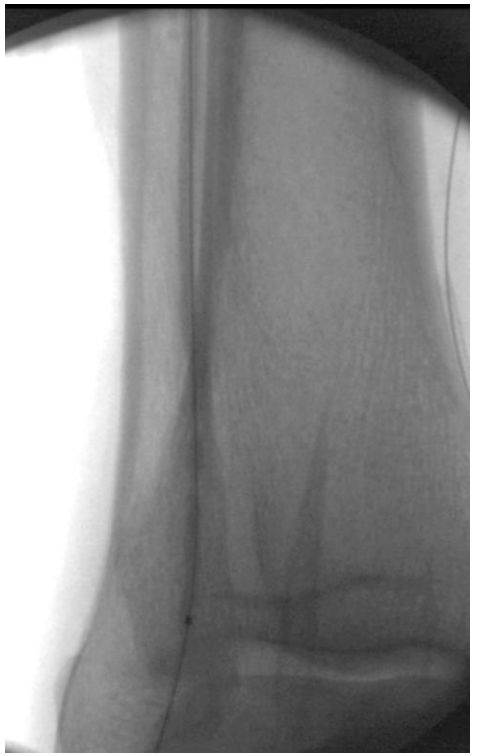




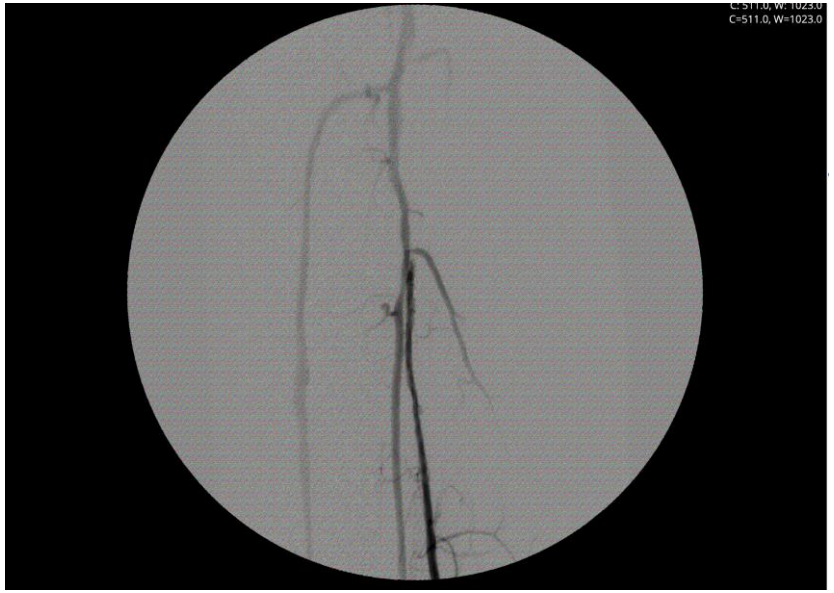


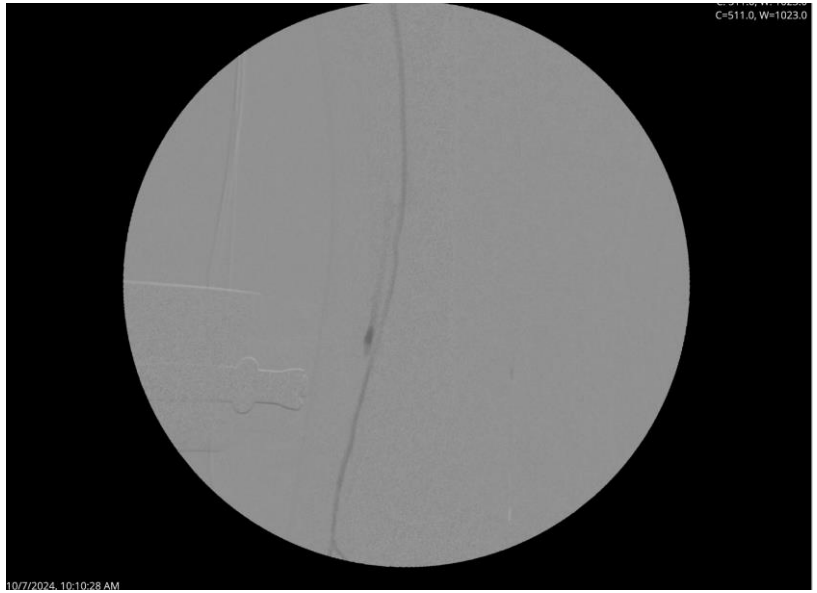
Crossing Devices for Complex Tibial Anatomy

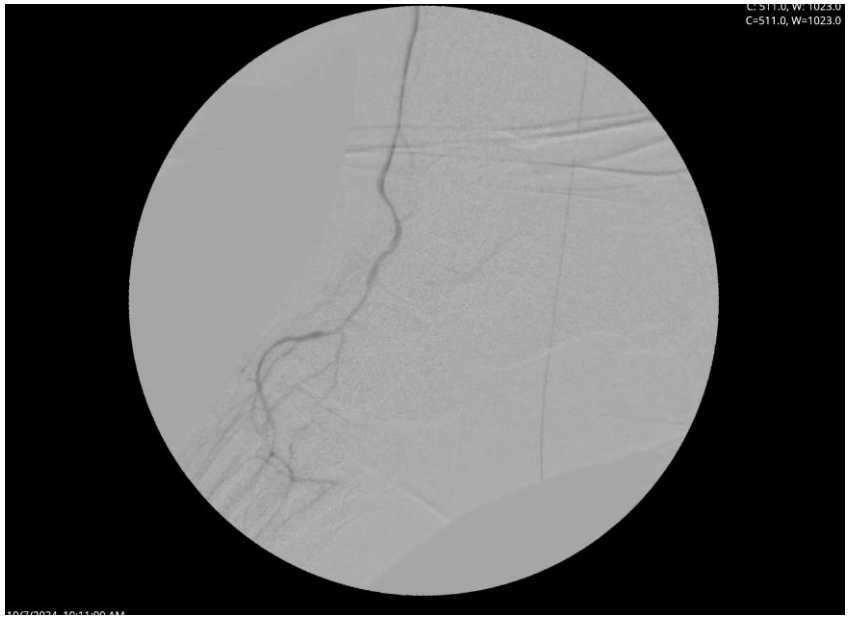
Second Occluded Vessel Access AT / Double Balloon Angioplasty

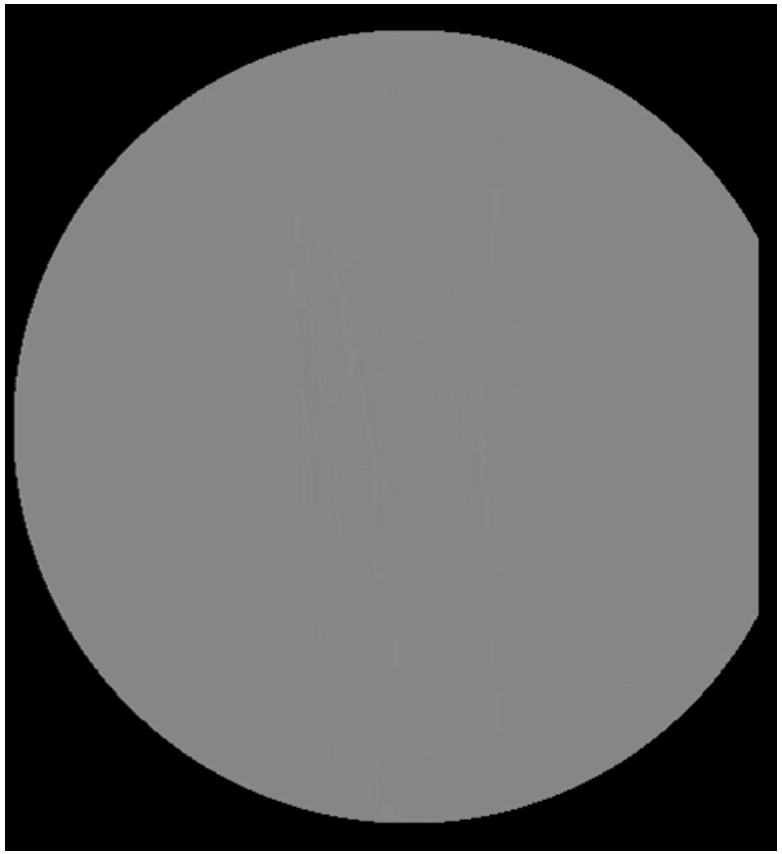
Final Angiography with Recanalized ATA

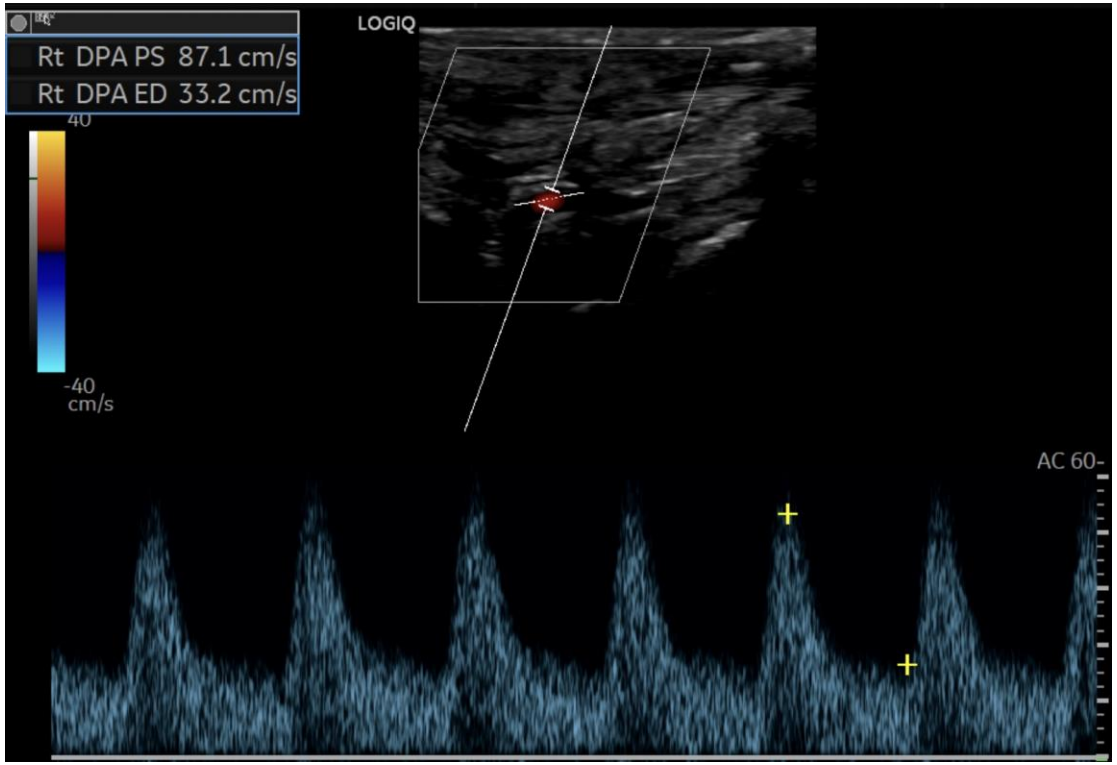






Dual Access / Double Balloon Can Also Be Performed





Crossing and Treating Long Segment Tibial Occlusions

- Consider occluded vessel access as primary access point when disease is predominantly tibial
- Minimize access size for patent tibial access to minimize risk of access point occlusion
- Multiple tibial access points can be safely utilized with occluded vessel access
- Switch strategy quickly in order to prevent fatigue and long procedure times
- Wire escalation followed by switch to dedicated crossing device (Wingman)
- Dual access / double balloon technique is possible even without femoral access (Spex LP)
- Recanalization distal to occluded vessel access is possible without femoral access