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**26 & 27 septembre
2024**

SESSION ARTÈRES DES MEMBRES INFÉRIEURS REPONSE AU CAS CLINIQUE

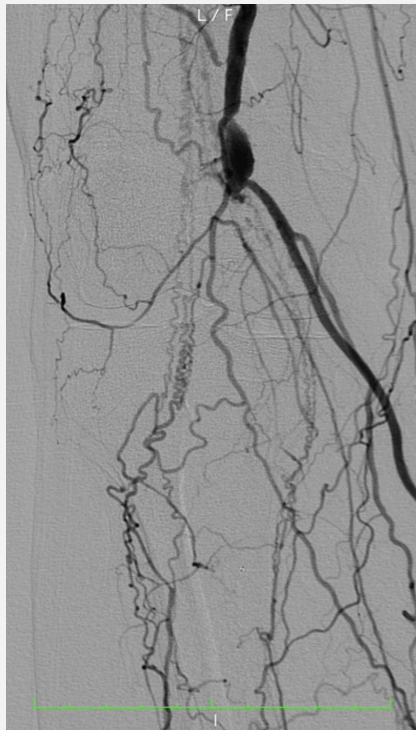
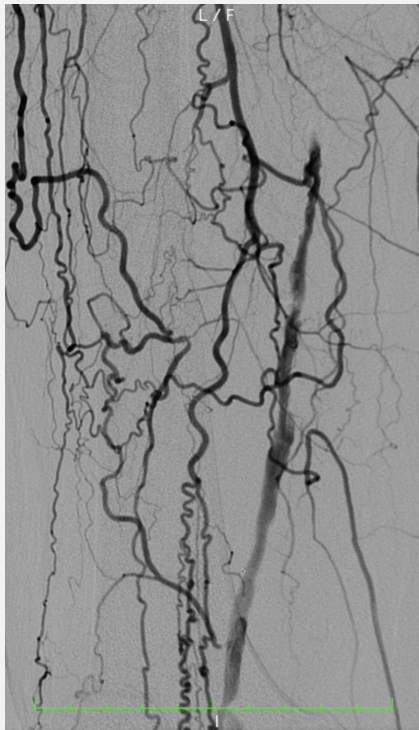
Rhena
CLINIQUE DE STRASBOURG

Philippe CHAMMAS
Dr. Junior, radiologue interventionnel
ICS - Clinique Rhéna

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Institut
Cardiovasculaire
de Strasbourg

Rappels

❖ Contexte : homme 80 ans, stenté coronaire, AO MI bilatérale stade IV à droite

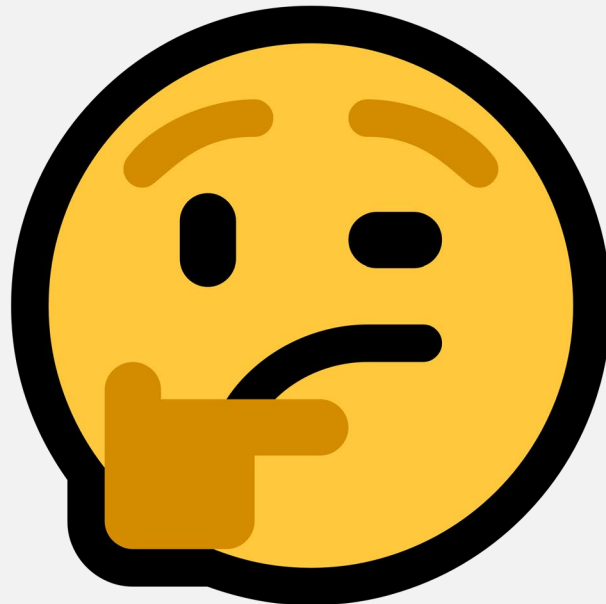


❖ Imagerie :

artères calcifiées +++

occlusions FS - poplitée - trifurcation jambière

QUE FAIRE ?



CHIRURGIE

❖ Occlusion longue → pontage chirurgical

- fémoro-poplitée ?
- fémoro-fibulaire ?

❖ Mais :

- état de la veine saphène ?
- patient opérable ?

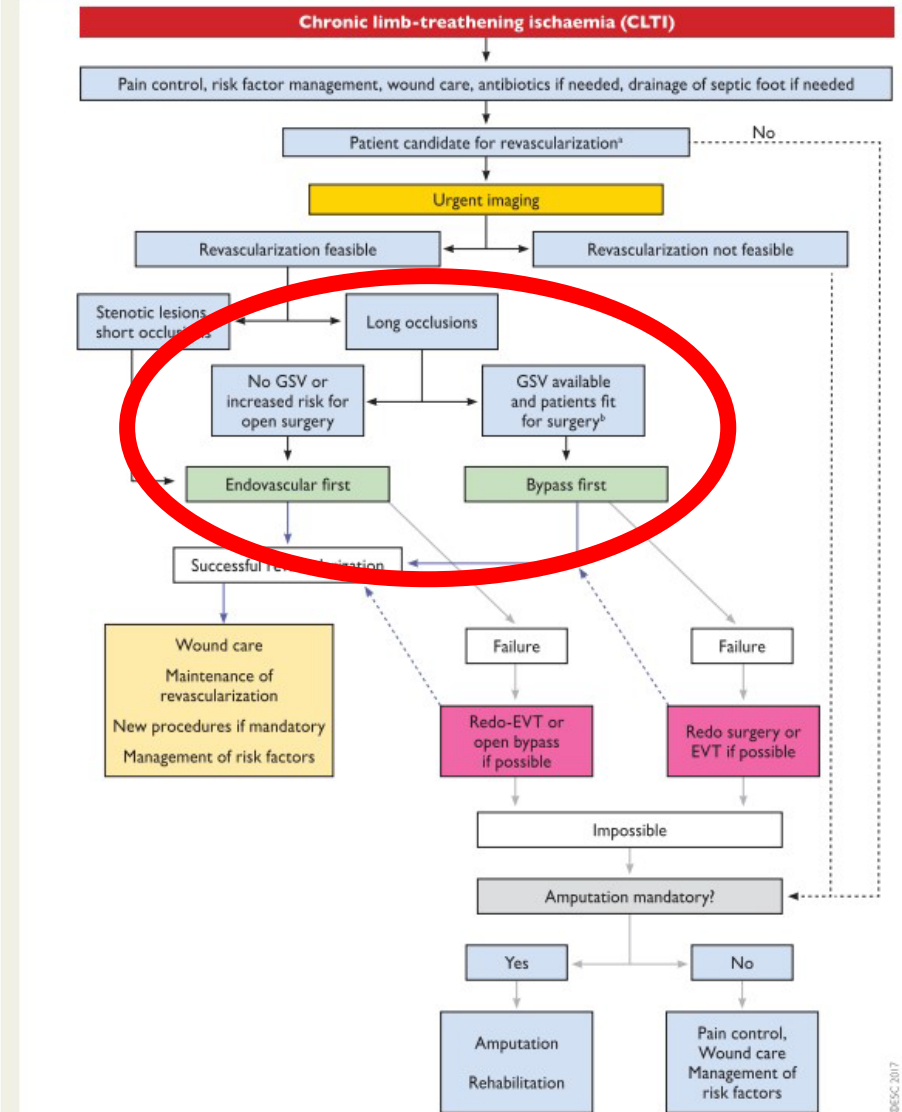


Figure 6 Management of patients with chronic limb-threatening ischaemia. EVT = endovascular therapy; GSV = great saphenous vein.

*In bedridden, demented and/or frail patients, primary amputation should be considered.

^bIn the absence of contra-indication for surgery and in the presence of adequate target for anastomosis/runoff.

❖ Objectif n°1 : remettre en charge la poplitée

❖ Elaboration d'une stratégie

1. Choix de la voie d'abord
2. Franchissement de la lésion
3. Préparation du vaisseau
4. Traitement de la lésion

TRAITEMENT ENDOVASCULAIRE

1. Choix de la voix d'abord

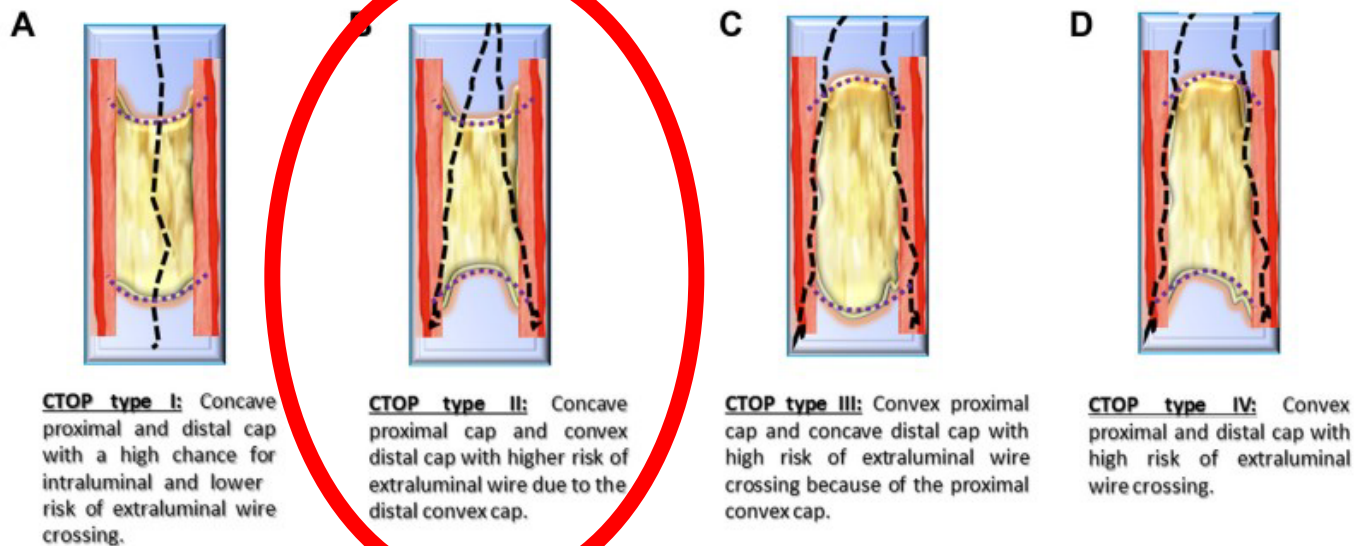
- ❖ Occlusion AFS proximale → fémoral rétrograde gauche et crossover
- ❖ Anticiper les difficultés → abords rétrogrades Hunter et fibulaire

Review > JACC Cardiovasc Interv. 2023 Feb 13;16(3):317-331. doi: 10.1016/j.jcin.2022.11.036.

Crossing Algorithm for Infrainguinal Chronic Total Occlusions: An Interdisciplinary Expert Opinion Statement

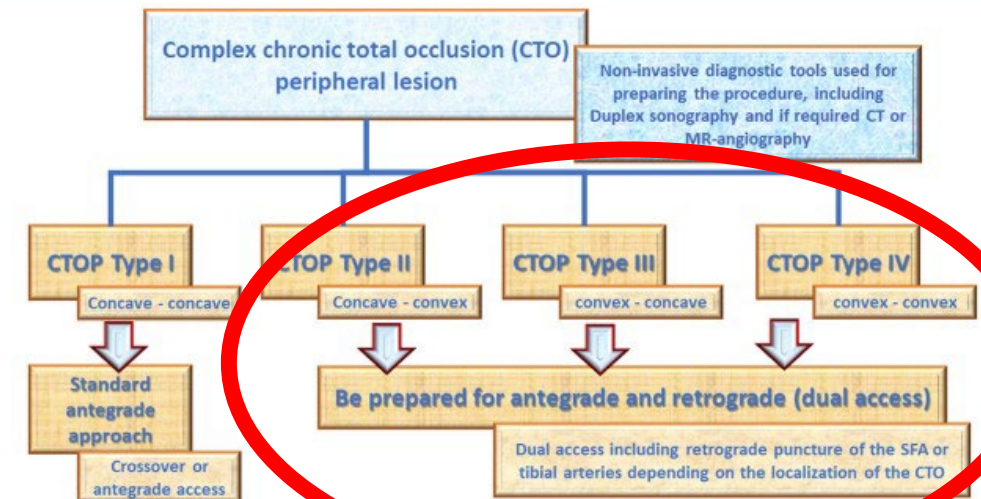
Grigorios Korosoglou¹, Andrej Schmidt², Michael Lichtenberg³, Giovanni Torsello⁴, Gerd Grözinger⁵, Jihad Mustapha⁶, Ramon L Varcoe⁷, Thomas Zeller⁸, Erwin Blessing⁹, Ralf Langhoff¹⁰

FIGURE 1 CTOP Classification System, Based on the Morphology of the Proximal and Distal Cap



Based on the morphology of proximal and distal caps of chronic total occlusions, the chronic total occlusion based on plaque cap morphology (CTOP) classification system has been developed. The morphologic appearance of the proximal and distal cap of chronic total occlusion lesions is considered. Four scenarios have been described, with ascending numbers (I to IV), being related to proximal and distal cap morphology.

FIGURE 2 Recommendations for Preprocedural Planning Based on the CTOP



(adapted from Saab et al¹⁴).

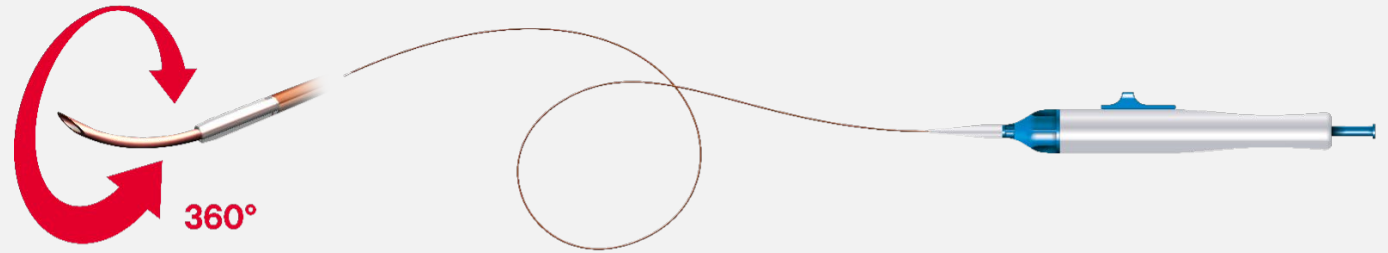
Based on the chronic total occlusion (CTO) based on plaque cap morphology (CTOP) classification and on other angiographic parameters, such as the presence of a flush occlusion, the presence of collaterals at the area of the proximal cap etc., a liberal retrograde or bidirectional approach needs to be considered, especially in type III and IV lesions. CT = computed tomography; MR = magnetic resonance; SFA = superficial femoral artery.

TRAITEMENT ENDOVASCULAIRE

2. Franchissement

❖ Cathéter de support :

- sonde 4F
- microKT de franchissement
- ballon d'angioplastie
- système de réentrée



❖ Choix du guide :

- 0.035, 0.018 et 0.014
- franchissement (ex : Connect 250T, Winn 200T, Halberd...)

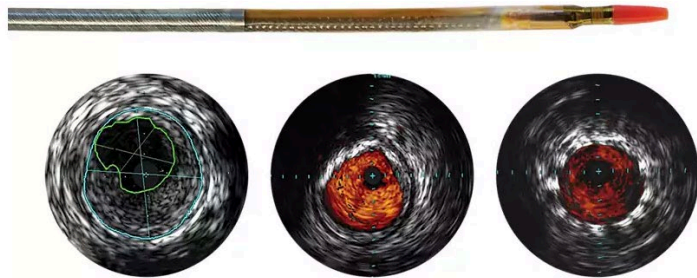


TRAITEMENT ENDOVASCULAIRE

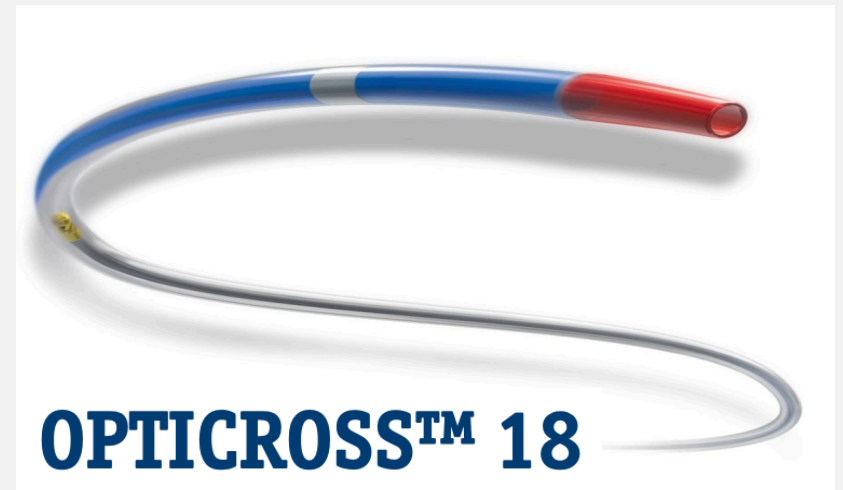
2. Franchissement

- ❖ Type de recanalisation : endoluminale vs. sous-intimale
- ❖ Comment le vérifier ?

→ IVUS



Reconnaissance PV .018 OTW



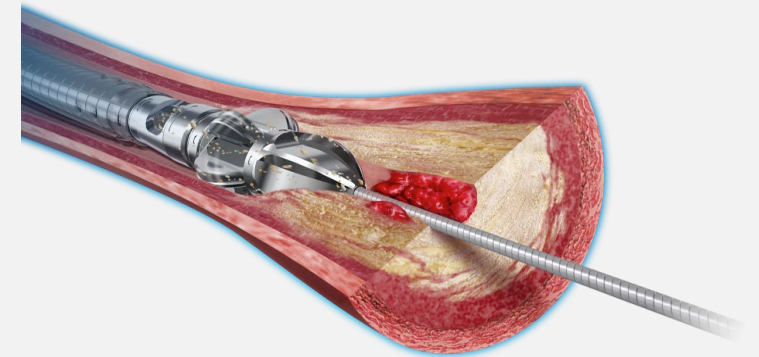
TRAITEMENT ENDOVASCULAIRE

3. Préparation et traitement du vaisseau

😄 1^{ER} SCENARIO = LA PERFECTION 😄

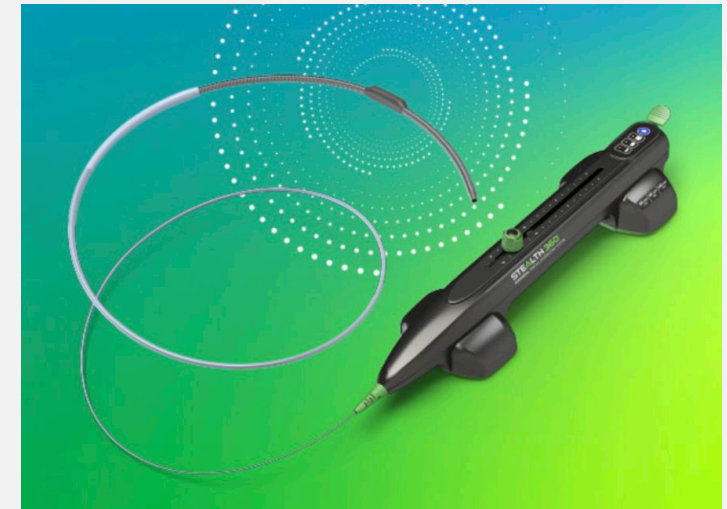
❖ Recanalisation endoluminale → **athérectomie** possible !

- orbitale (Stealth, Abbott)
- rotationnelle avec aspiration (Jetstream, Boston)



❖ Contrôle post-POBA : « leave nothing behind »

- DEB



TRAITEMENT ENDOVASCULAIRE

3. Préparation et traitement du vaisseau

😭 2^{ÈME} SCÉNARIO = LA RÉALITÉ ? 😭

❖ Recanalisation sous-intimale → **athérectomie interdite !**

- lithotripsie intravasculaire possible (Shockwave)

❖ Contrôle post-PO BA : dissections, sténoses résiduelles ... → stenting

- endoprothèse couverte (Viabahn, Gore)
- stent mimétique (Supera, Abbott)
- stent actif (Eluvia, Boston)

The GORE® VIABAHN® Endoprosthesis with PROPATEN Bioactive Surface* has demonstrated excellent patency and durability independent of lesion length^{4, 10-13}

SPORTS confirms that Eluvia is the definitive treatment for long complex lesions in the SFA²⁻¹¹

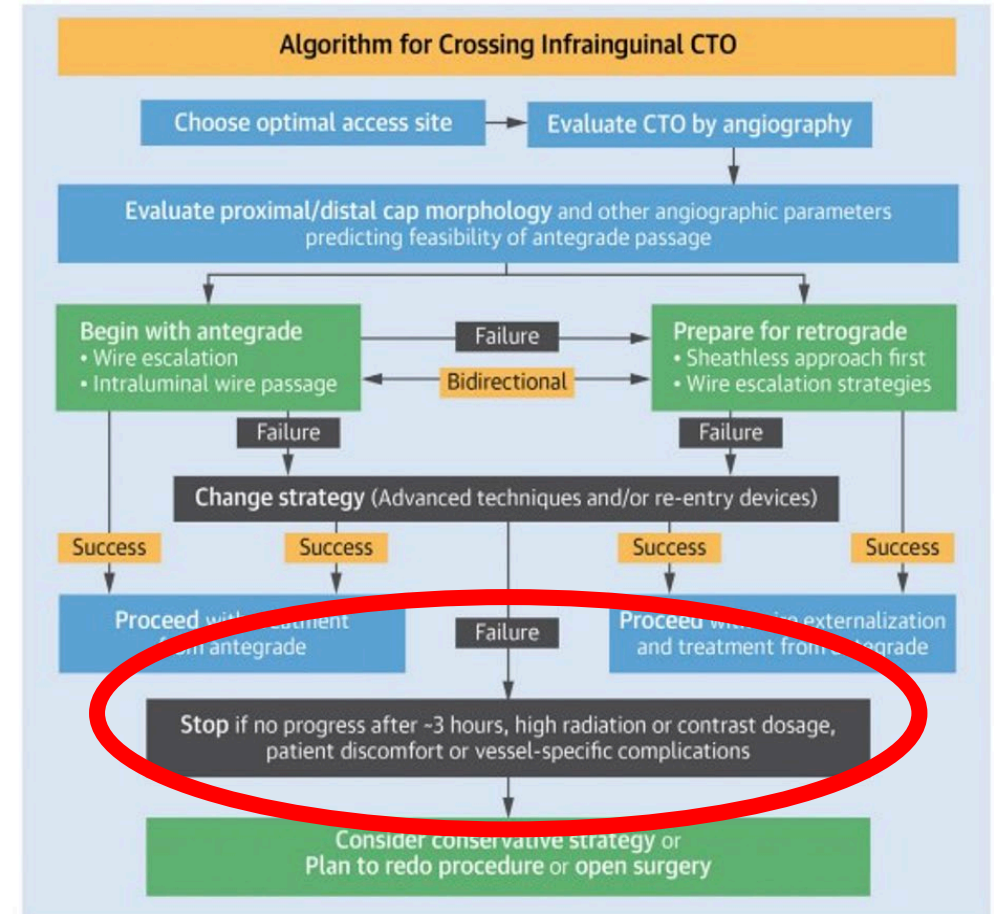
Excellent Patency in Both Simple and Complex Lesions

Whether treating simple (TASC A&B) or complex (TASC C&D) lesions, the Supera™ Stent is associated with impressive, consistent patency performance data.^{2-4,21}

TRAITEMENT ENDOVASCULAIRE

- ❖ Objectif n°2 : quand faire la recanalisation poplitée et fibulaire ?
- ❖ Stratégie
 1. abord → rétrograde +++
 2. franchissement → guide 0.014
 3. préparation et ttt du vaisseau (cf. scénarios précédents)

CENTRAL ILLUSTRATION CTO Crossing Algorithm



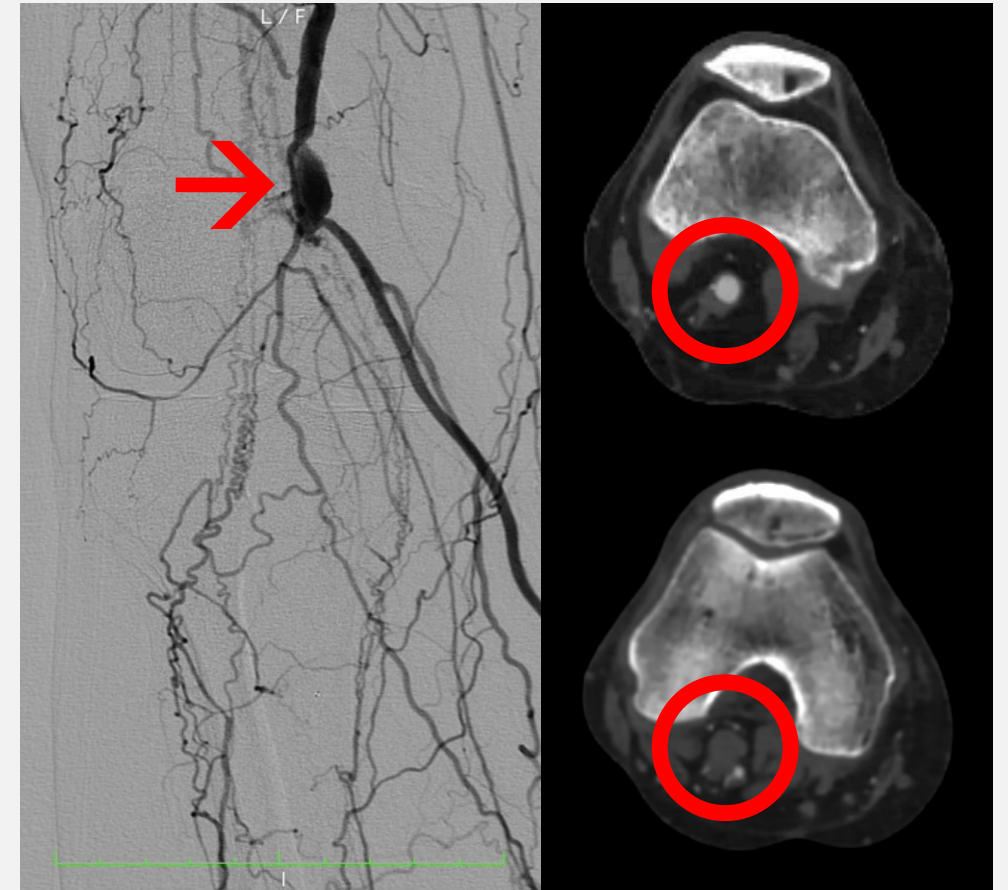
Korosoglou G, et al. J Am Coll Cardiol Interv. 2023;16(3):317-331.

The chronic total occlusion (CTO) crossing algorithm encompasses antegrade, retrograde, bidirectional, and advanced techniques for the endovascular repair of complex infrainguinal CTOs. The corresponding steps and considerations include preprocedural planning, angiographic evaluation of the lesion and of distal vasculature, ante- and retrograde wiring, including wire escalation and re-entry techniques, and management of the distal access sites.

TRAITEMENT ENDOVASCULAIRE

❖ Objectif n°3 : et cet anévrisme poplitée ?

→ endoprothèse couverte (Viabahn, Gore)



The GORE® VIABAHN® Endoprosthesis is an established PAA treatment option associated with short and mid-term clinical results that are comparable to surgical bypass.²⁻⁷

EN CONCLUSION

- ❖ Occlusion longue et complexe : considérer la chirurgie et le traitement endovasculaire
- ❖ Elaborer une stratégie
- ❖ Savoir s'adapter aux résultats plus ou moins bons, continuer ou s'arrêter au bon moment