WHERE TO PUT SHEATH IN WHEN NEITHER IPSILATERAL CFA NOR CONTRALATERAL CFA IS POSSIBLE?

63 YEAR-OLD MAN UNDERWENT FEMERO-FEMERAL BYPASS, RIGHT CFA ENDARTERECTOMY, BALLOON ANGIOPLASTY AND STENTING OF RIGHT EXTERNAL ILIAC ARTERY AND DISTAL SFA, CATHETER DIRECTED THROMBOLYSIS FROM THREE OPERATIONS.

He has had acute-onset right leg pain and dry gangrene of big toe for 1 month. CTA showed thrombosis along right SFA to popliteal artery, occlusion of left iliac artery and bypass graft. (Fig.1) Mid SFA was punctured retrogradely into thrombus to insert 4-Fr sheath. (Fig.2) Small piece of thrombus was aspirated. Hard end of Terumo wire penetrated through organized thrombus. CDTs failed. CFA and SFA was opened with 4Fr 4mm balloon. (Fig.3) Six-Fr sheath couldn’t be inserted antegrade in ipsilateral CFA due to previous scar and big belly, then was placed in proximal SFA. Wire couldn’t passed distal SFA. (Fig.4) Retrograde puncture was done at posterior tibial artery. With CART by 5mm balloon, reversed CART by 3mm balloon, double CART and rendezvous technique, Command-18 wire with Rubicon catheter from foot could be snared in Vertebra catheter. (Fig.5) Five-mm. balloon was inflated along SFA. Wire was unintentionally lose and stuck at reentered point in SFA. With many attempts, Command-18 was steered through reentered point. Stent was placed at reentered site. (Fig.6) Posterior tibial artery developed spasm around puncture site then nitroglycerine was injected. Puncture sites were successfully compressed at proximal SFA and internally compressed by balloon at mid SFA. Posterior tibial artery gained strong pulse. Stump of amputated big toe had good granulation.

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