Video Live case
-complex FP lesion with severe CKD-

1 Asahi General Hospital, Cardiology, Chiba, Japan, 2 Radiology

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Disclosure

Speaker name:

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I have the following potential conflicts of interest to report:

☐ Consulting
☐ Employment in industry
☐ Stockholder of a healthcare company
☐ Owner of a healthcare company
☐ Other(s)

☐ I do not have any potential conflict of interest
Video Live Case

【Case】 A 50’s male

【Chief Complaint】 Severe claudication

【Dx】 ASO (Rutherford-3)

【Past medical history】
HTN, DM, DL, OMI(post PCI), CKD

【Pre Cre/eGFR】
1.67 mg/dl, 34.7 ml/min/1.73m²

【ABI】
Rt 1.06, Lt 0.73

【Duplex echo】
Lt SFA proximal to distal(nearly P1) 100%
How to treat

#1 long SFA CTO
Proximal & distal landing (+)
Severe calcification(-)

#2 Patient’s background
1st time endovascular treatment
Claudicant
Reratively young patient
History of self-interruption

Treat “leave nothing behind” strategy by DCB after intraplaque wiring

#3 CKD
To prevent renal insufficiency

Use contrast medium as little as possible
Case Summary

① Bi-directional wiring with IVUS guided
→ All intraplaque wiring within relatively short time

② Long balloon step up + additional scoring balloon + DCB
→ Get sufficient luminal gain with small dissection
→ To achieve “leave nothing behind”

③ Diluted contrast angioplasty
→ Reduce the amount of contrast medium without lowering the quality of intervention

Total contrast: 25ml
Total DSA: 22
Contrast per shot: 1.3ml
Fluoro times: 65.3min
DAP: 50.7Gycm2
eGFR: 34.7 → 40.5
ABI(rt): 0.73 → 0.90
Conclusion

• To use DCB after performing intraplaque wiring enables “leave nothing behind” strategy even though long CTO

• How to build retrograde approach is most important point

• Our diluted contrast angioplasty has a possibility of being useful for treating CKD patients.
• Thank you for your attention
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