Ultrasound-guided direct needle engagement for flush-occluded SFA

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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
81 / M Lt. calf claudication
3yrs ago (right toe gangrene)
   Rt Fem-AK pop (PTFE)
   Rt Graft to PTA bypass (GSV)
Flush occluded SFA lesion
Flush occlusion
Ultrasound guided direct needle engagement for flush occluded SFA
75 yrs / male
CC Lt calf claudication (CD 100m)
PHx DM / HTN
Ex-smoker
1. Ultrasound-guided direct SFA access

(1) Affiniti 70 (Phillips), linear probe
(2) Micropuncture set (Cook)
Measurements
- CFA length: 2.8cm
- Depth: 1cm
Measurements

SFA angle

SFA direction

straight needle direction

$\theta$
2. Angioplasty

(1) J shaped Glidewire (Terumo), 0.035
(2) KMP catheter (Cook), 40cm, 5Fr
(3) Pre-balloon, VascuTrak (Bard), 5mm
(4) DES (Eluvia, Zilver PTX, 6mm X 12cm, 3#)
(5) Post-balloon, 5mm
2017/12
Pre-angioplasty

2018/11
1yr FU
• Flush ostial occlusion of the SFA is a frequent cause of failure of endovascular treatment


• Other options:
  (1) Hybrid procedure
  (2) Retrograde popliteal approach
  (3) Propunda anchor technique, etc.

• This technique can be an option to treat flush occluded SFA lesion

• Potential limitations:
  Obesity, High bifurcation, Calcification, and so on
감사합니다
Thank you!
An innovative modification of the retrograde approach to angioplasty and recanalization of the superficial femoral artery (2014, Diagn Interv Radiol, 20, 164)
Advanced SFA lesion

**Troublesome = Access**

**Ipsilateral**
Short working distance
Unstable sheath support

**Contralateral**
Poor pushability
Poor trackability

• Aorto iliac
• Kissing stent...
My first Case

84 yrs / female
CC  Left toe gangrene
PHx  DM / HTN / old CVA / PTCA