Aggressive Below-the-ankle intervention

CCT@LINC, pre-recorded live case

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Disclosure

Speaker name: Tatsuya Nakama MD.

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I have the following potential conflicts of interest to report:

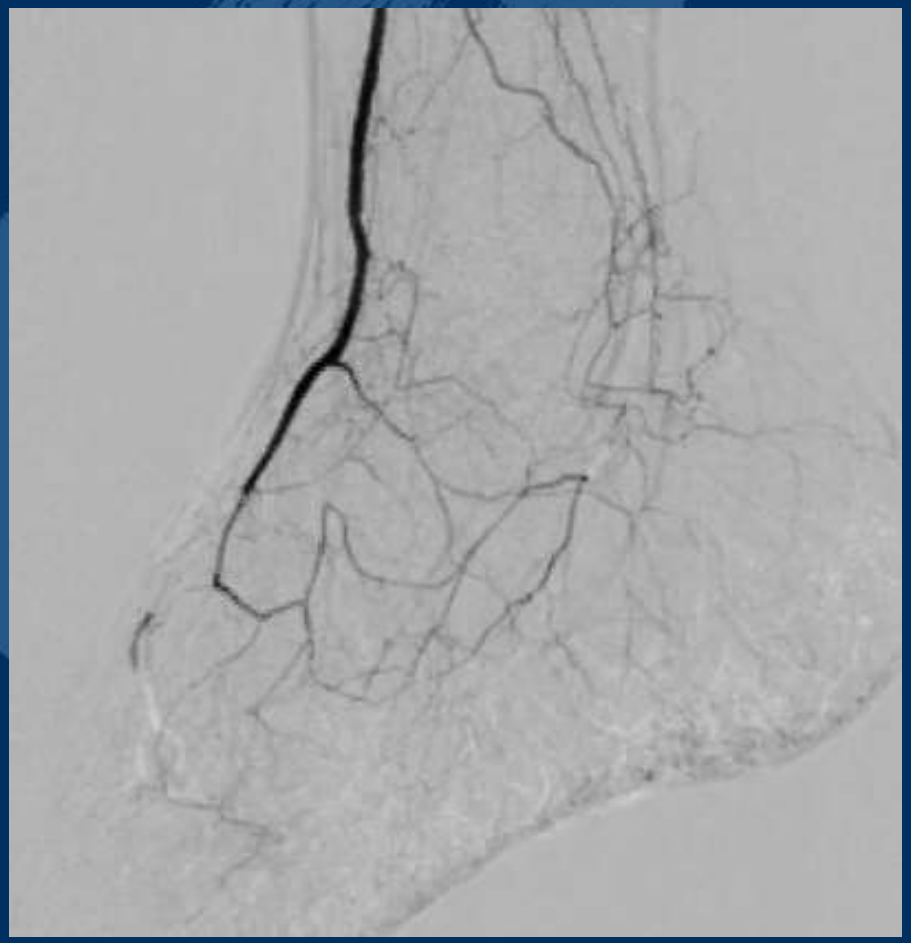
- **Consulting:** Boston Scientific Japan, Century Medical Inc. TORAY
- Employment in industry: None
- Stockholder of a healthcare company: None
- Owner of a healthcare company: None
- **Other(s): Honoraria recieved from**

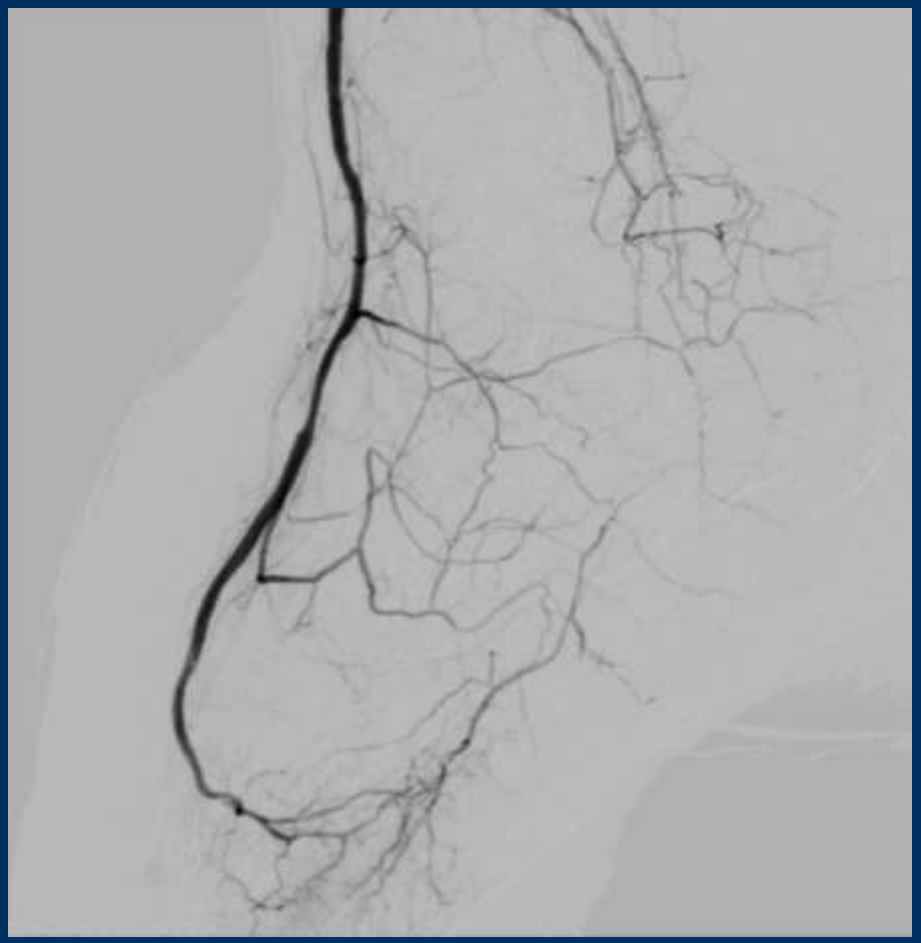
  Abbot Vascular, Asahi Intecc., Boston Scientific, COOK, Cordis, NIPRO, KANEKA, Lifeline, Medikit, Medtronic, Orbus Neichi, Terumo,

Why below-the-ankle EVT needed?

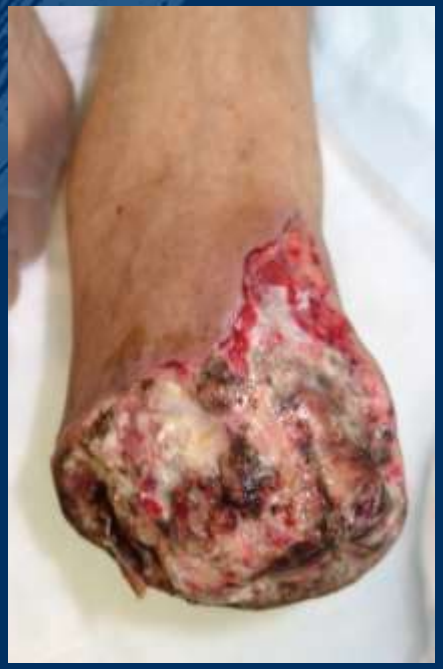
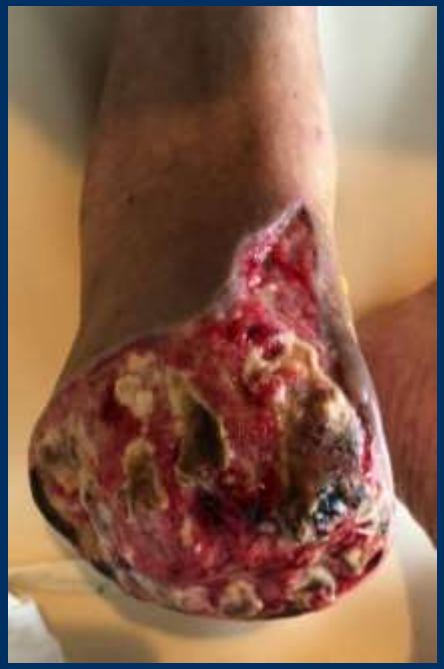
What is the clinical **Implication** of **Challenging** procedure

Aggressive BTA revascularization



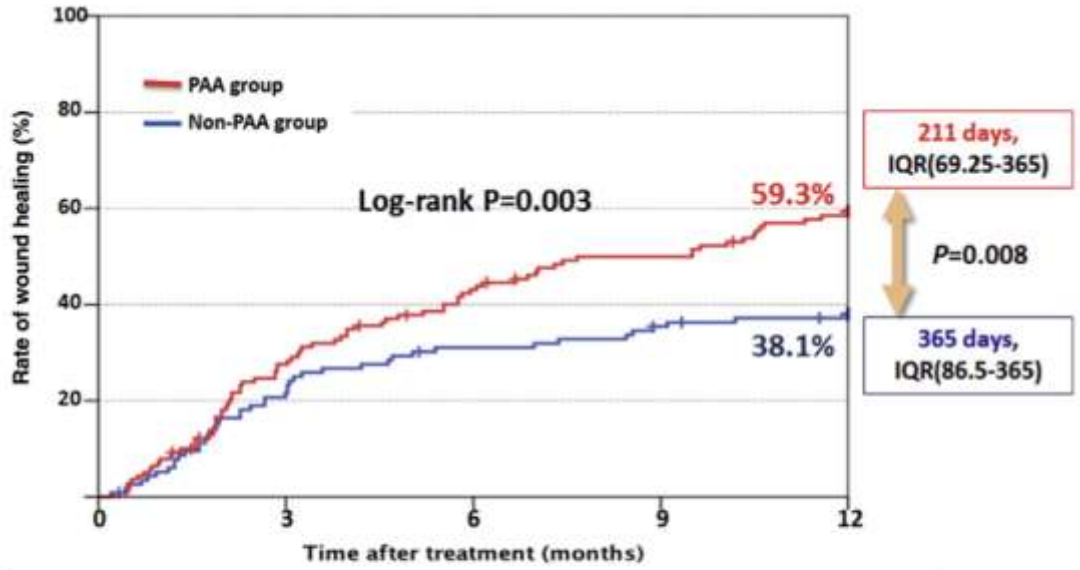


Improvement of wound healing


Higher rate of wound healing &
Shorter time to wound healing

Real world evidence showed its efficacy



Interval (months)		0	3	6	9	12
PAA group (n= 140)	at risk	140	99	75	65	52
	%	0.0	28.3	43.8	49.9	59.3
Non-PAA group (n= 117)	at risk	117	88	79	72	68
	%	0.0	24.1	31.0	36.3	38.1

Higher

Rate of wound healing

59% vs. **38**%

Faster

Time to wound healing

211d vs. **365**d

Nakama T, et al. J Am Coll Cardiol Intv 2017; 10: 79-90

Should we treat all BTA disease?

No!!

BTA intervention include important **problems**

Differences between BTK and BTA

BTK

1. Antegrade approach: standardized
2. Retrograde approach: standardized
3. Calcified lesion → unsolved

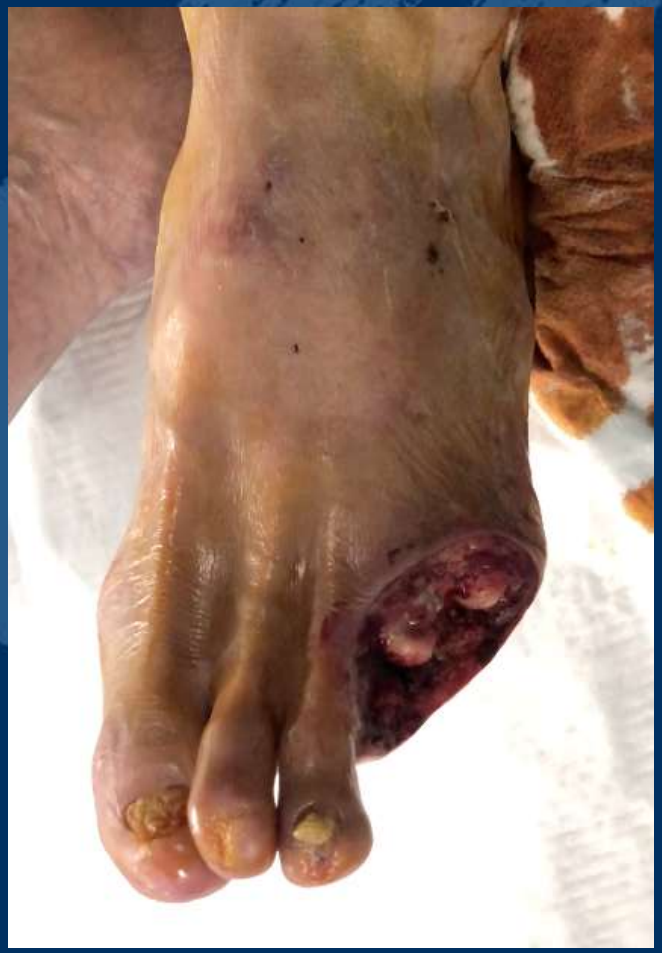
Almost standardized procedure

BTA

1. Antegrade difficult anatomy
2. Retrograde sometimes impossible
3. Calcified lesion → of course unsolved

Procedure sometimes fail

Case overview



80s female on hemodialysis

- Ischemic gangrene in her 4th and 5th toe with infection
- Rutherford 5
- W:2, I:3, FI:2 (**Clinical stage4)**
- CRP: 15mg/dl

- Toe Amputation was already conducted 2days ago.

Summary of pre-recorded procedure

1. ATA to DP was recanalized with conventional technique (bi-directional approach with distal puncture and retrograde subintimal angioplasty). **Common procedure**

2. ATA to pedal arch recanalization seemed impossible, PTA to plantar revascularization was done.

3. PTA to plantar was revascularized but these procedure was not standardized. **Uncommon, challenging procedure**

Future of BTA intervention

1. Evaluation of **clinical value of BTA intervention**
   it may improve the direct flow to wounds, and
   it may positively affected the process of wound healing

2. Technique for BTA recanalization is not standardized yet.

3. Technique for BTA revascularization should be established, like BTA intervention.

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