BOLDY go where no man has gone before… BTK extreme

Metatarsal artery puncture and more…

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Disclosure

Speaker Name: Tatsuya Nakama MD.

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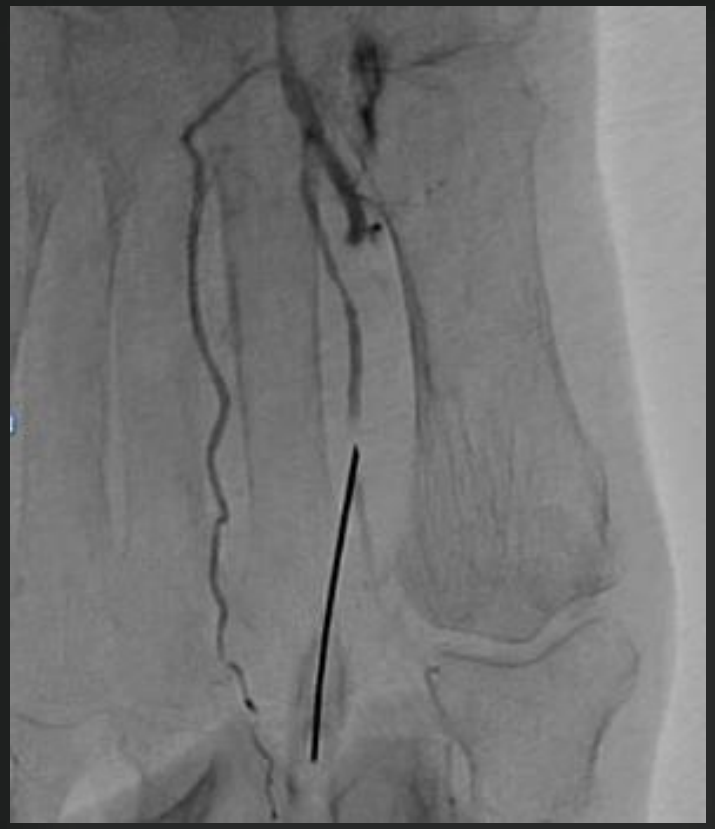
I have the following potential conflicts of interest to report:

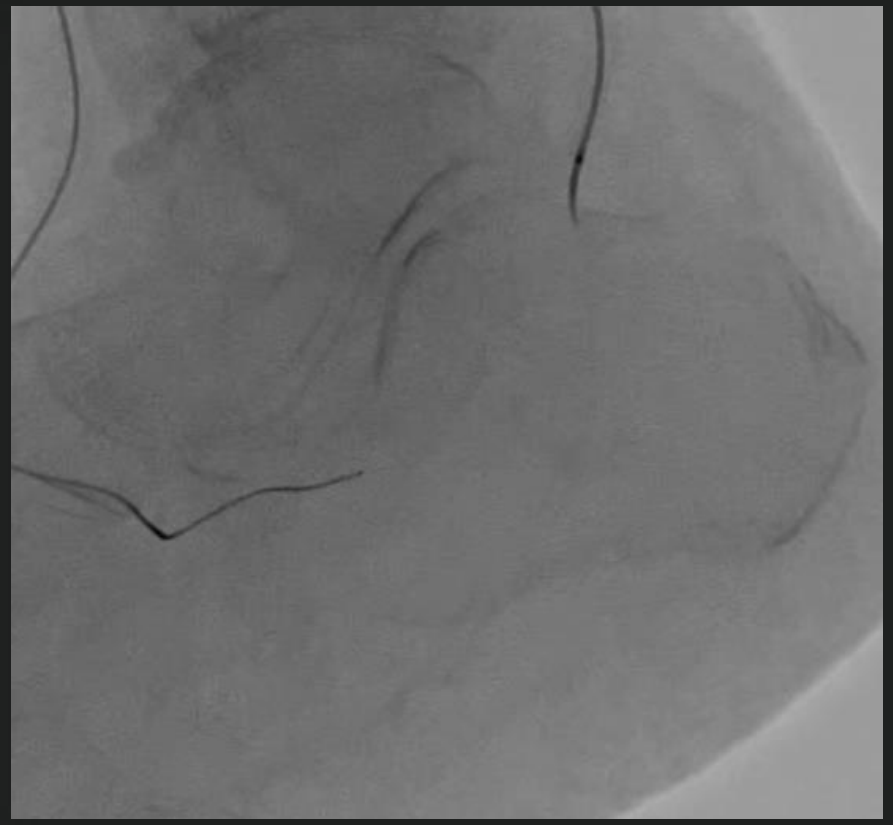
- **Consulting:** Boston Scientific Japan, Century Medical Inc. TORAY
- Employment in industry: None
- Stockholder of a healthcare company: None
- Owner of a healthcare company: None
- **Other(s): Honoraria recieved from**

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

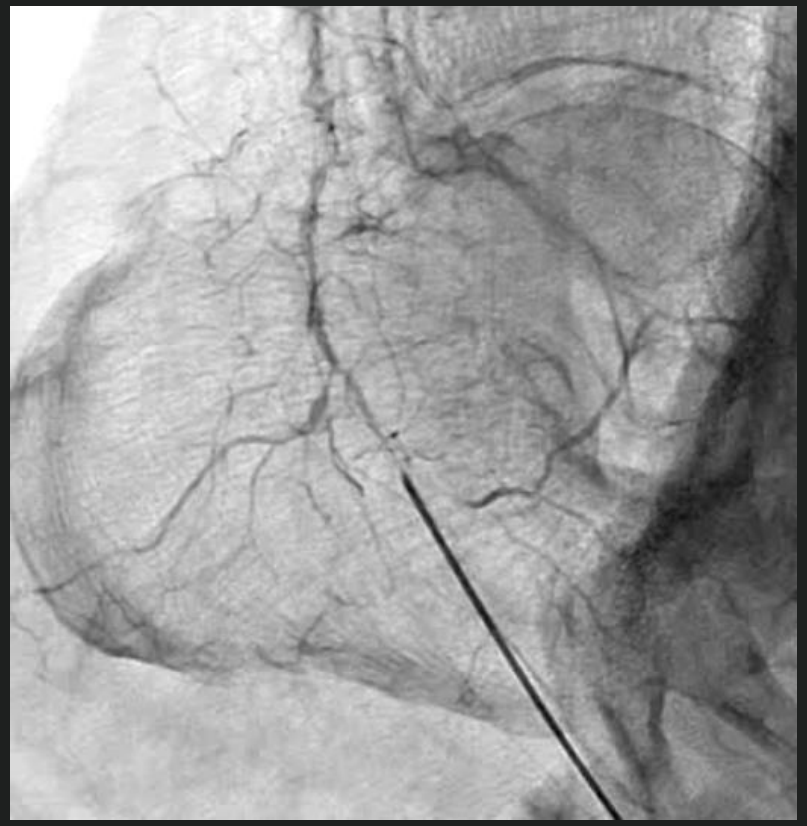
Why does the challenging technique need?



Metatarsal puncture



Trans-collateral/ pedal



Plantar puncture


We needs
Retrograde access
for crossing CTO

Antegrade approach is standard technique

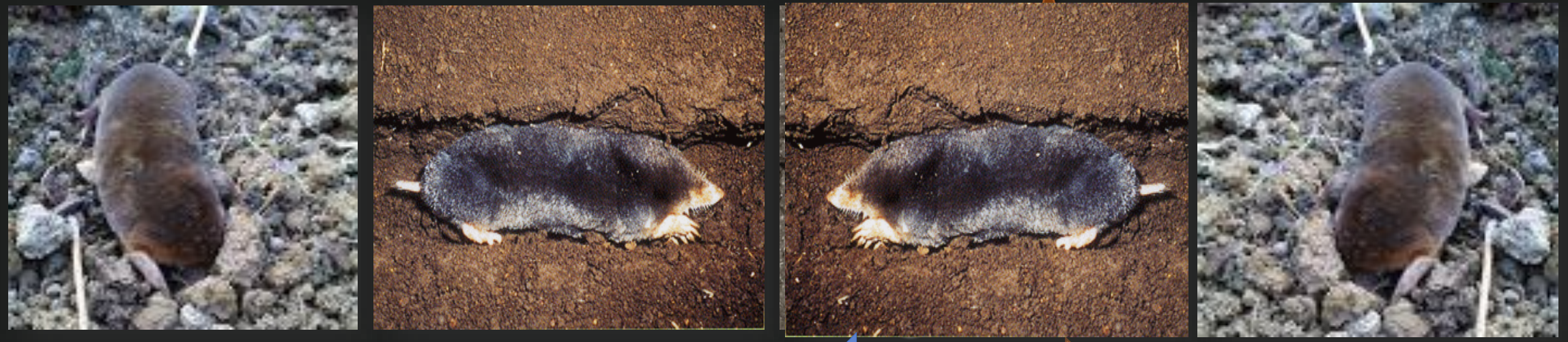
Advancing into CTO lumen

Wiring in CTO

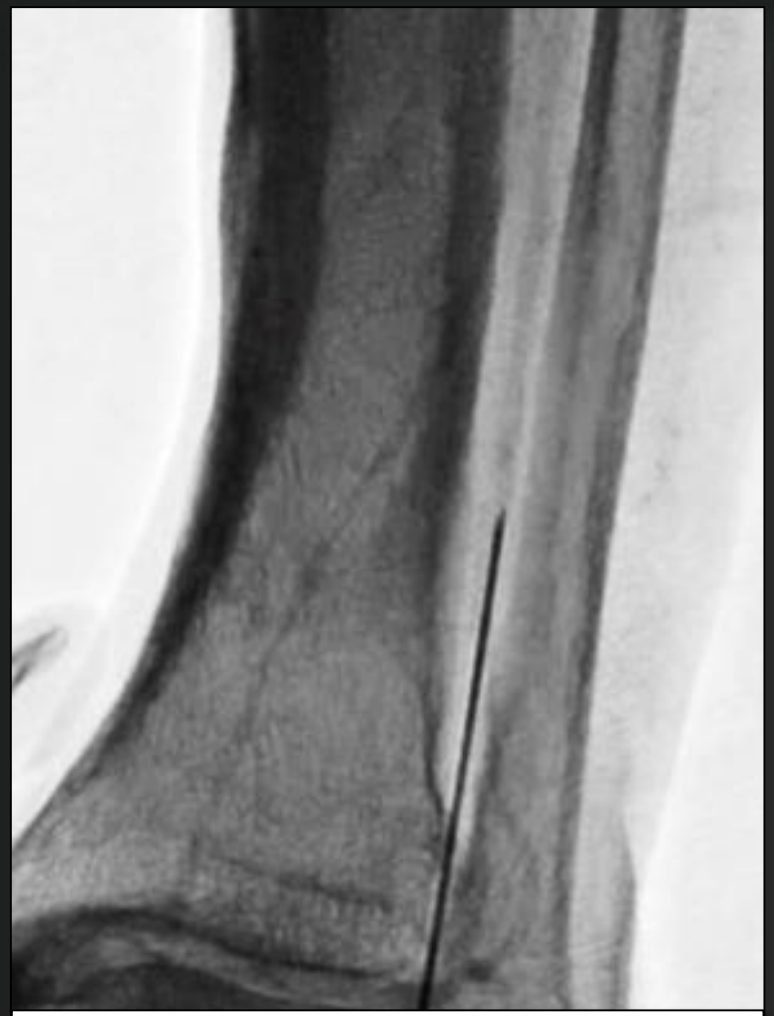
20 to 30 % Antegrade Fail

Successful penetration

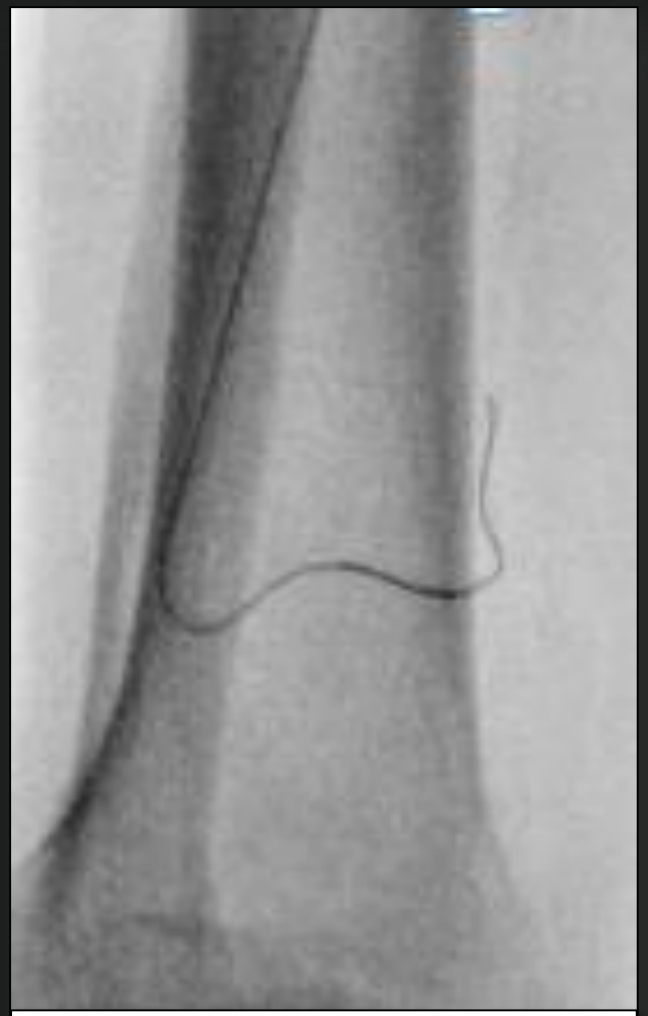
Retrograde access is key to success



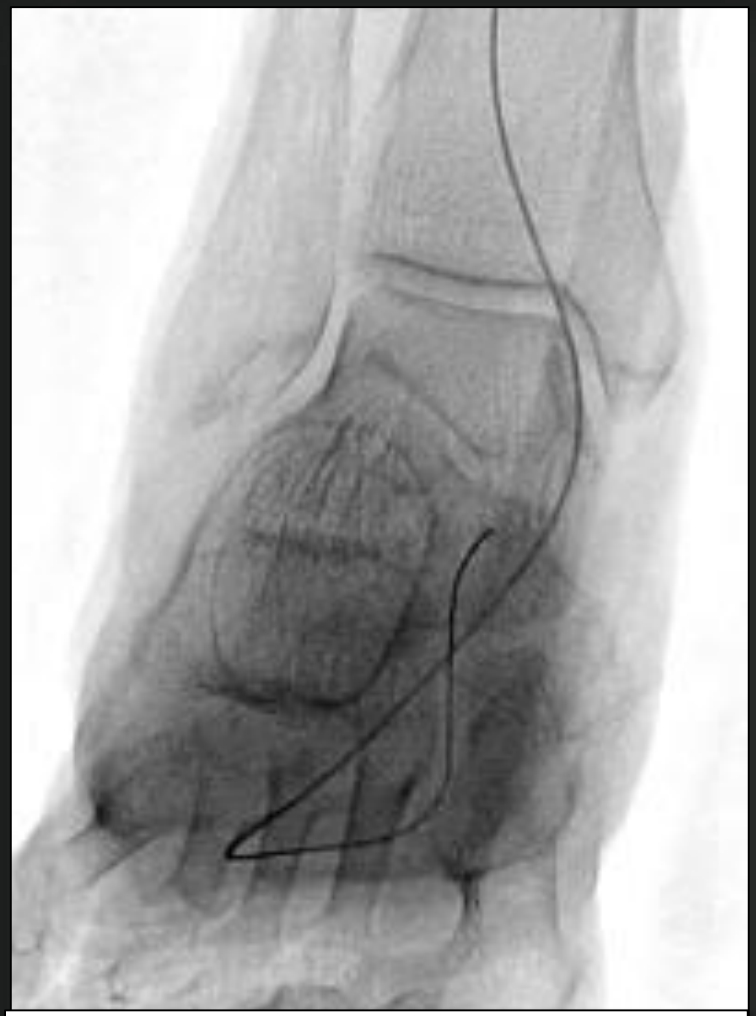
Various retrograde access technique



Distal puncture



Trans-collateral



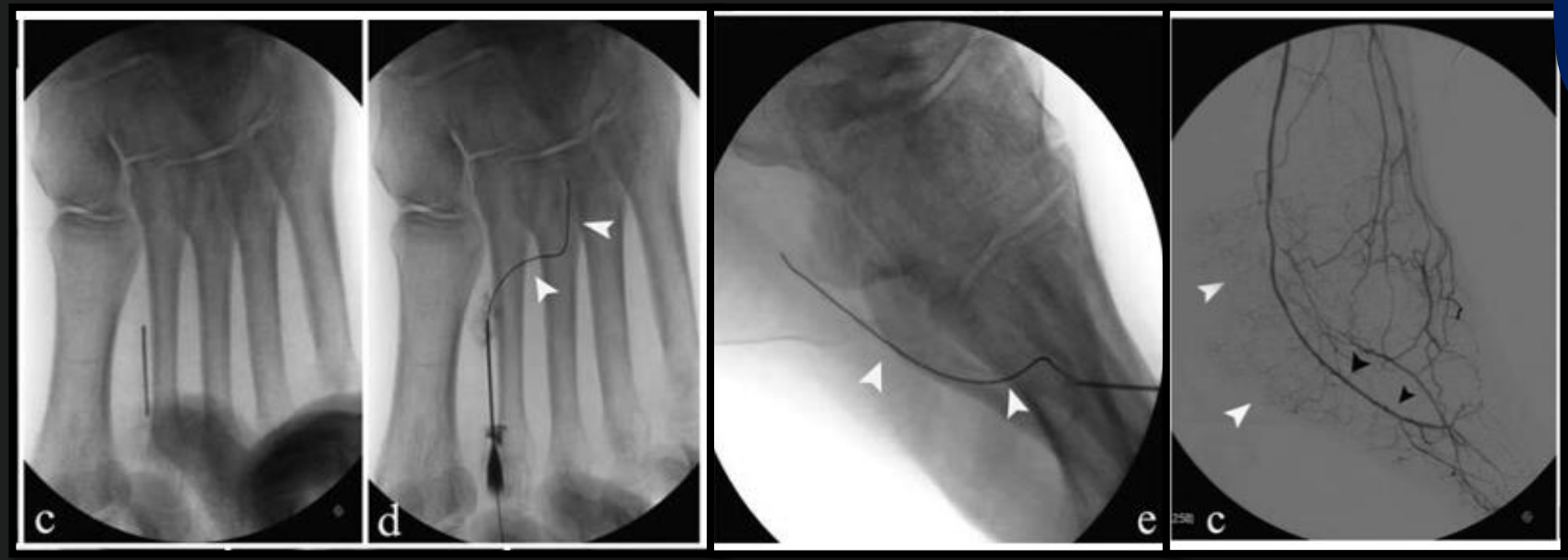
Pedal plantar loop

Distal puncture

Challenging metatarsal puncture

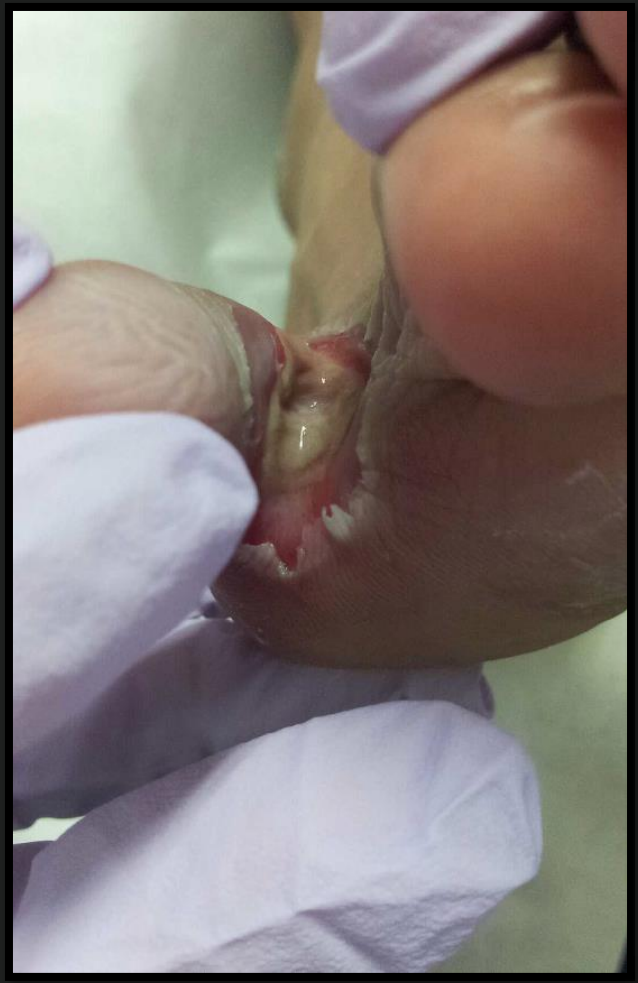
The Clinical Utility of Below-the-Ankle Angioplasty using "Transmetatarsal Artery Access" in Complex Cases of CLI

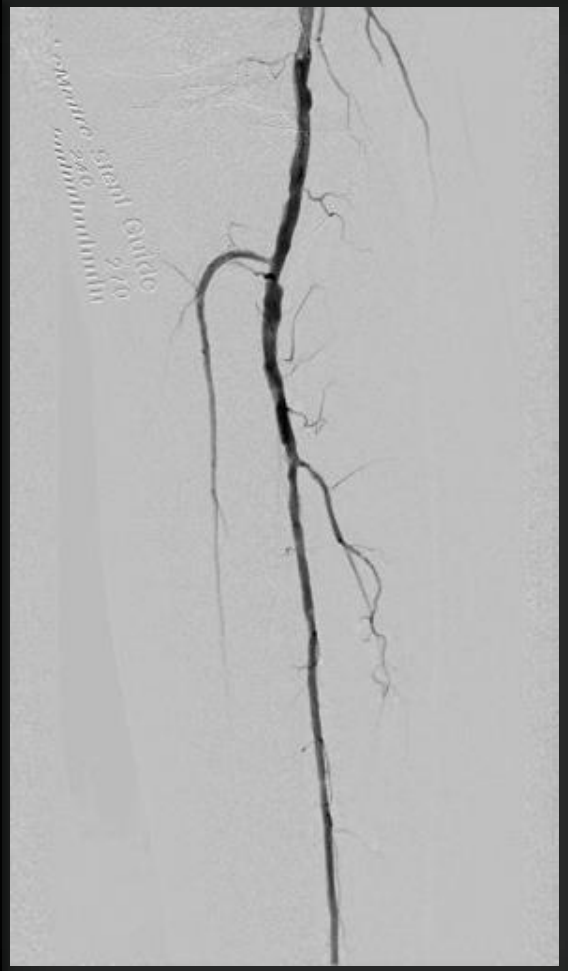
Luis Mariano Palena,[1*] MD, Enrico Brocco,[2] MD, and Marco Manzi,[1] MD

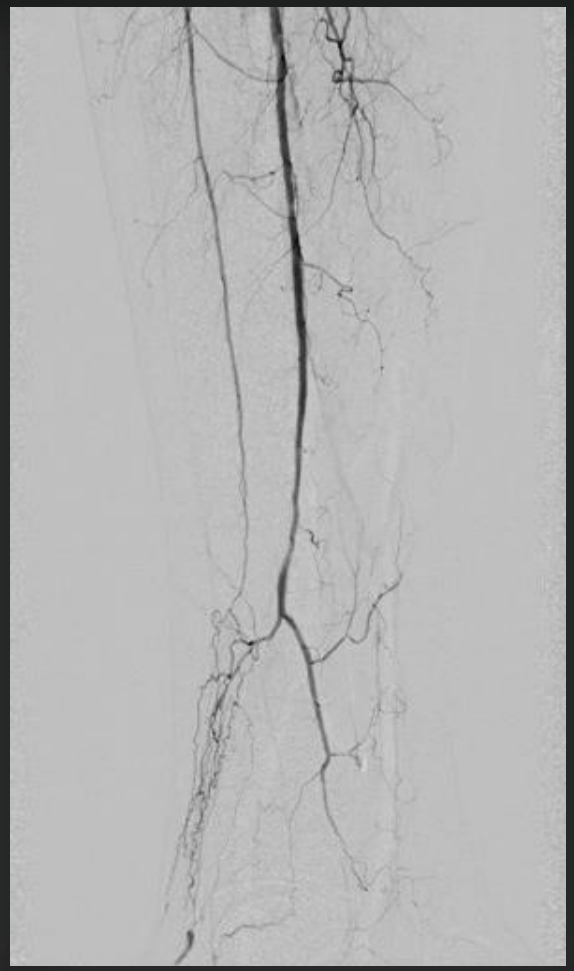


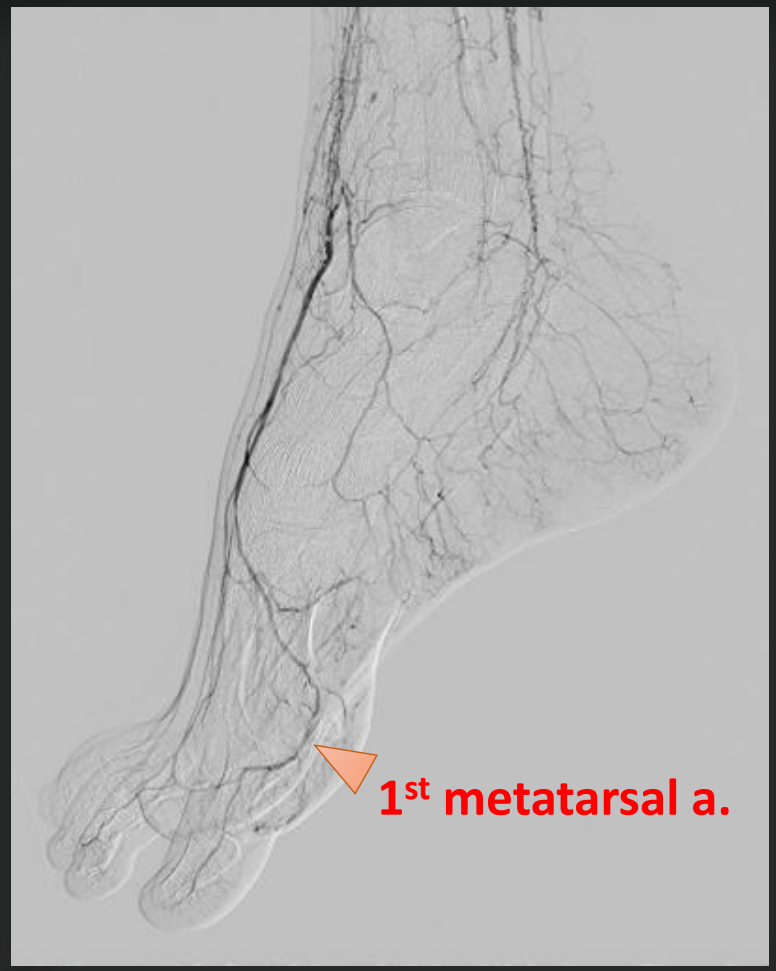
Palena LM, Manzi M. et al. CCI 83: 123-129 (2014)

A case of metatarsal artery puncture

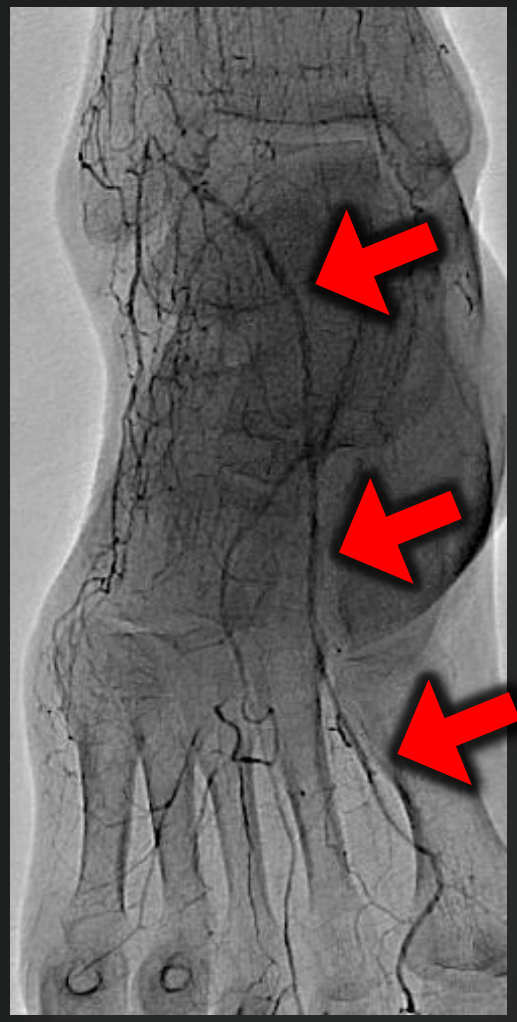


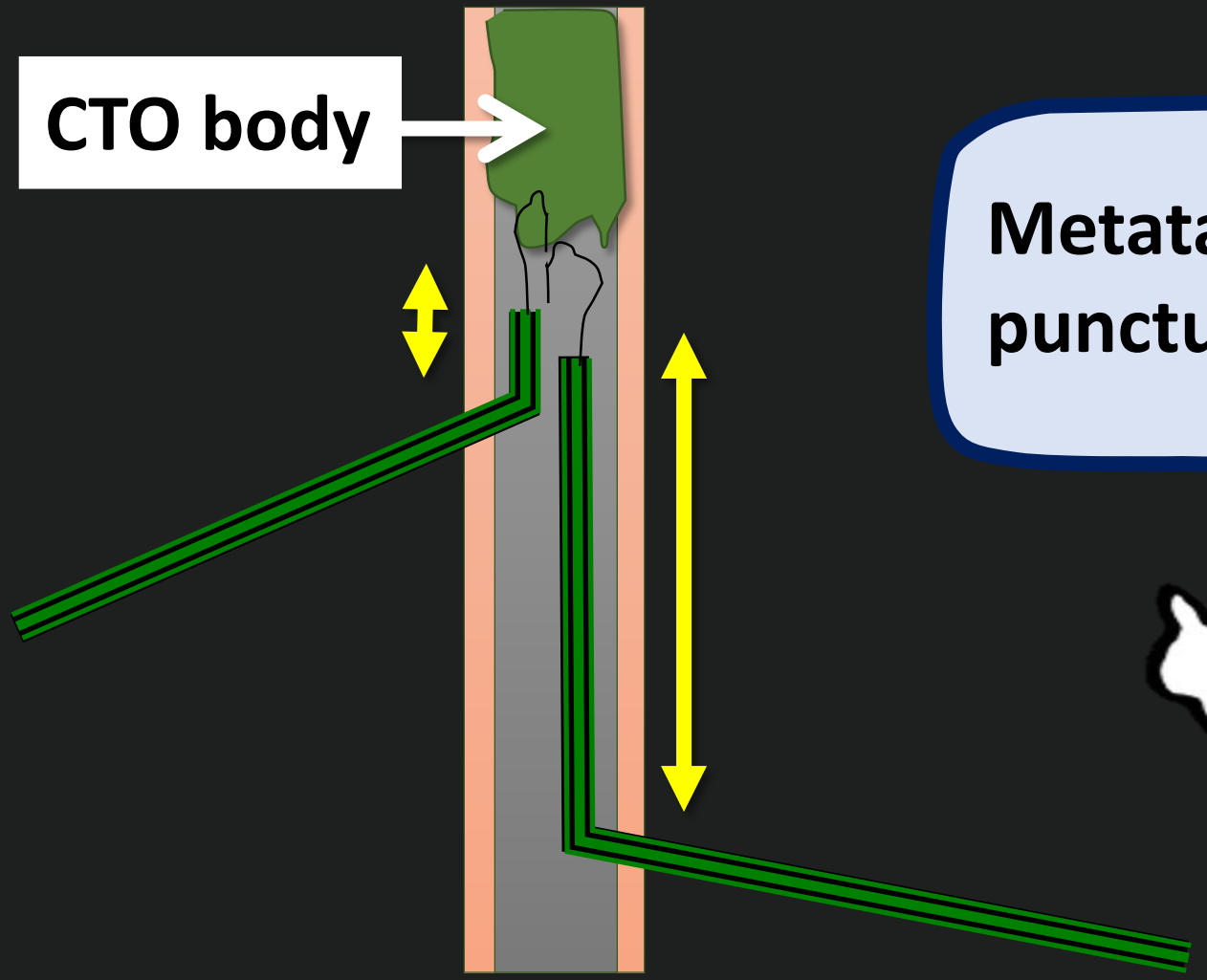




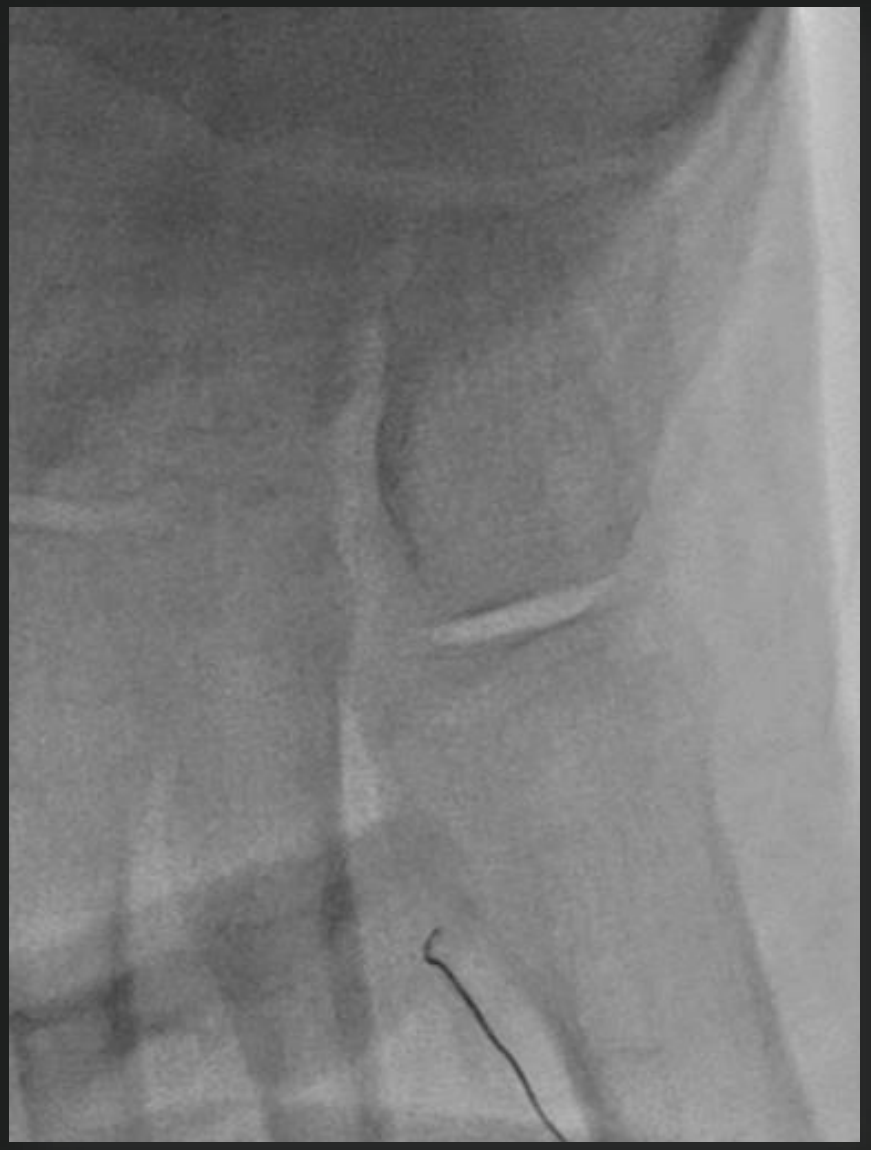


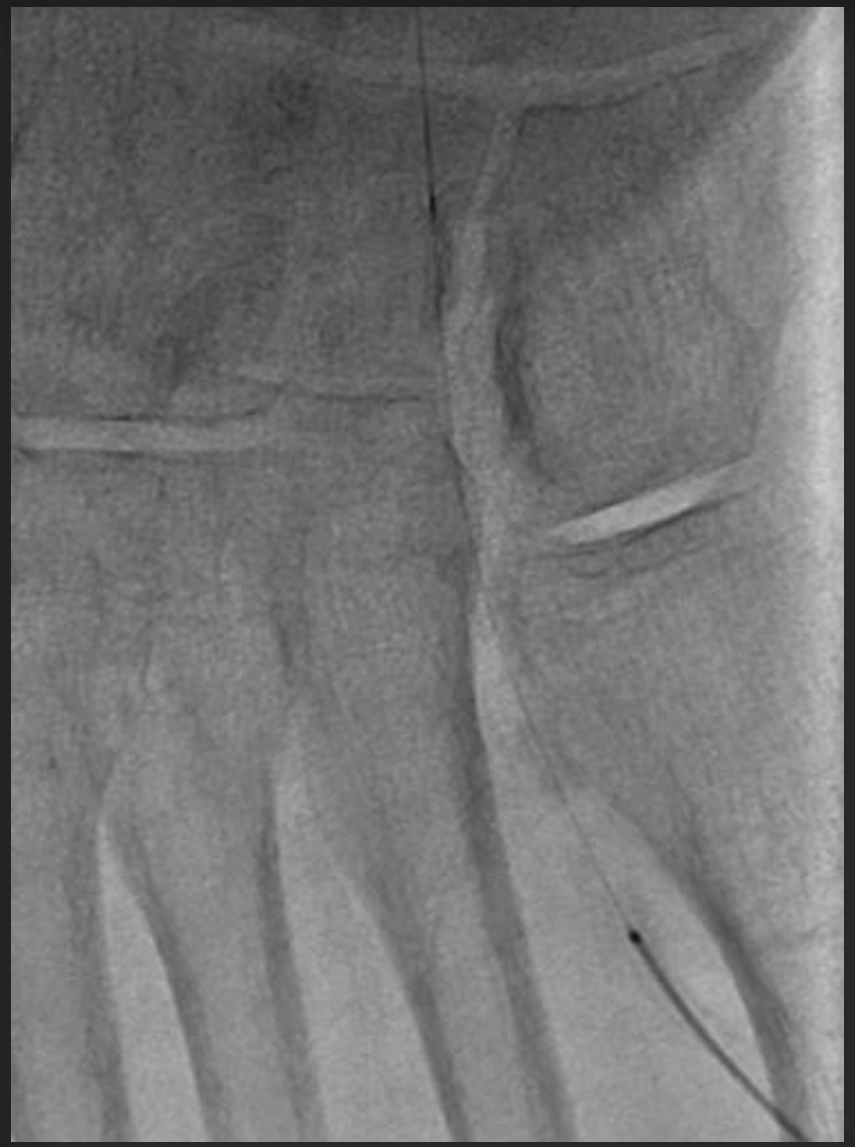
Long landing length provide us strong back up

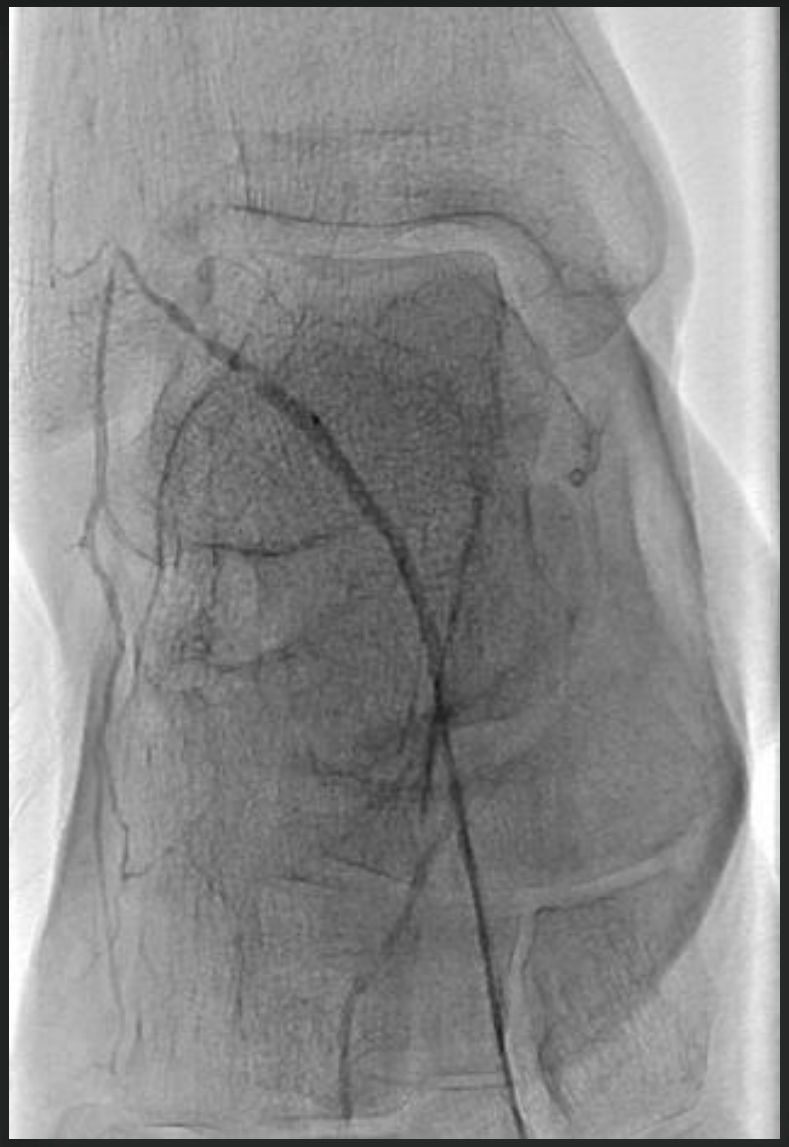




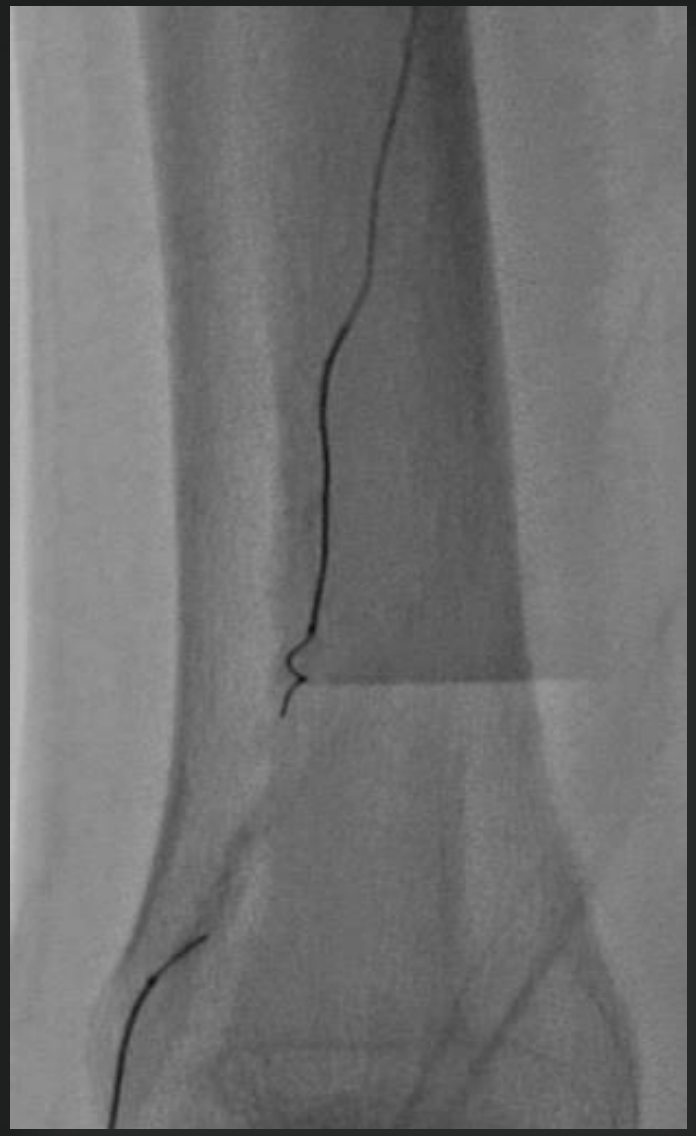
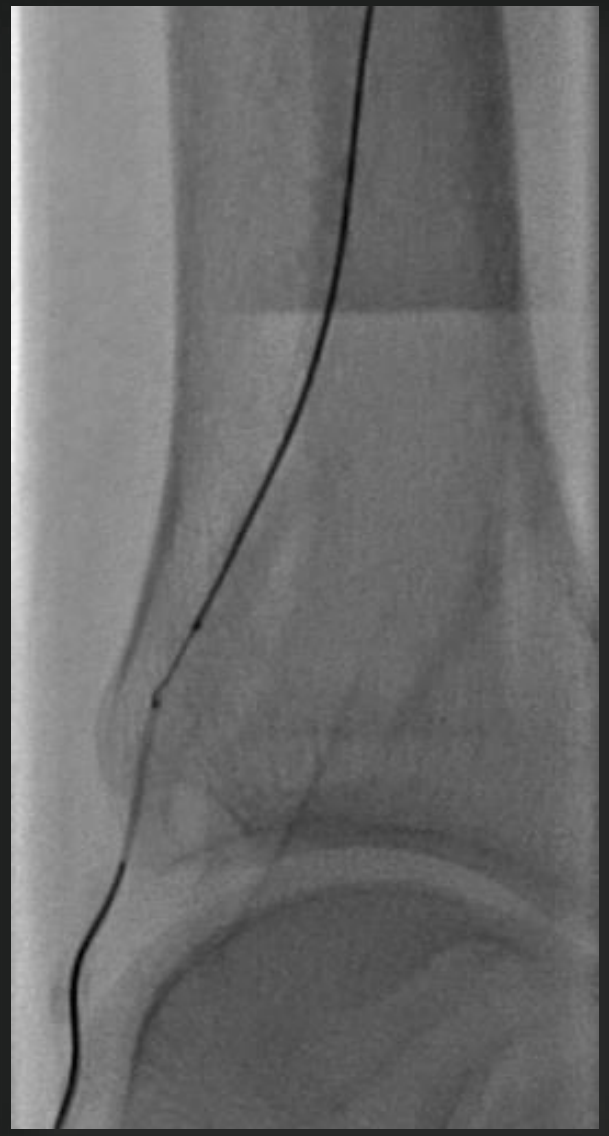
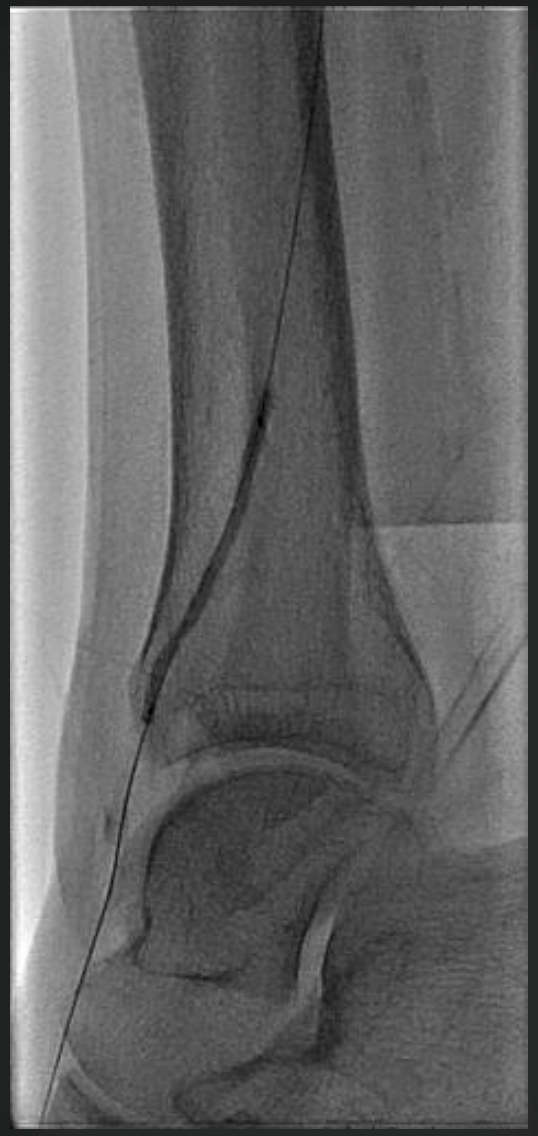
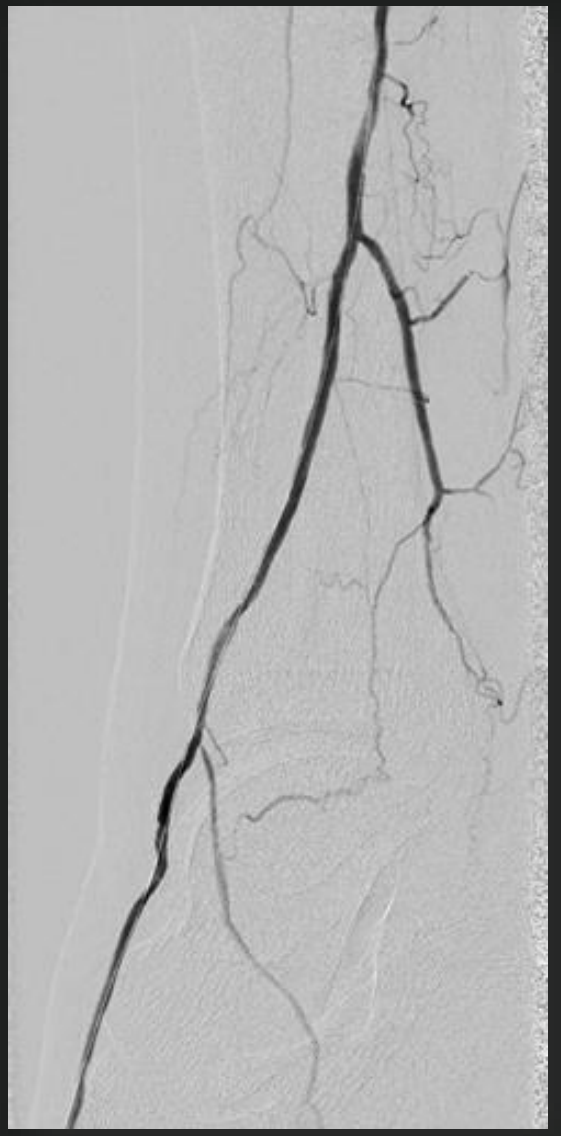
Metatarsal artery puncture was performed



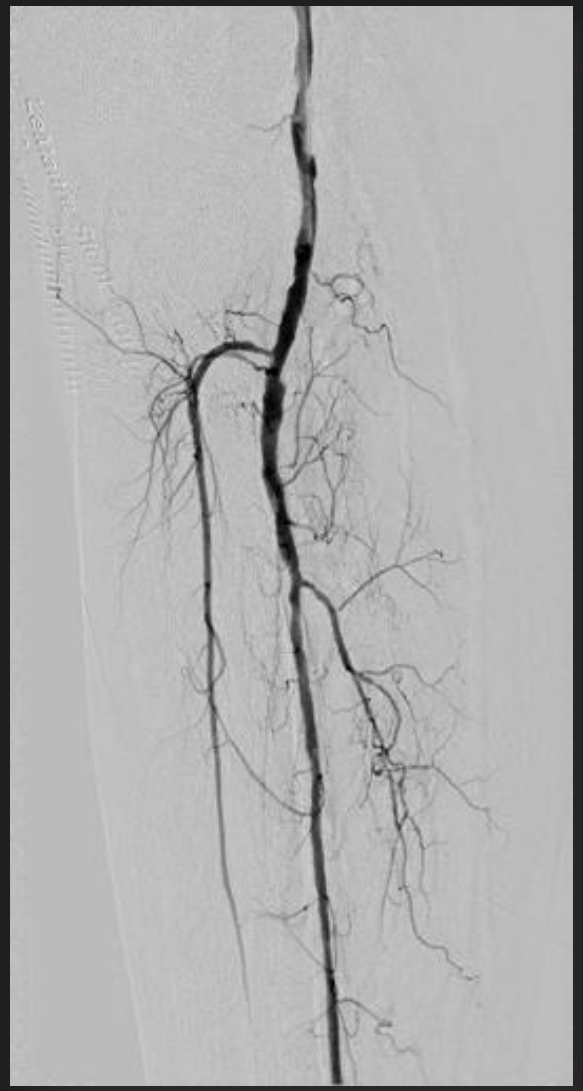


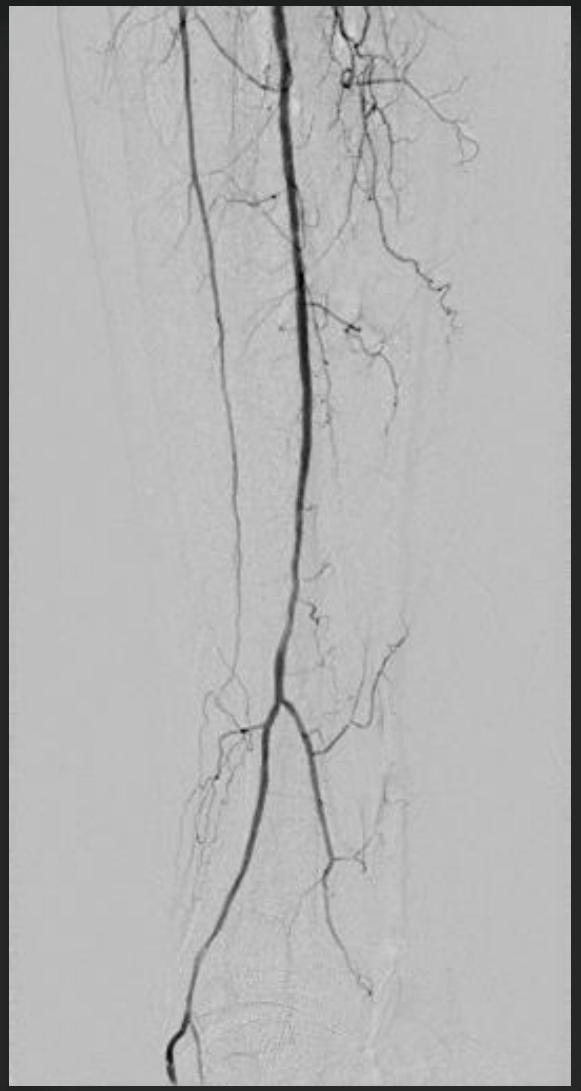


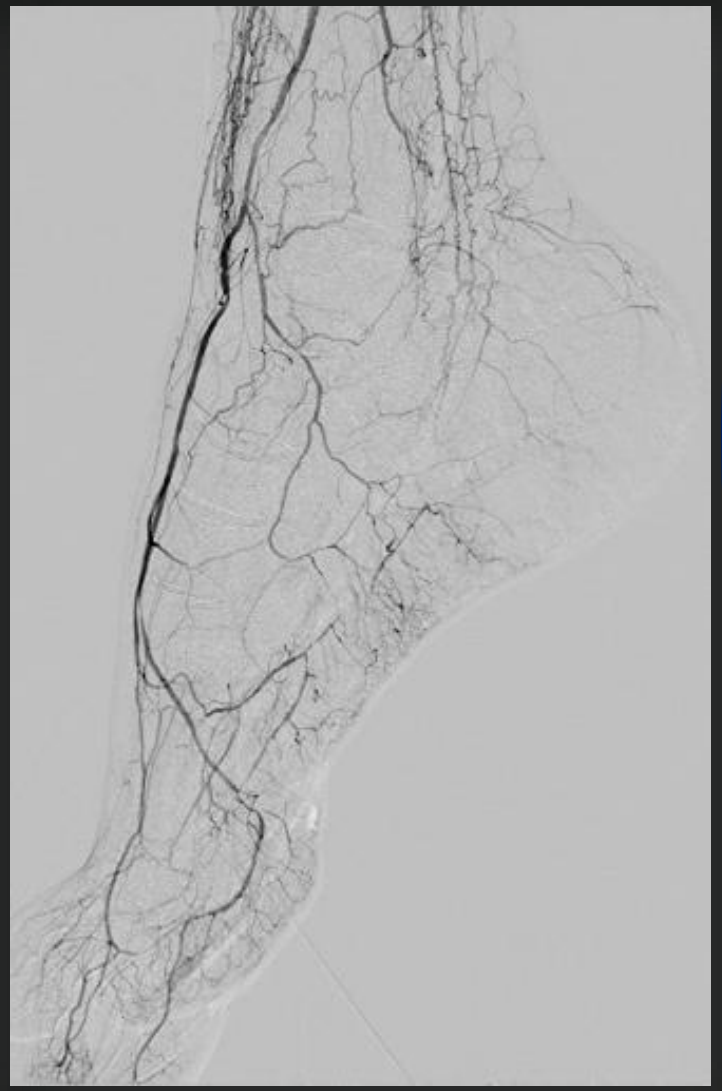
Bi-directional approach → rendezvous

Final angiogram







Summary of the distal puncture

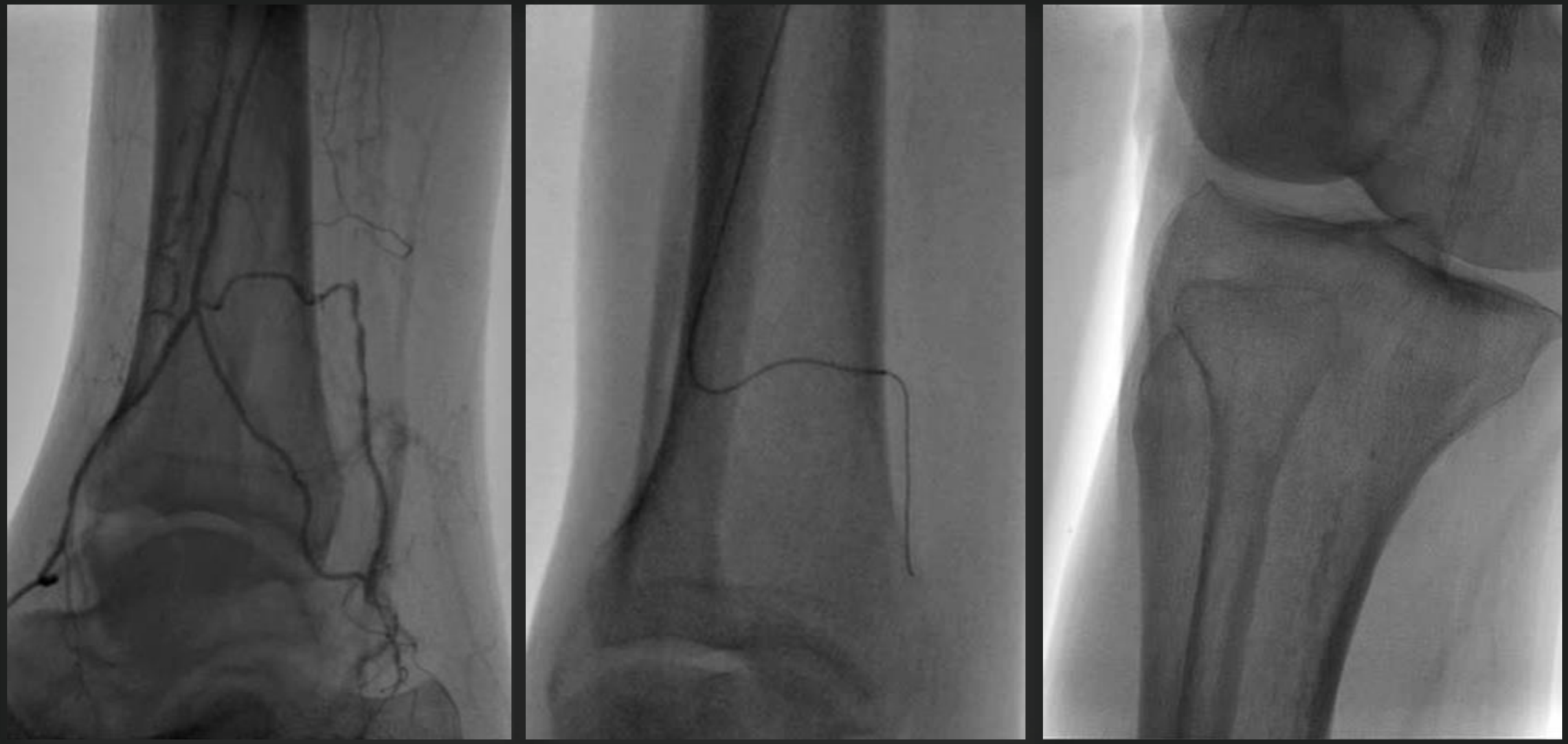
- Standard technique for BTK-retrograde access
- Understand the precise puncture position

  ATA & Dorsal: AP (+ cranial), PTA & Plantar: contra lateral
- Sheathless technique is mandatory
- Retrograde subintimal approach is useful in case of long CTO
- Rendezvous, snaring technique is necessary
- Hemostasis is important

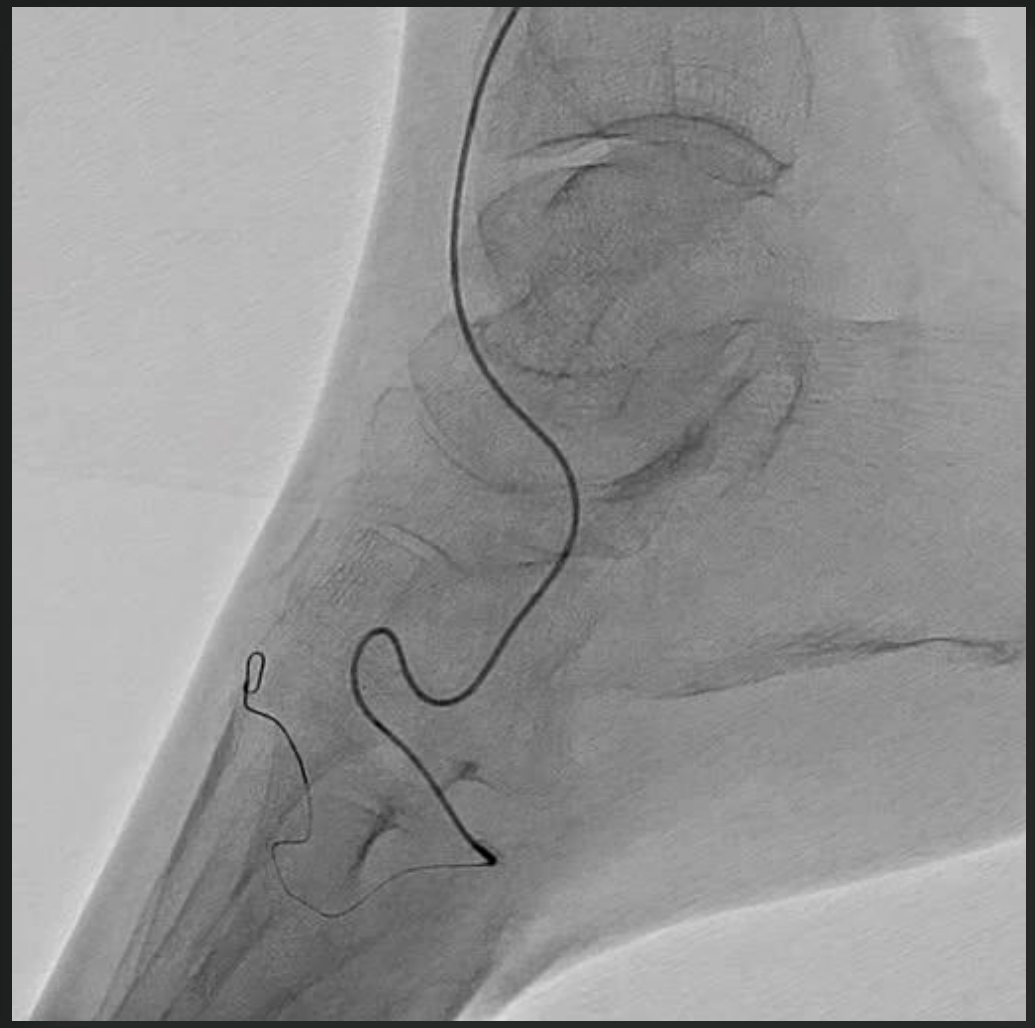
  manual compression or balloon assisted hemostasis

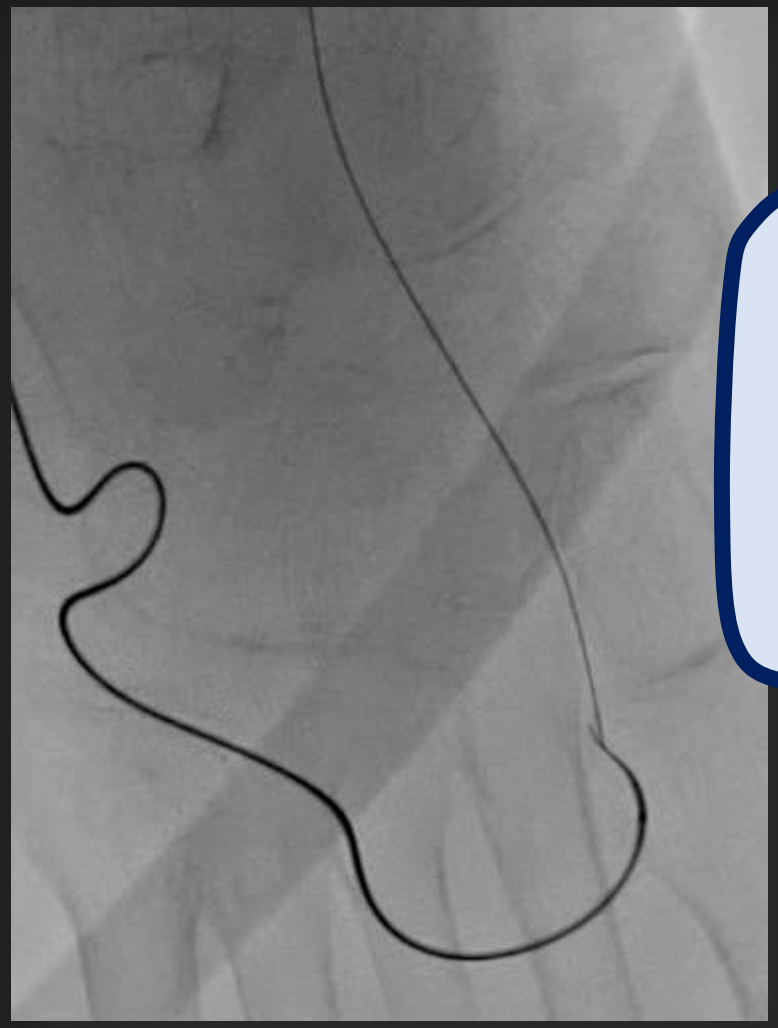
Trans-collateral

Representative case of collateral approach



Channel tracking success is not equal procedural success





Summary of trans-collateral approach

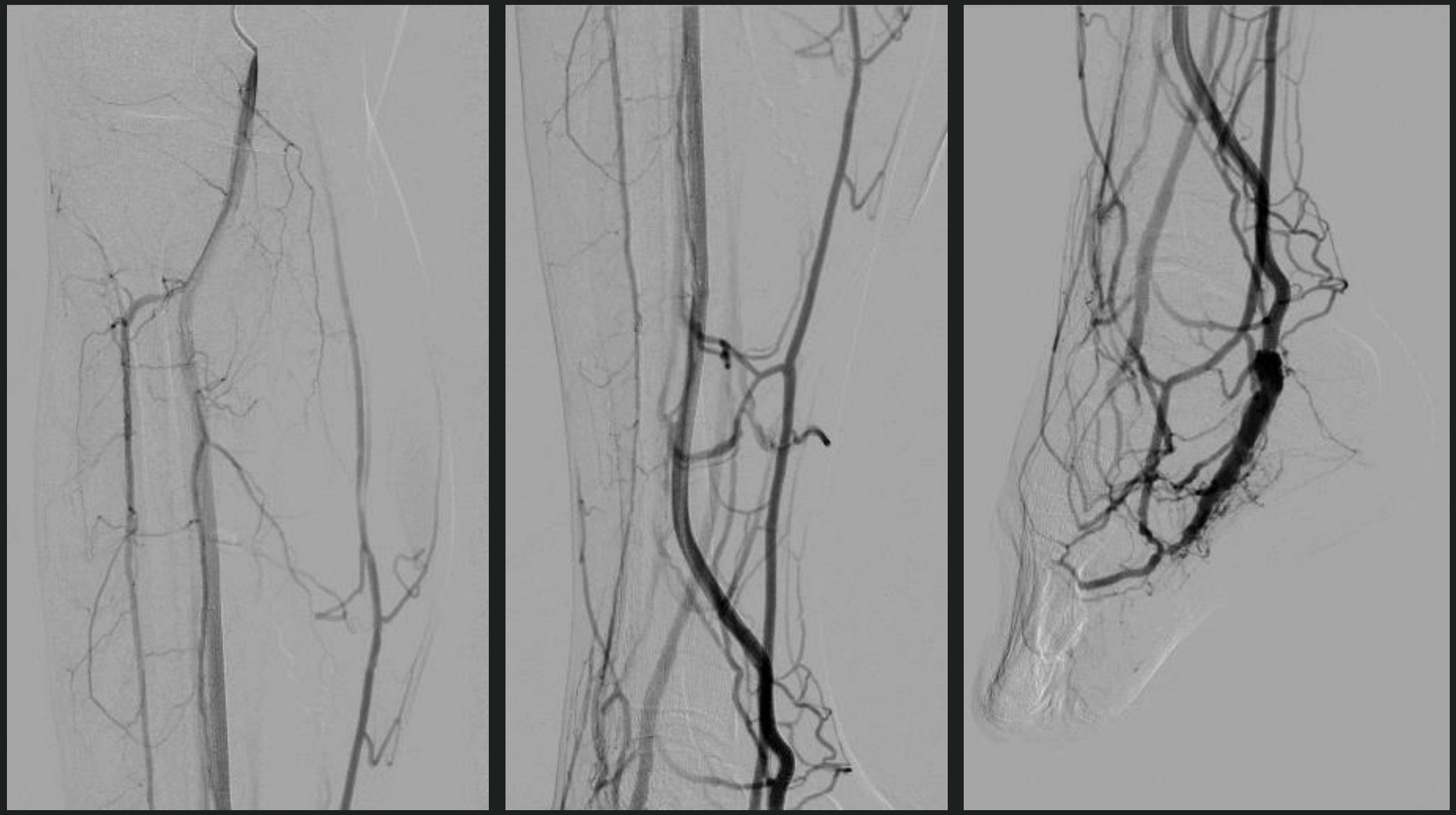
- TCA makes bidirectional setting without any DP

  → We can avoid to make additional wound to ischemic foot
- Polymer jacketed GW is useful for channel tracking
- Collateral channel tracking success ≠ procedural success

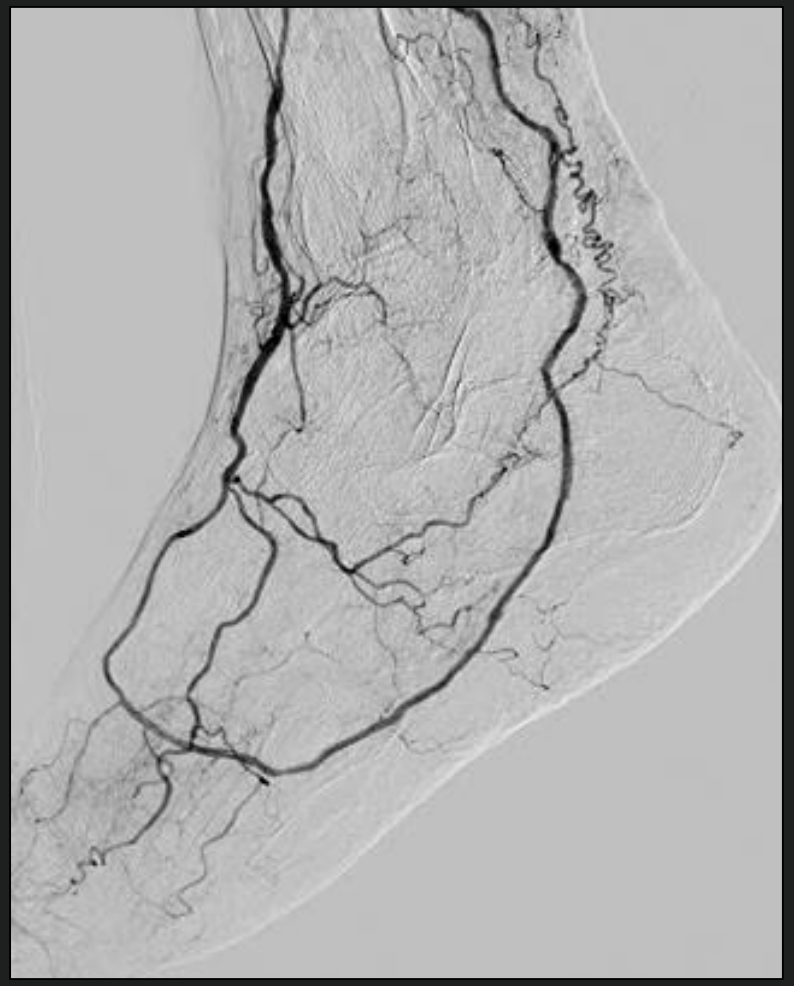
  → GW trackability and pushability are lost..
- In case of no retrograde puncture site = useful option

No-option case

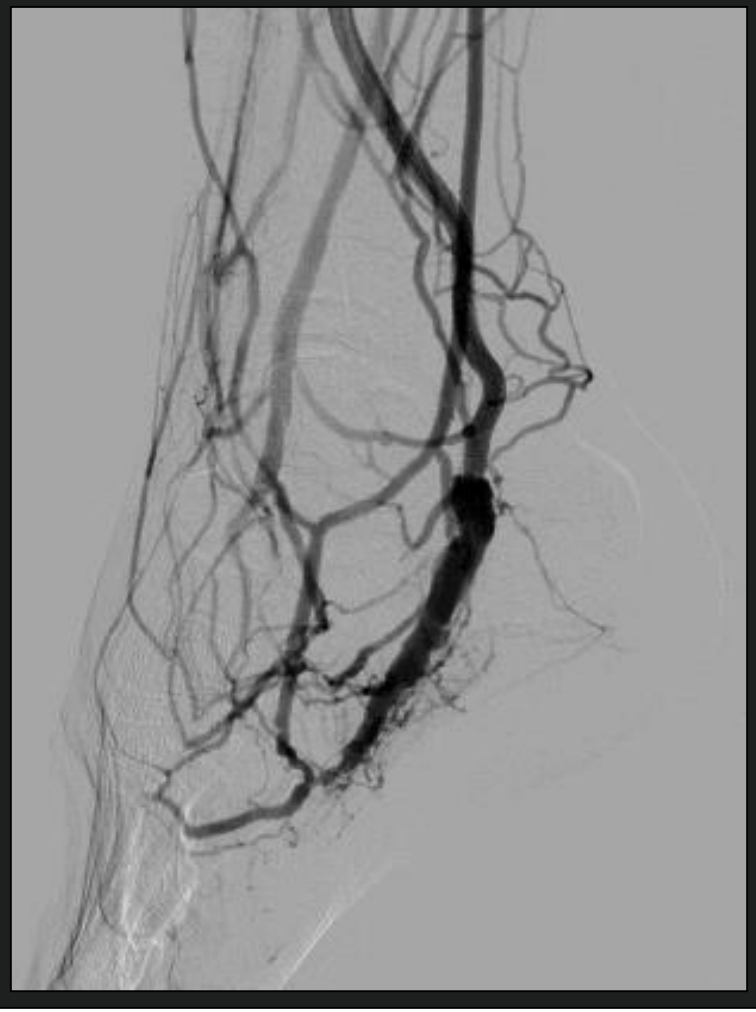
Final angiogram



PAA



DVA



Re-built Pedal circulation

Make New Pedal circulation

Summary of my presentation

- BTK CTO crossing is always challenging
- Establish a bi-directional system is quite important for procedural success
- DP is standard technique, TCA is useful option in selected case
- Percutaneous DVA may be future option for no-option CLTI

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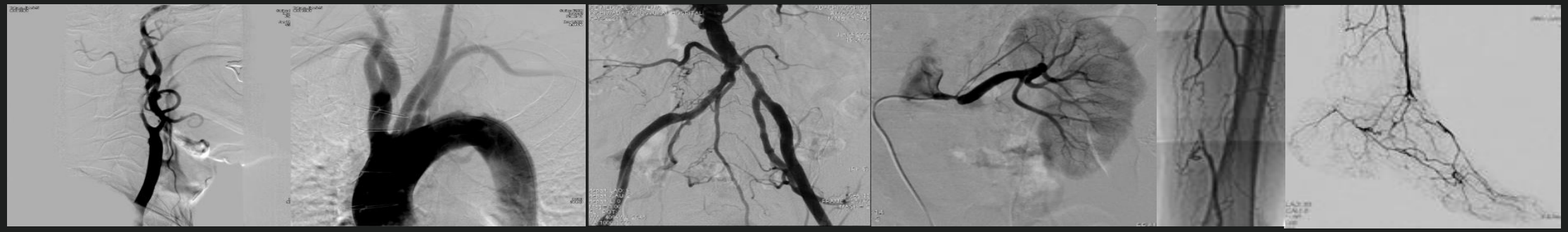

Thank you for your attention

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