Ideal strategy for long SFA-CTO according to pathological findings

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Disclosure

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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
Chronic patency of FP lesion after EVT is associated with lesion length.

Lesion Length vs Primary Patency

- PTA
- BNS
- DES
- DCB
Similar patient & lesion background & procedural step

Case 1

CTO length: 23cm

Case 2

CTO length: 25cm

pre  post  12 m

6mm BNS  7mm BNS

Few intimal hyperplasia

pre  post  12 m

6mm BNS  7mm BNS

Much intimal hyperplasia
How do you guess CTO progress

A: \( \leq 5\text{cm} \)
B: \( 5<\text{lesion}\leq15\text{cm} \)
C: \( 15<\text{lesion}\leq20\text{cm} \)
D: \( >20\text{cm} \)
Different etiologies of stenotic lesion

Case 1

Case 2

unstable

stable
Have you seen the inside of CTO
To clarify the etiology of long SFA CTO

Angioscopy

Pathology
Take the CTO’s specimen from the proximal site
Take the CTO’s specimen from the distal site
Result: Etiology of long SFA CTO

Type A:
- Organized thrombus
- Intimal Thickness

Type B:
- Intimal Thickness
We need to make the different strategy for each type CTO

**Type A**

**Ideal Strategy**

Proximal -> BNS

Distal -> DCB or DAART or DES

**Type B**

**Ideal Strategy**

Proximal -> DES or DCB or DAART

Distal -> DCB or DAART or DES
To get satisfactory excellent outcome after EVT for long SFA CTO

We need to choose appropriate devices according to the each lesion morphology
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