Radial approach for CLI patient with unexpected trouble

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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
Patient

- 62 y.o. male
- Stage 1 Arterial hypertension
- 40 pack-year smoking
- Severe COPD
- Severe claudication history previously
- CLI of the left foot, rest pain (Rutherford – stage 4)
Acute angiography
PTA for CLI

- Radial approach with a 6F reinforced introducer sheath system – 100 cm
- 0,035” Guidewire (Glidewire Advantage)
- POBA balloons (5x60mm & 7x120 mm)

PTA:
- Common iliac artery POBA
- External iliac artery POBA
- Deep femoral artery POBA
PTA for CLI

- Left common iliac artery with BMS
  Self-expandable stent
  (9 x 60mm, Astron)
- Postdilatation
  (9x40 mm)
Unexpected trouble

- Vasospasm during reinforced introducer sheath extraction
- i/a NTG multiple injections
- Sedation
  - i/v Mophine 10 mg
  - i/v Midazolam 5 mg
6 Fr foreign body endovascular removal

- Distally inserted 4 Fr introducer sheath logged inside 6 Fr
- Anchor OTW balloon inflated proximally to the 6Fr
- Haemostasis assisted by 2x TR Band devices
6 Fr foreign body endovascular removal
Learning points in radial vasospasm

• Guidewire position should be controlled by fluoroscopy all the time during introducer sheath extraction
• Anchor balloon inflation may help in safe introducer extraction
• Routine proximal radial artery catheterization can leave a possibility of secondary distal artery catheterization in case of introducer sheath rupture
Thank you for your attention!

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