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Volume 67, Issue 16_S, April 2016 >

Endovascular: Carotid & Neurovascular Intervention (TCTAP C-183 To TCTAP C-188) | April 2016

TCTAP C-187 Challenging Anatomy Carotid Artery Angioplasty Combined Femoral - Radial Route (CFRR)

FREE

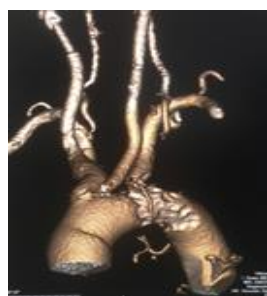
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J Am Coll Cardiol. 2016;67(16_S):S322-S323. doi:10.1016/j.jacc.2016.03.400

Article Figures

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Figures in this Article

[Clinical Information]

[Clinical Information] | [Interventional Management]

Patient initials or identifier number

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Relevant clinical history and physical exam

A 75 years-old nonsmoking female with history of hypertension, chronic obstructive pulmonary disease presented to Republican Cardiac Center with severe dizziness, headaches and visual disturbances. Auscultation revealed systolic bruit above left carotid artery bifurcation. Neurologic exam was uneventful.

Relevant test results prior to catheterization

Workout with carotid ultrasound revealed right ICA stenosis 65-70% with bifurcation up to 50%, left ICA 55-60%. CT with contrast of aortic arch with main branches found type III aortic arch with erosive calcified atherosclerotic plaque, ostial stenosis of left subclavian and left CCA.

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TCTAP C-188 Bilateral Carotid Artery In-stent-restenosis in a Patient with Malignant Atherosclerosis

J Am Coll Cardiol. 2016;67(16_S):S323-S324. doi:10.1016/j.jacc.2016.03.401.

GW26-e2456 Orphan Nuclear Receptor Nur77 deletion exacerbates low shear stress-induced carotid artery remodeling in mice

J Am Coll Cardiol. 2015;66(16_S):. doi:10.1016/j.jacc.2015.06.289.

GW26-e2494 Relationship of postprandial hypotension and carotid artery atherosclerosis in hypertensive patients



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Relevant catheterization findings

Right ICA stenting via right femoral artery were scheduled. Bilateral carotid angiography was performed. 60-70% stenosis of right ICA and 50-60% of left ICA were confirmed as well as type III aortic arch with calcification.

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Procedural step

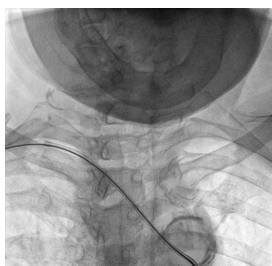
6F sheath has been placed after right femoral artery puncture. We tried to pass to right ICA by the different types of guidewires, but without success. The wires could not pass because of the angle in the aortic arch and presence of calcification there. We tried different types of guidewires and catheters to solve the situation.

As a plan B, we decided to use right radial arterial approach. It was impossible to pass to right carotid artery from this route too because of sharp angle of brachiocephalic trunk bifurcation with right CCA.

Finally, 0.35" 260 cm hydrophilic wire had been passed through the radial artery to iliaca externa, where it had been captured by goose neck retriever from femoral introducer and had been withdrawn outside of the patient.

Other side of the wire (radial) had been fixated outside of the introducer by the clamp. As the result one side of the wire was clinched outside radial introducer. From femoral side of the wire guiding catheter had been inserted and passed to the right subclavian artery. After that guiding catheter had been gently withdrawn to ostium of right CCA. Right CCA had been wired by 0,35 Amplatzer Superstiff wire and guiding sheath had been placed to the right CCA.

Carotidstent 7.0x40.0 mm had been uneventfully placed at the level of stenosis. Patient was discharged 3 days after surgery without neurologic complications.



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J Am Coll Cardiol. 2015;66(16_S):. doi:10.1016/j.jacc.2015.06.740.

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Case Summary

Carotid artery stenting is a treatment option for atherosclerotic disease of the cervical internal carotid artery in high-risk patients. The traditional transfemoral approach sometimes is not suitable for patients with challenging anatomy. Radial approach is available as a plan B.

We suggest combined femoral-radial route (CFRR) in difficult femoral or radial cases when angulations and calcifications are present.

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