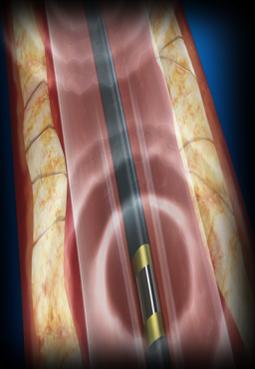
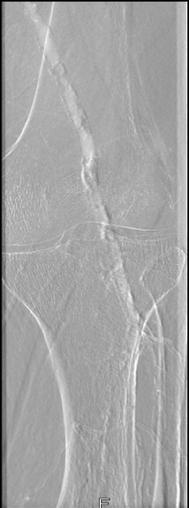




VASCUPEDIA



Endovascular lithotripsy and DCB angioplasty for a calcified popliteal lesion in a patient with chronic kidney disease

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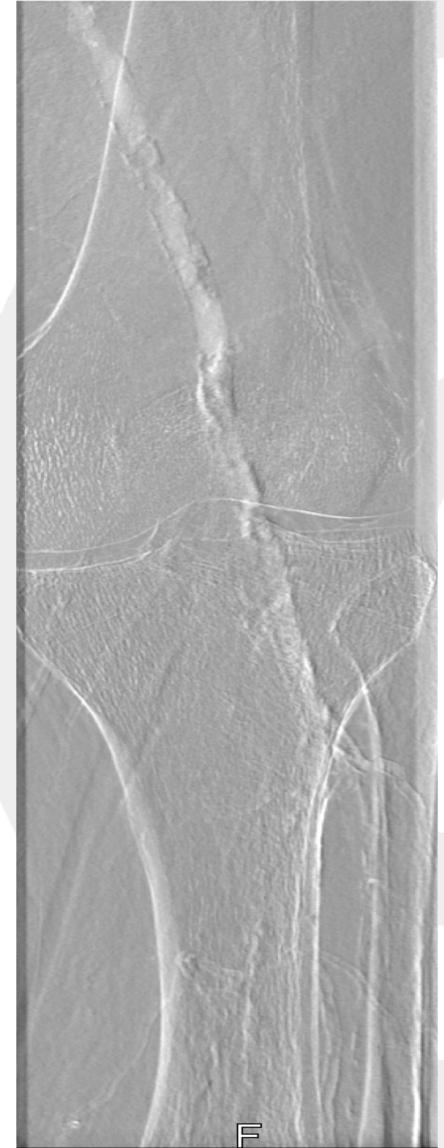
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Case Presentation

- Male, 80 yrs. old
- **Comorbidity:** Chronic Kidney disease (IV), Coronary heart disease, Type II diabetes, Hypertension
- CLI of the left limb
- Severely calcified popliteal stenosis, chronic occlusion of the AT and PT



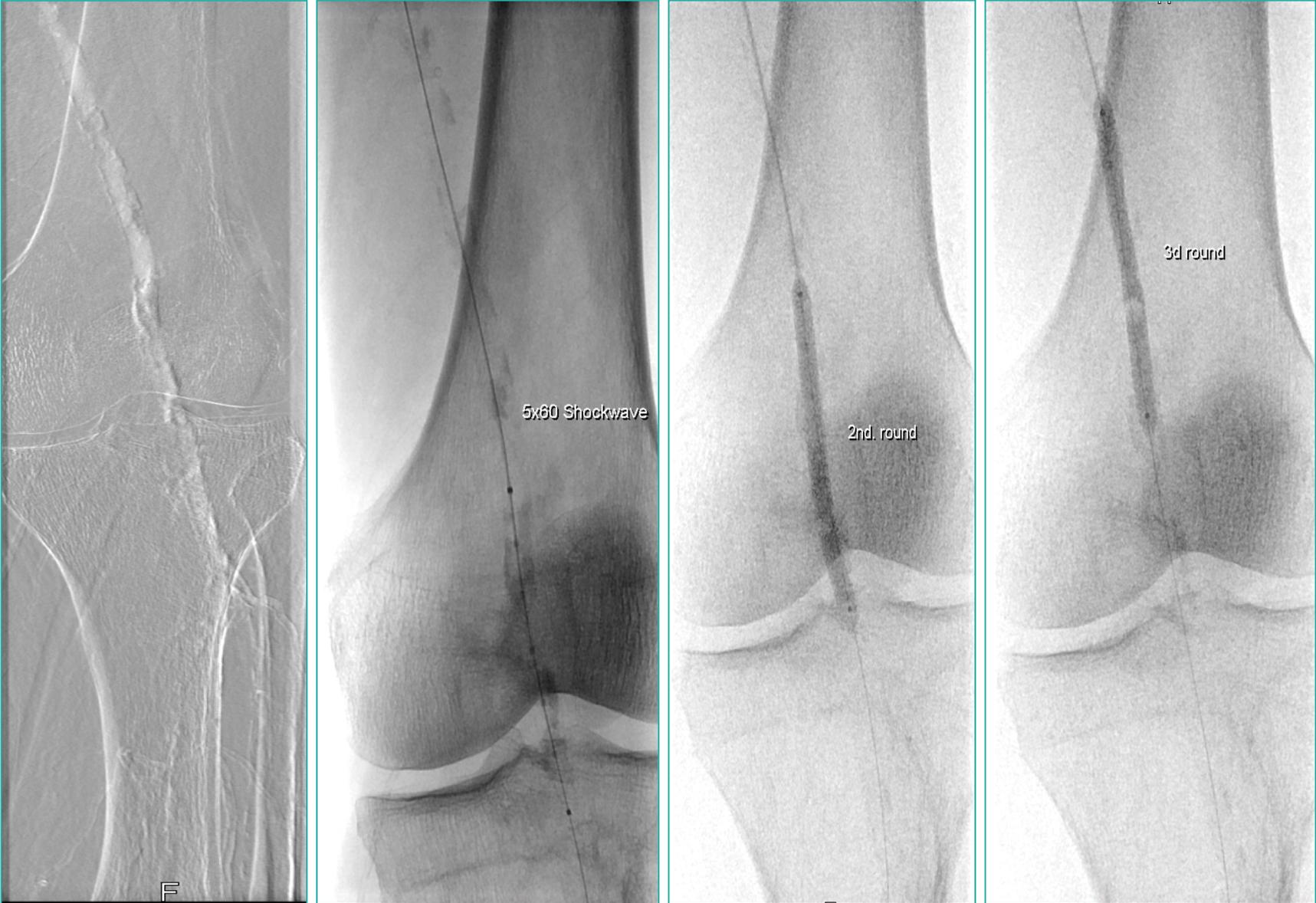
How would you treat this lesion?

- Plain old balloon angioplasty (POBA)
- Primary stent deployment
- Primary stent-graft deployment
- POBA + Drug Coated Balloon (DCB) Angioplasty
- Vessel prep + DCB angioplasty

Our Approach

- Because of the impaired renal function CO₂ angiography with the Angiodroid Carbon Dioxide Injector
- We suggest a primary ``leave-nothing-behind`` approach due to the high mechanical stress of the popliteal fossa
- Vessel prep prior to DCB because of the poorer outcomes of DCB in severely calcified lesions
- Endovascular lithotripsy as vessel prep in order to avoid repeated angiograms and consequently the possible use of contrast agent

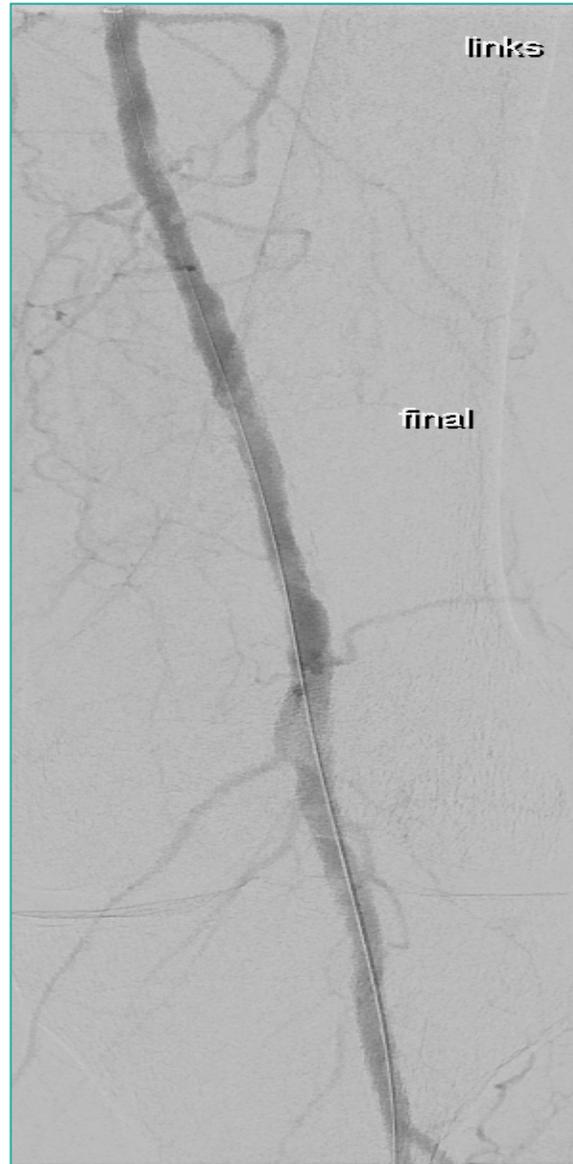
CO₂ Angiography + Lithotripsy + DCB



CO₂ Angiography + Lithotripsy + DCB



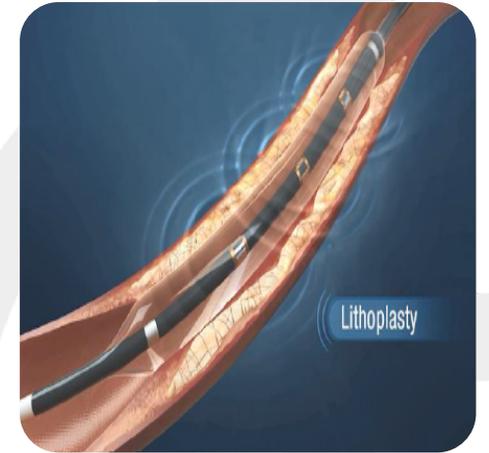
CO₂ Angiography + Lithotripsy + DCB

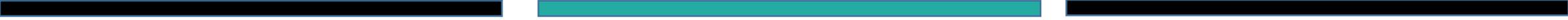


**Final Result
with Only 10 ml
Contrast Agent**

Endovascular Lithotripsy +DCB: The DISRUPT III

- Multi-center
- Single blind
- Randomized (1:1)
- Lithotripsy + DCB vs. POBA+ DCB
- Moderate and severely calcified SFA/
Pop
- 334 Patients
- 45 Centers (Europe, USA, New Zealand)





Questions to the Vascupedians

- Does Chronic Kidney Disease impact your treatment strategy?
- Do you agree with a primary leave nothing behind approach for popliteal disease?
- How do you prepare a calcified vessel prior to DCB/ Stent deployment?
- Do you routinely perform CO₂ angiography?