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Retrograde tibial anterior approach for challenging popliteal occlusion in CLI patient

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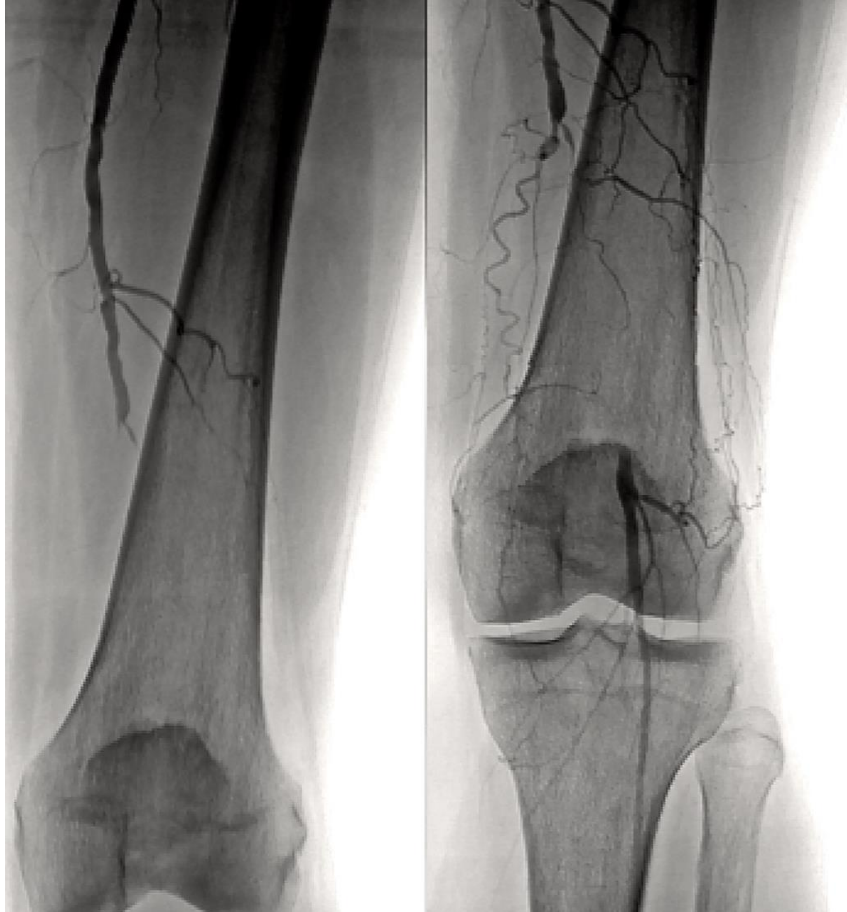
Case presentation

- Woman
- 66 yrs old
- Rest pain for 2 months (RF:4)

- Risk factors:
  - aHT
  - previous smoker
  - dyslipidemia

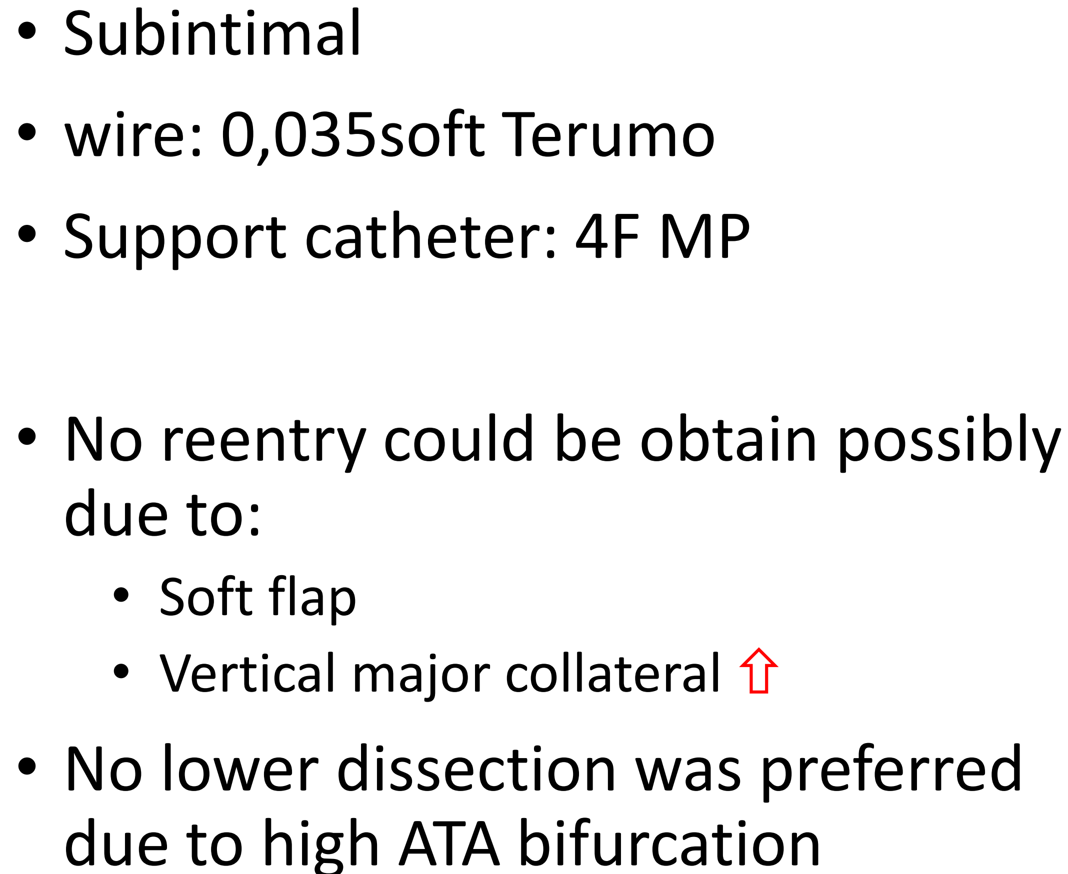
- Previous intervention
  - PTA right popliteal artery

Angiography



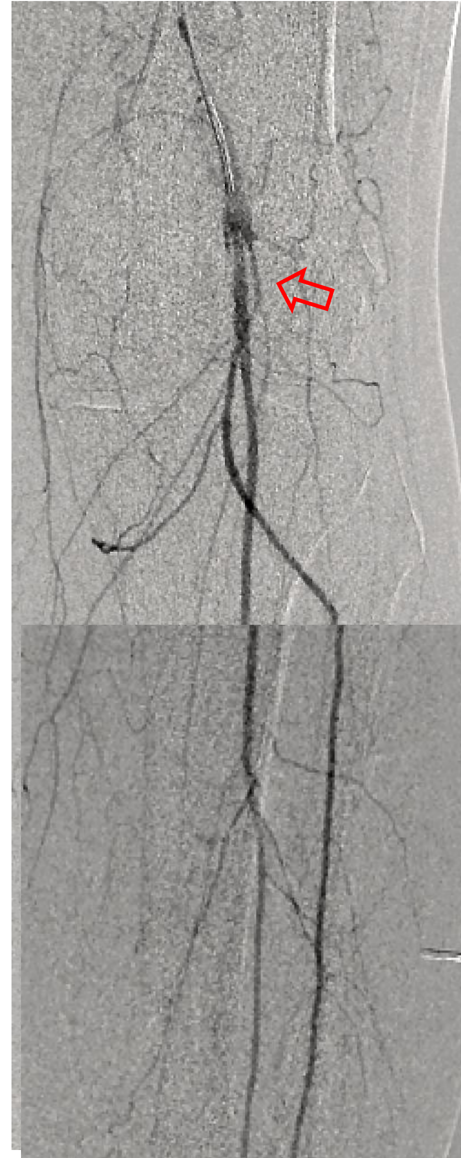
- Distal left AFS/P1 occlusion
- Mild Ca^{2+}
- 95mm long

Recanalisation



- Subintimal
- wire: 0,035soft Terumo
- Support catheter: 4F MP

- No reentry could be obtain possibly due to:
  - Soft flap
  - Vertical major collateral ⇧
- No lower dissection was preferred due to high ATA bifurcation

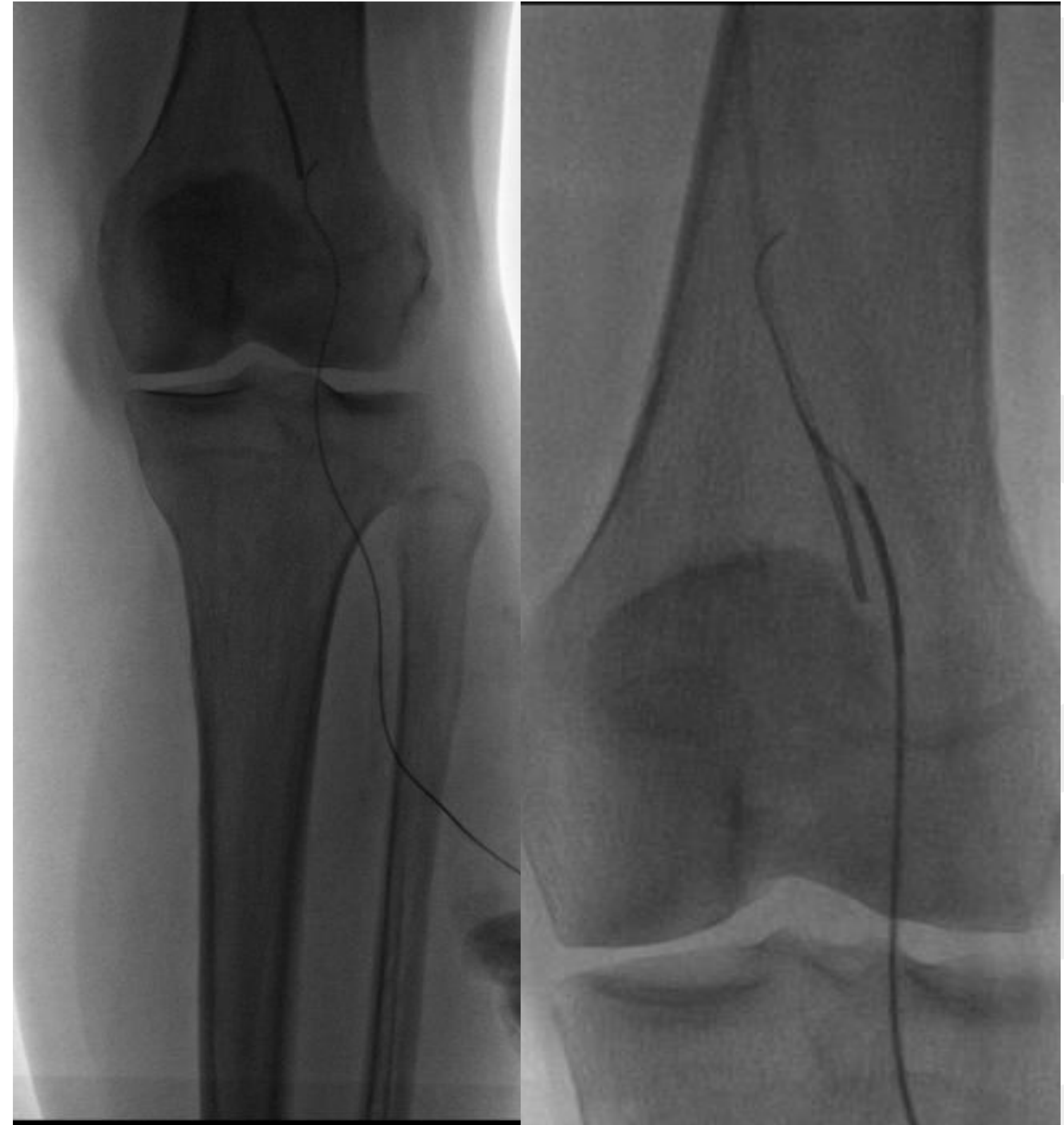


Possible options:

- Try to reentry lower down and sacrifice the peroneal artery or ATA
- Leave it like this
- Reentry device
- Retrograde approach

Selected option

- **Retrograde approach** via the **ATA**
- Fluoro-guided puncture
- Micropuncture set
- 0,035 soft angled tip wire (Terumo)
- Sheathless
- 4F MP catheter
- SAFARI technique
- Antegrade recanalisation



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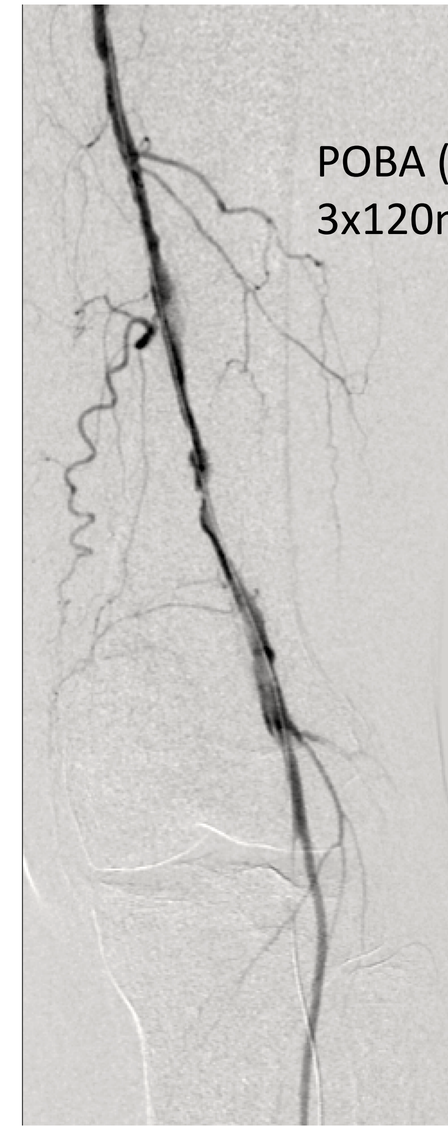
Next step

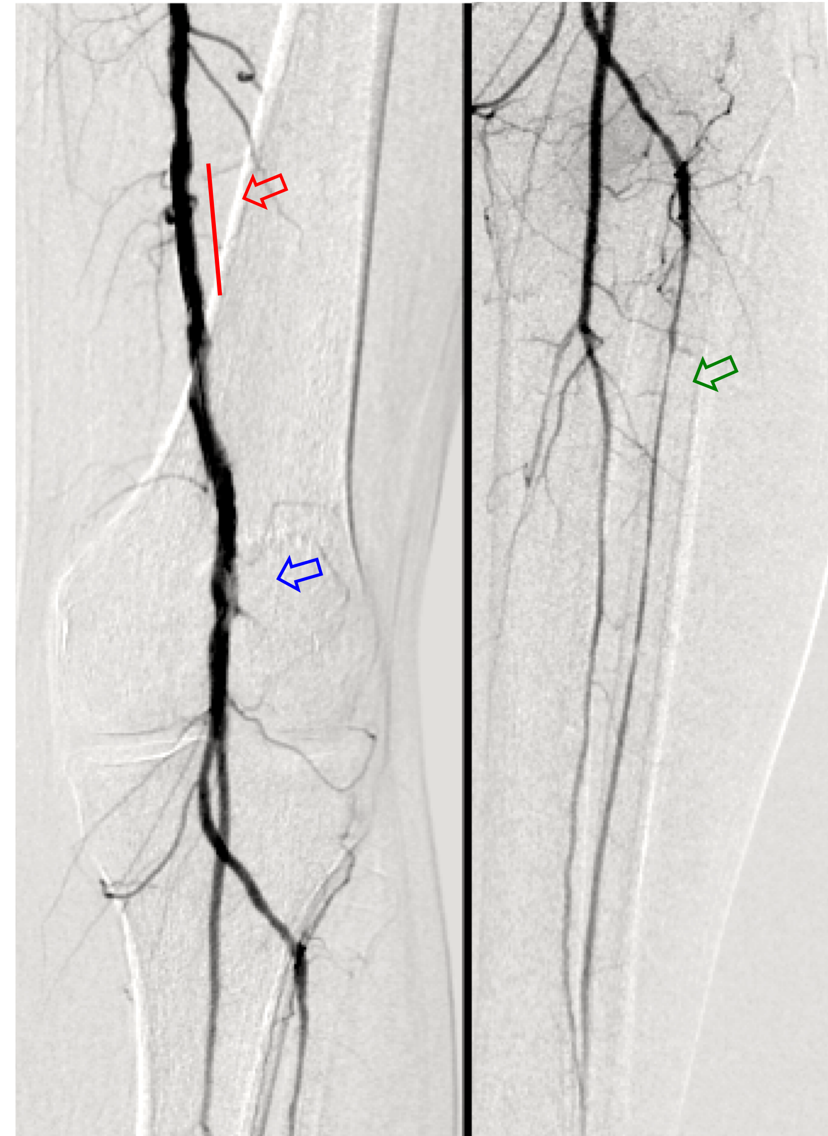
- 0,018 from top to the distal ATA (passing the puncture zone)
- Removing the 0,035 from the retrograde approach
- Ballooning the ATA with a POBA (sterling 2x60mm) for 5min to obtain hemostasis
- POBA (sterling 3x120mm) predilatation followed by DCB Passeo 18 Lux 4x120mm)



POBA (sterling 3x120mm) predilatation

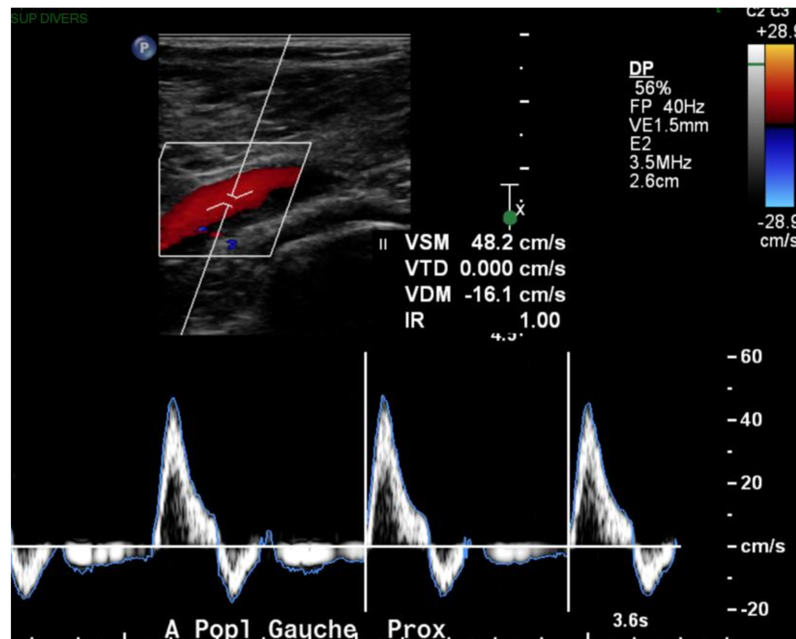
Next step

- Spot stenting of the distal SFA (Innova 5x40) due to residual stenosis (>50%) ⇧
- Final angio shows:
  - Persistant stenosis at P2 level but not significant ⇧
  - Vasospasm of the ATA for what we injected 1cc of papaverine ⇧

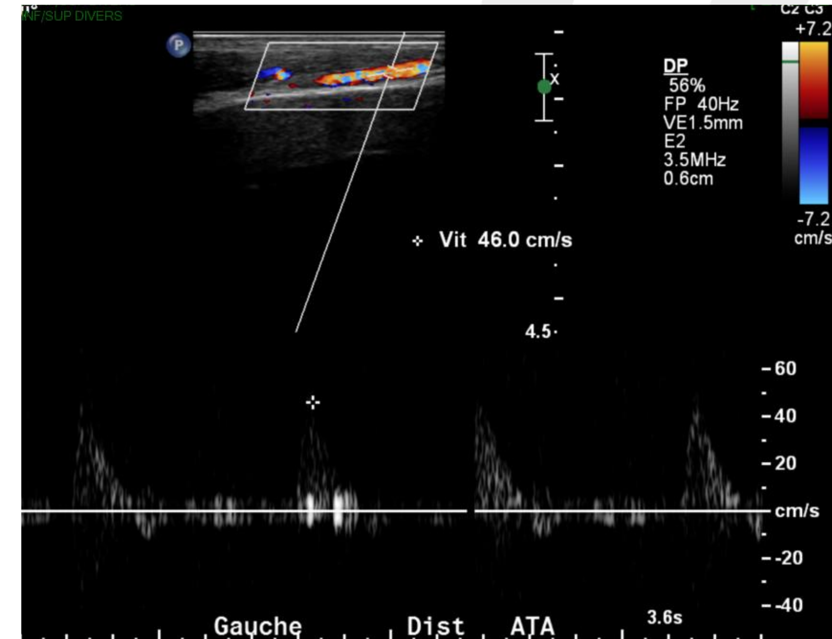


Follow up

- 2 months
  - Patent femoropopliteal segment



- Patent anterio tibial artery



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Questions

- Would you have chosen another recanalization option?
- Would you have stent the residual P1 stenosis?
- Would you have stent the entire occluded popliteal segment?
- Would you perform an additional treatment on the vasospastic ATA?