

Subclavian CTO Recanalisation

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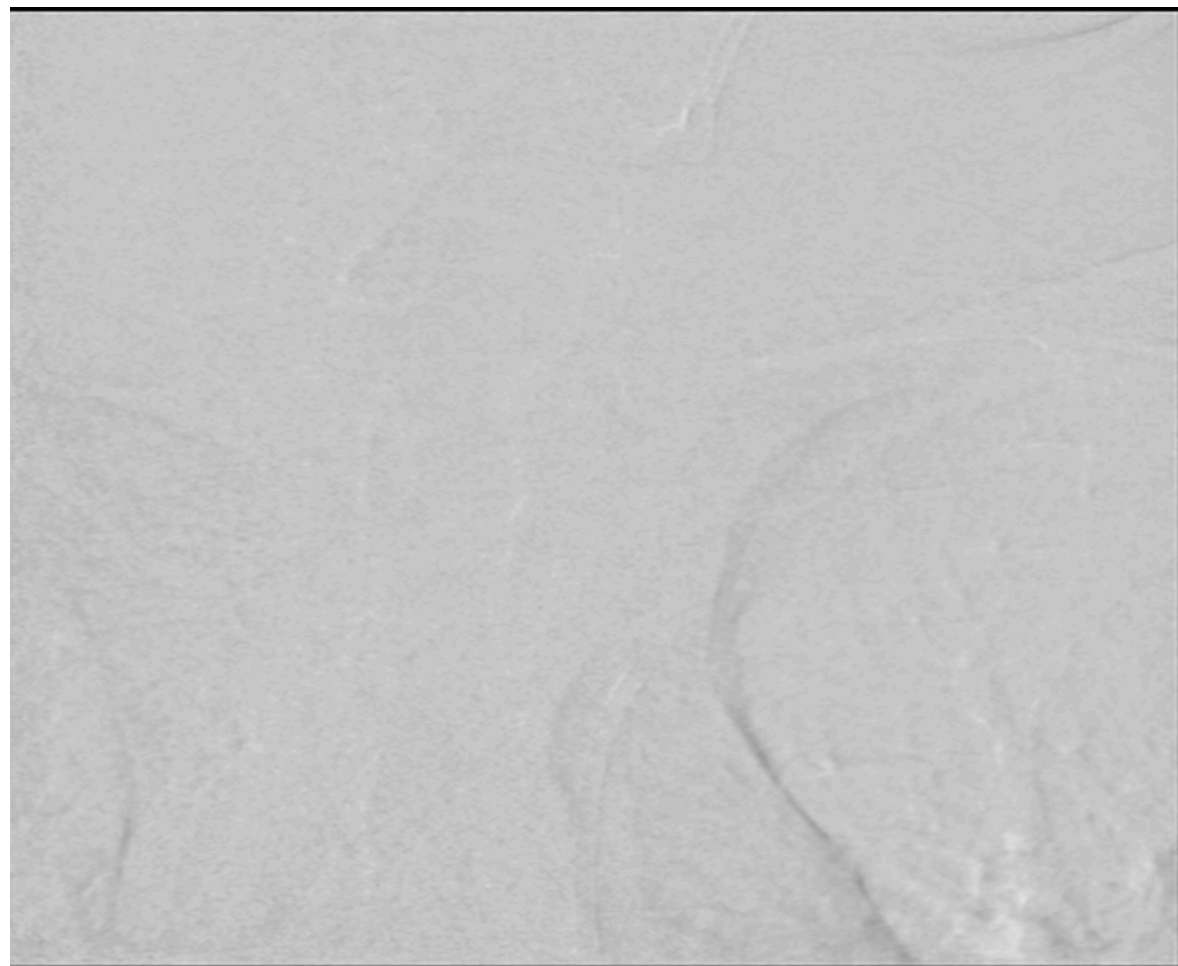
Patient Profile

- 70 yrs old male
- Heavy smoker, diabetic and hypertensive
- Effort angina FC II and Intermittent claudication of left upper limb – 6months
- Absent left radial and brachial pulses
- Systolic BP difference of 100 mmHg
- CVS – NAD
- ECHO - LVH and Good LV function. No RWMA
- TMT positive
- Planned CAG and PAG



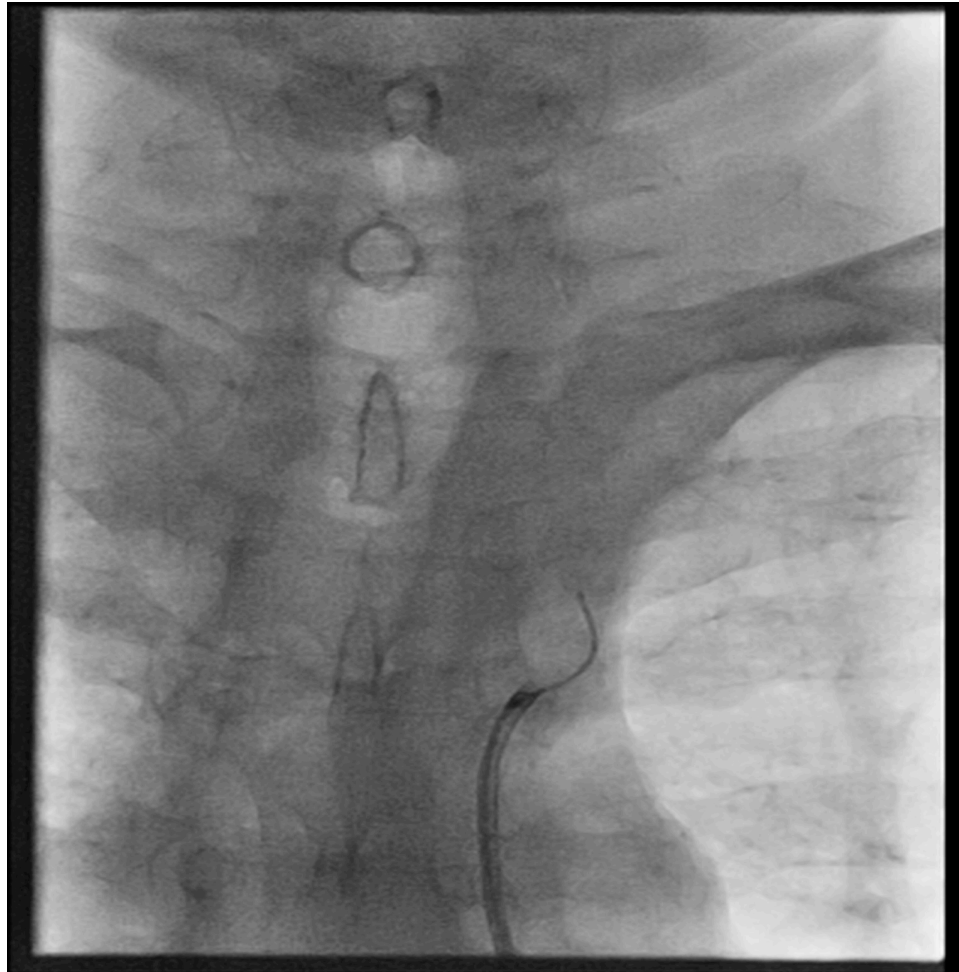
CAG – SVD LCx lesion

PAG – Left Subclavian CTO



6F JR 4 guide → MP guide

035 Terumo J tip wire

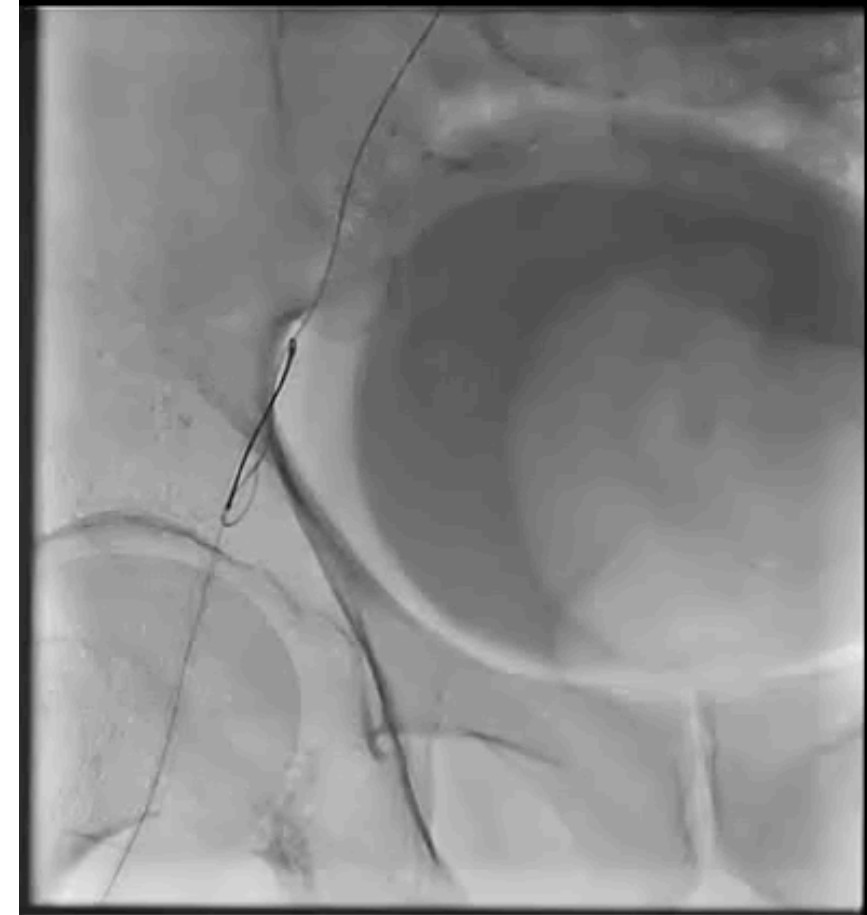
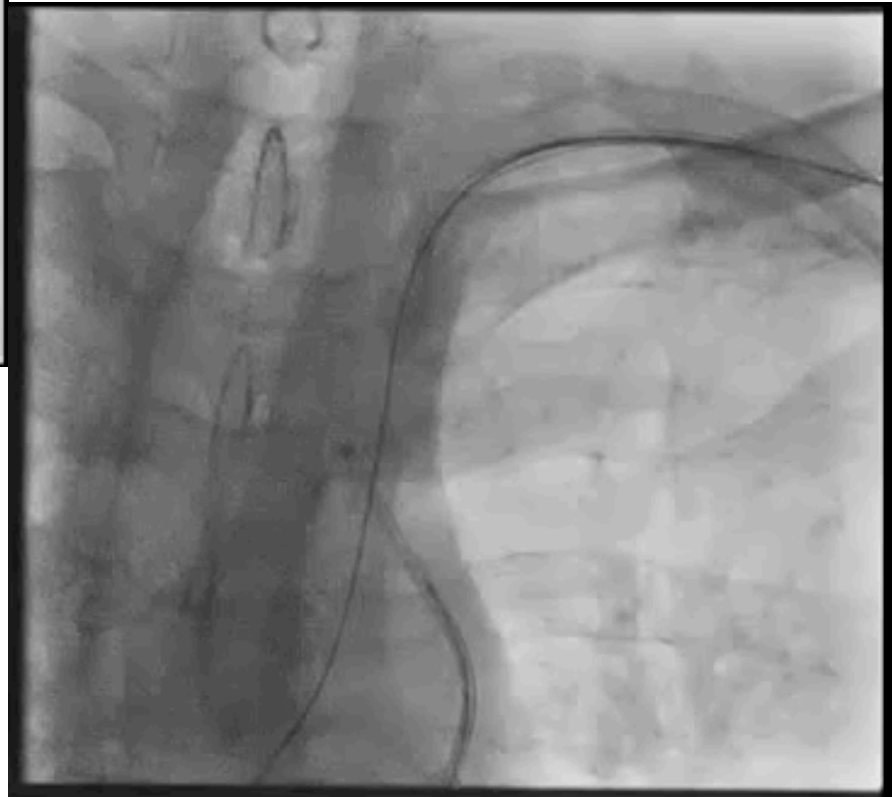


Retrograde approach

Radial Access , JR diagnostic and
035 Terumo J tip wire

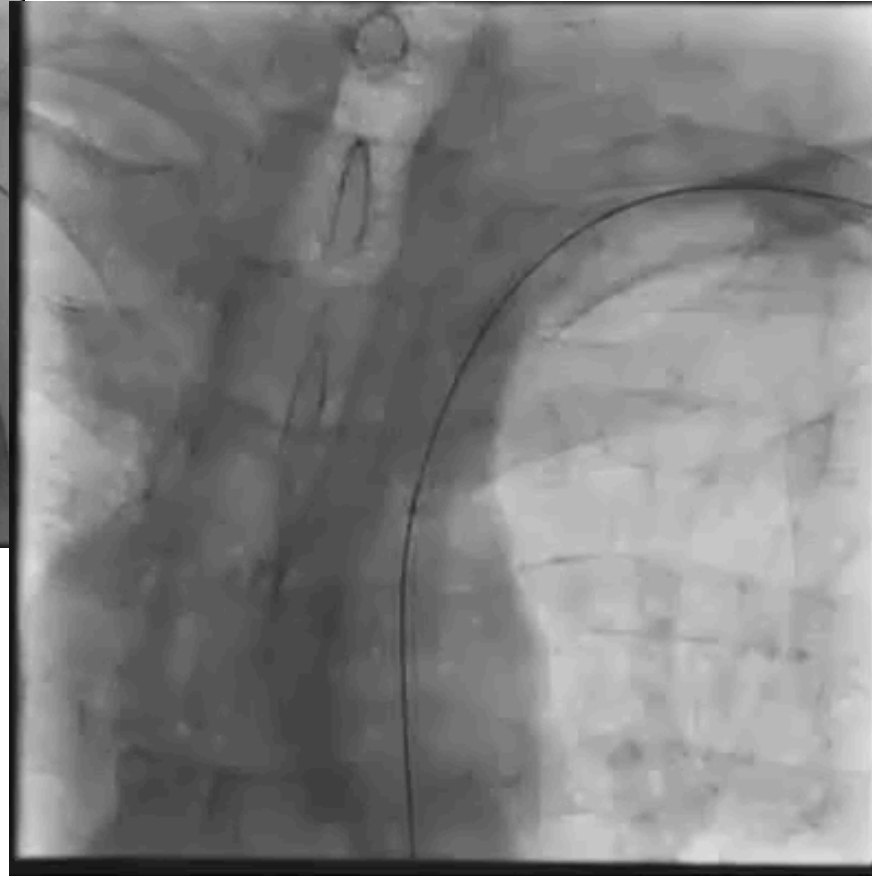


Lesion crossed , wire snared out

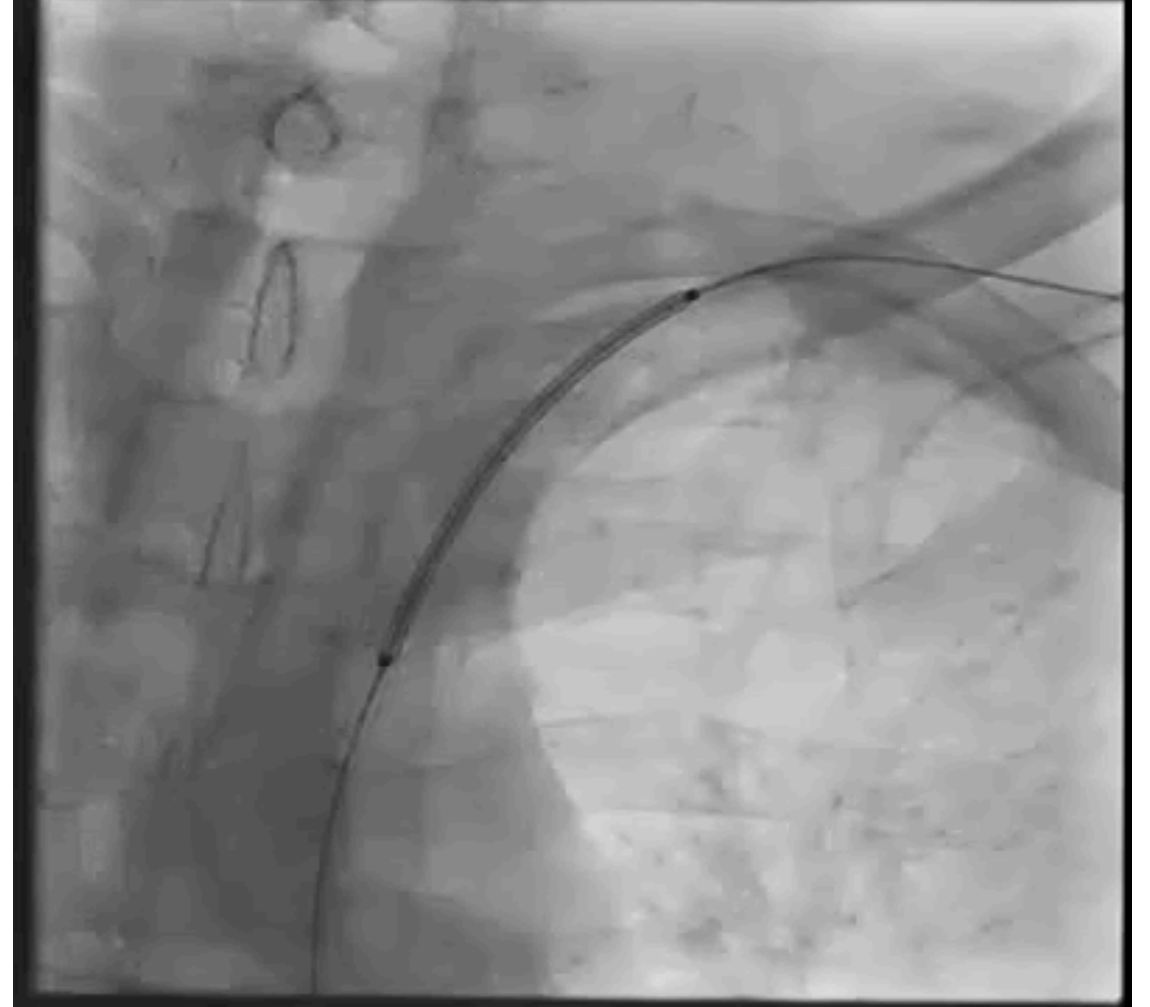
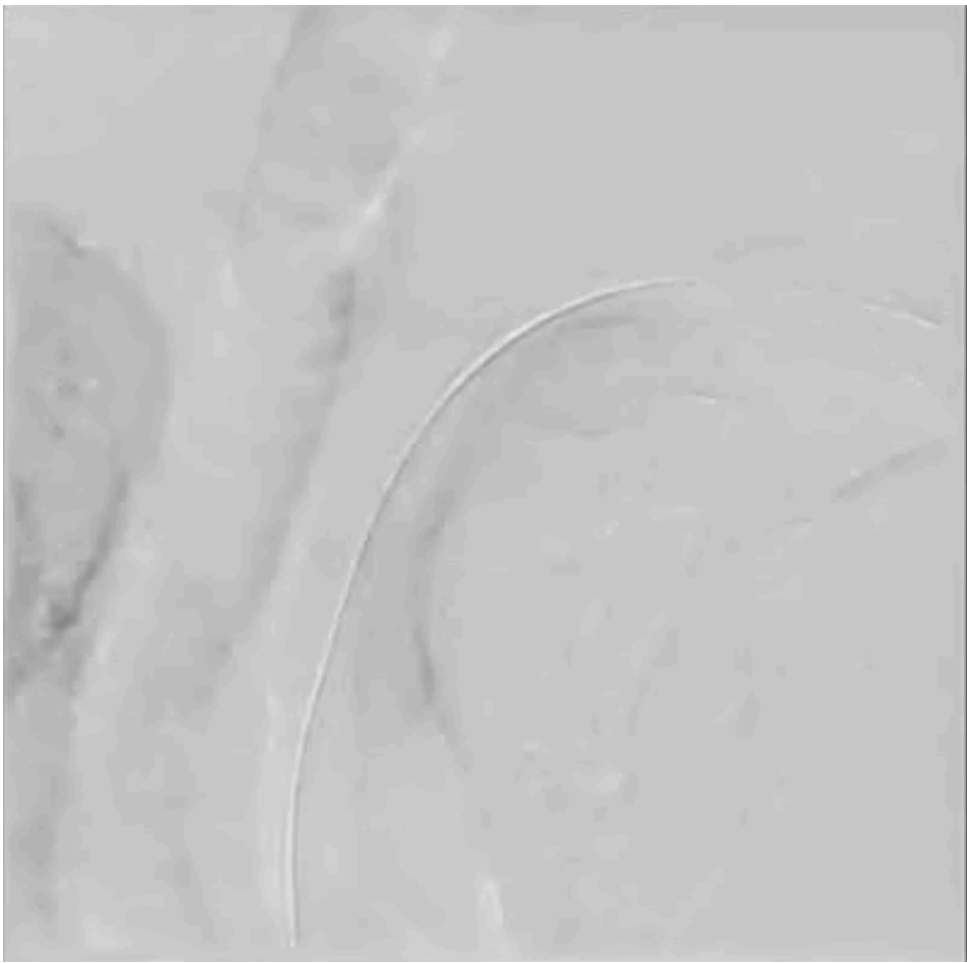


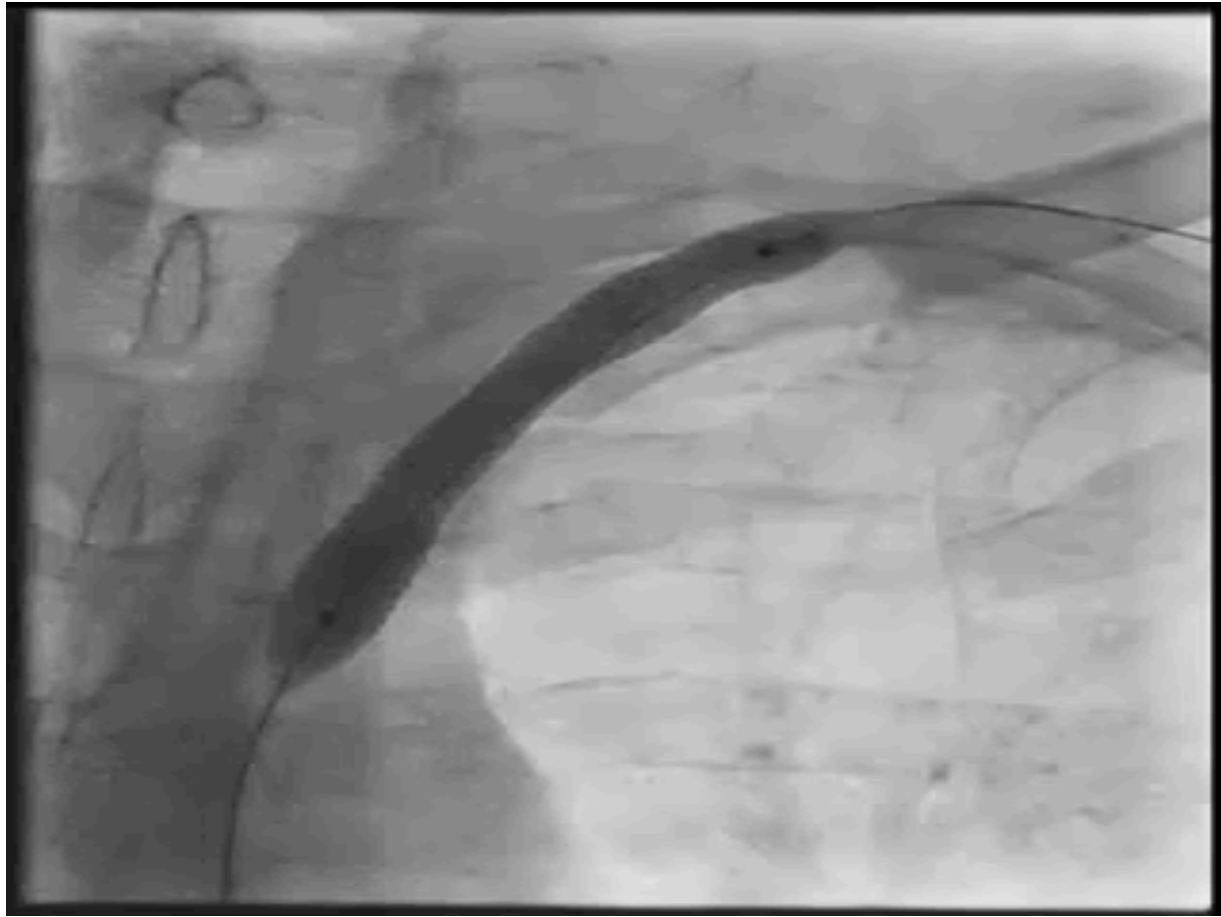
JR catheter over externalised wire

Pre dilatation 6X 40 and 7X 40 balloon

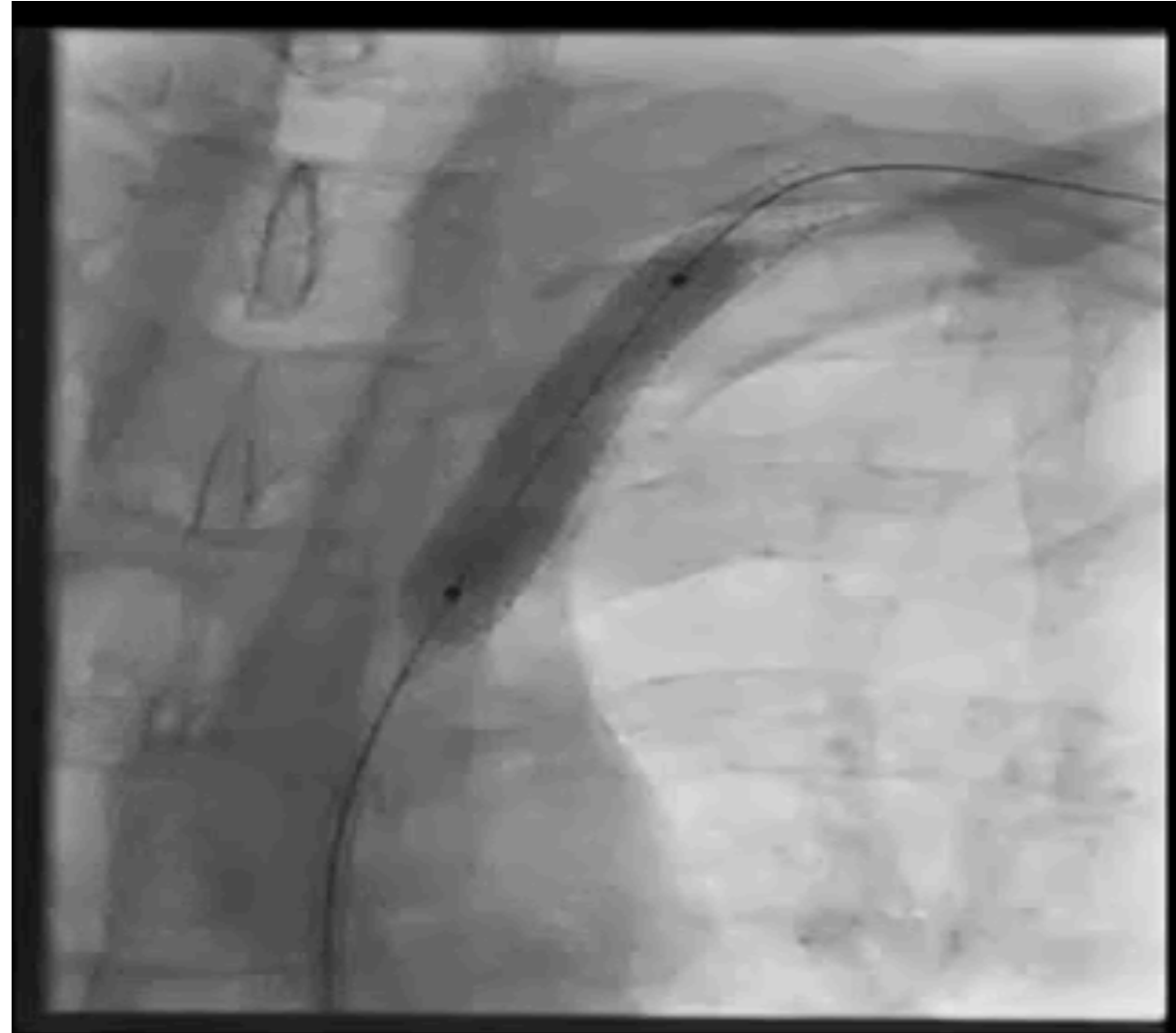


9X55 INVATEC SCUBA stent





POST DILATATION WITH 9 X 40 BALLOON



FINAL RESULT



- **AORTA – RADIAL PRESSURE GRADIENT OF 70 MMHG REDUCED TO ZERO**
- **ASYMPTOMATIC**

FOLLOW UP

- PTCA TO LCX WITH DES
- DRUG DEFAULTER , NO REGULAR FOLLOW UP AND CONTINUED SMOKING
- PRESENTED AFTER ONE YEAR WITH RECURRENT ANGINA
- NO CLAUDICATION. NO PULSE / BP ASYMMETRY
- CHECK ANGIO AFTER ONE YEAR – NORMAL SUBCALVIAN ARTERY FLOW BUT HAD ISR IN LCX
- RECENT FOLLOW UP – NO SYMPTOMS



Take home message...

- Failed ante grade approach – short stump, no guide support
- Successful retrograde approach - tapering stump, better support
- Retrograde approach by radial or brachial route is preferred for subclavian occlusion