

An Endovascular Treatment Of SFA And BTK Lesions

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Over the past decades major advancement have been made in treatment of PAD. The “tool box” has expanded with several devices: cutting/scoring balloons, wires, stents, atherectomy devices, and now accompanies by the drug-eluting therapies. The “leave nothing behind” strategy has gained in popularity, with the aim of leave the treated vessel without stent and intact for potential future treatment and avoid potential stent-related problem. In long SFA lesion, there are now increasingly being handle using and endovascular approach. Many DCBs offer a significant clinical benefit in term of primary patency, cd-TLR, and quality of life. However, in case of suboptimal result; recoil or flow limited dissection, or limited drug penetration in calcified segment, we can use focal stenting or debulking device with better result. DCB vs DES RCT shows no significant difference in primary patency at 1 year, however significant better 2year primary patency of the DES and also in mid and long lesions. Latest result from the RAPID trial showed high efficacy of using DCB plus SUPERA stent in long SFA/popliteal artery occlusion rather than DES. ZEPHYR investigated 3-year real-world outcomes of Zilver PTX treatment for FP long lesions. The restenosis occurred in half of cases, whereas MALE occurred in one third. Viabahn registry in the long lesion in Japan shows excellent result with 88% 12 month and 78% 24 month primary patency without acute limb ischemia or amputation

The early DCB-BTK evidence from Leipzig and DEBATE study showed high promise for IN.PACT Amphirion to reduce restenosis and reintervention rate vs standard PTA. DEEP IN.PACT trial is the latest RCT of DCB which failed to showed benefit of IN.PACT. Amphirion over plain balloon due to higher major amputation rate in DCB arm. However, there is good evidence for the treatment of short BTK lesion with conventional metallic DES. Lately, BVS shows similar efficacy with excellent 12-month patency and also added benefit of no permanent implant, even in long lesions, some of which are calcified. So, case selection, lesion preparation is key. For the no option CLI patient, early experience with LimFlow shows good result at 1 year.