

CONTROVERSES ET ACTUALITÉS EN CHIRURGIE VASCULAIRE
CONTROVERSIES & UPDATES
IN VASCULAR SURGERY



JANUARY 23-25 2014

MARRIOTT RIVE GAUCHE & CONFERENCE CENTER PARIS, FRANCE

Do we really need a stent in long SFA lesions ?
Newest stents are perfect for the job

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www.cacvs.org



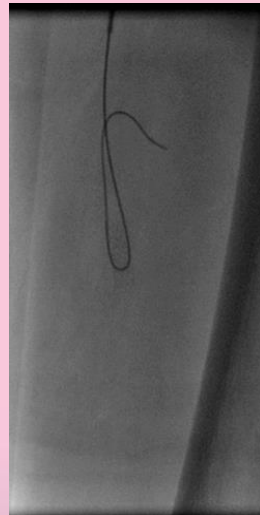
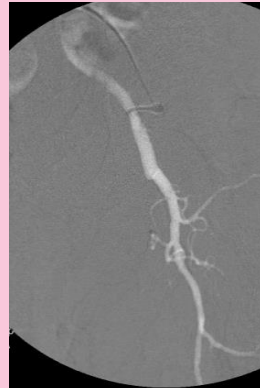
Disclosure

Speaker name:

Yann Gouëffic

- ☒ I have the following potential conflicts of interest to report:
- ☒ Consulting: Medtronic, Cook, Cordis and Abbott
- ☐ Employment in industry
- ☐ Shareholder in a healthcare company
- ☐ Owner of a healthcare company
- ☐ Other(s)
- ☐ I do not have any potential conflict of interest

TASC C and D: challenging cases



>15-cm

Popliteal involvement

Stenoses – occlusions

Calcifications

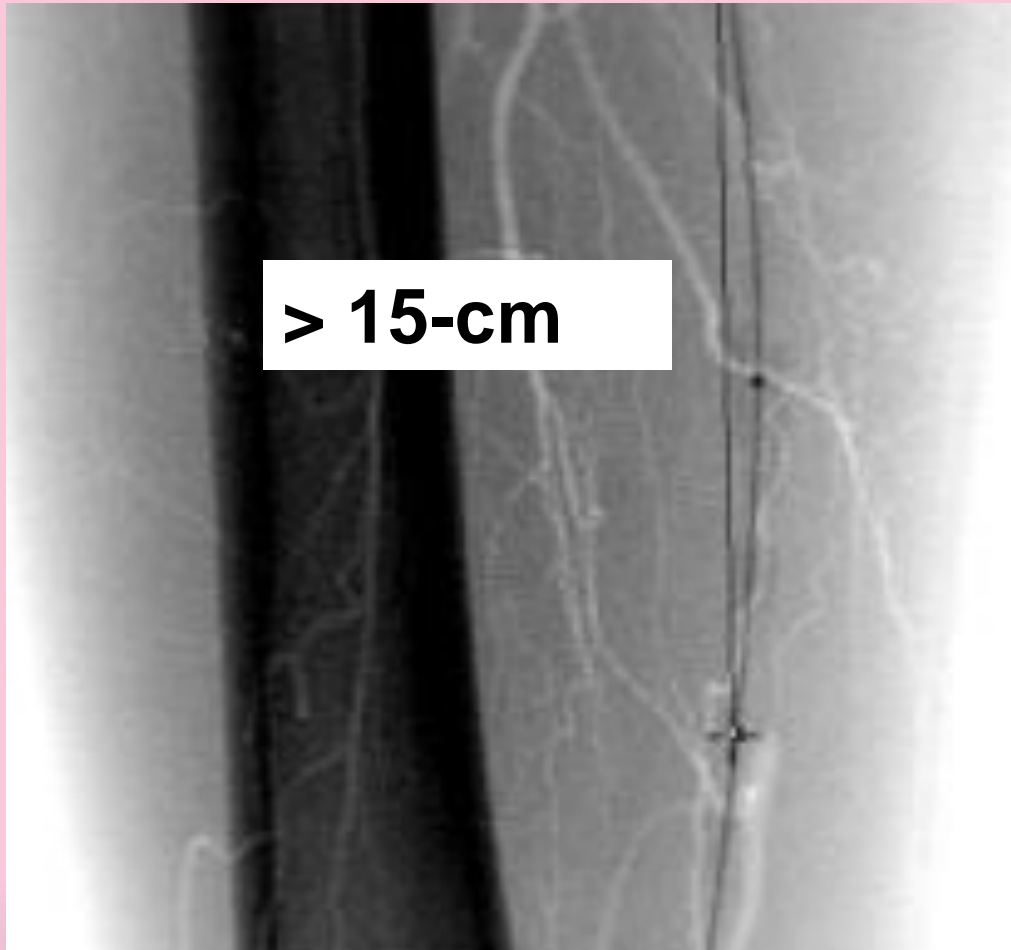
CLI by alteration of the re-entry

Entry / Re-entry

Intra and subintimal

Long balloons - stents

After crossing the lesion...



PTA

Bare metal stent

Covered stent

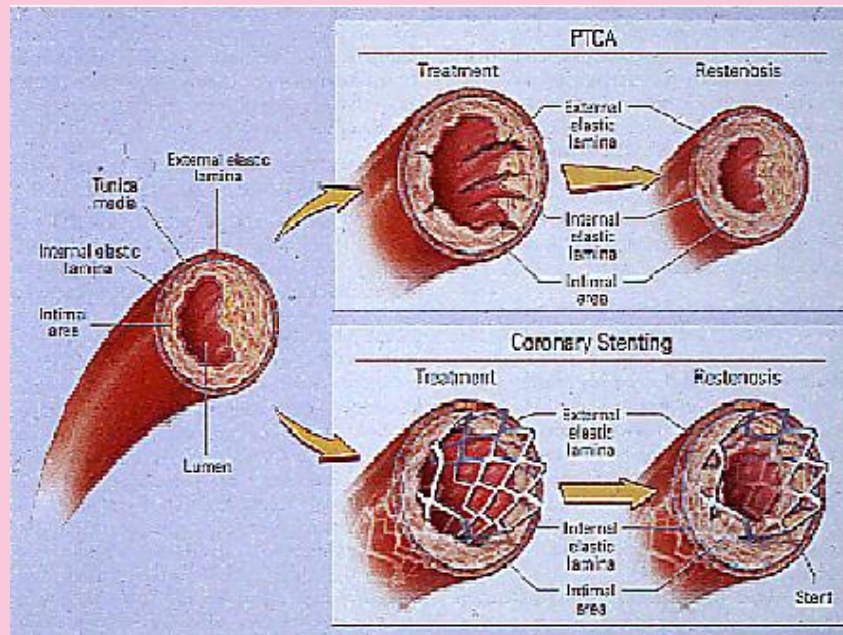
Drug eluting stent

Drug eluting balloon

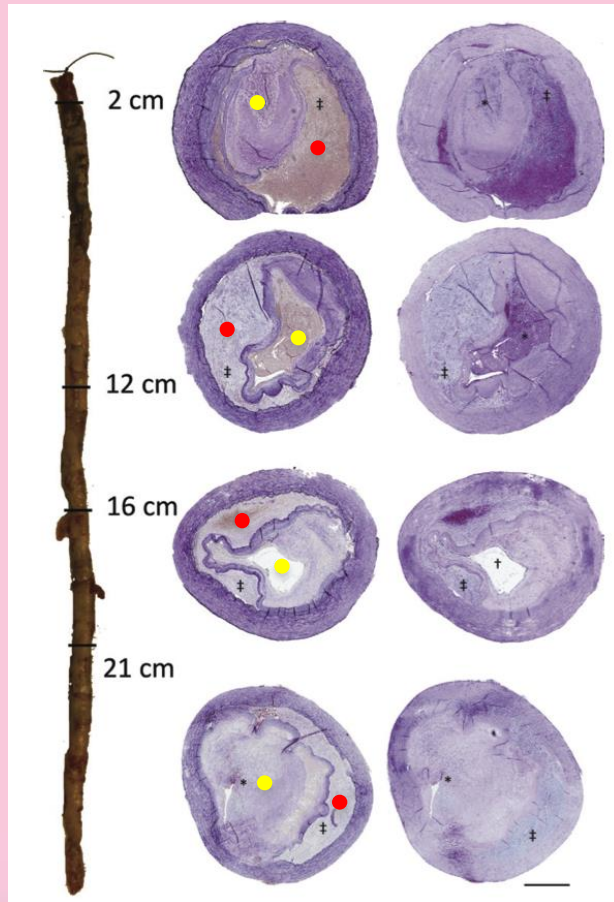
Bioresorbable stent

Scaffolding

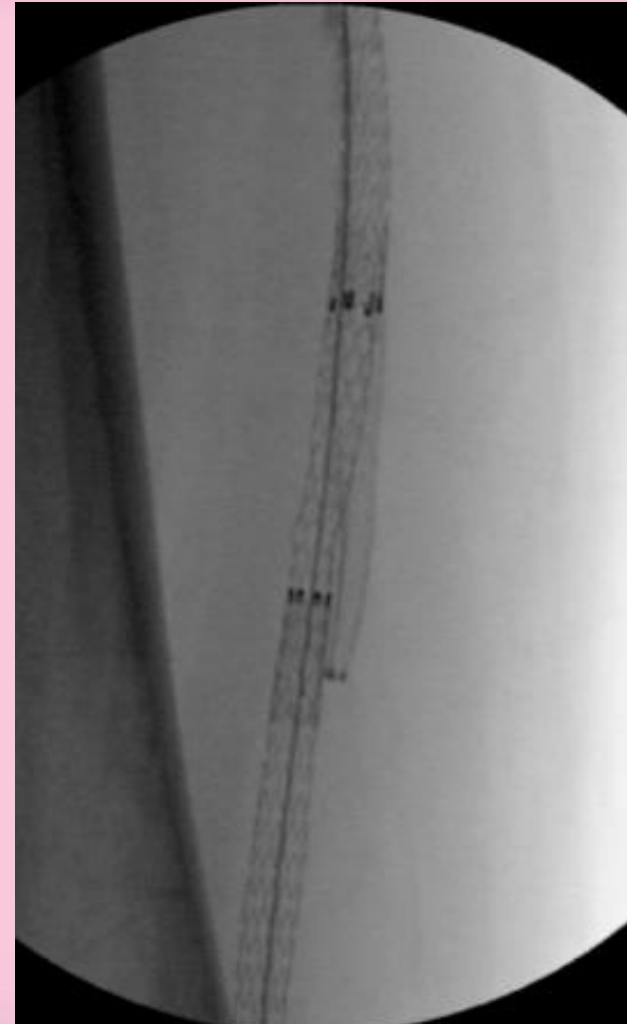
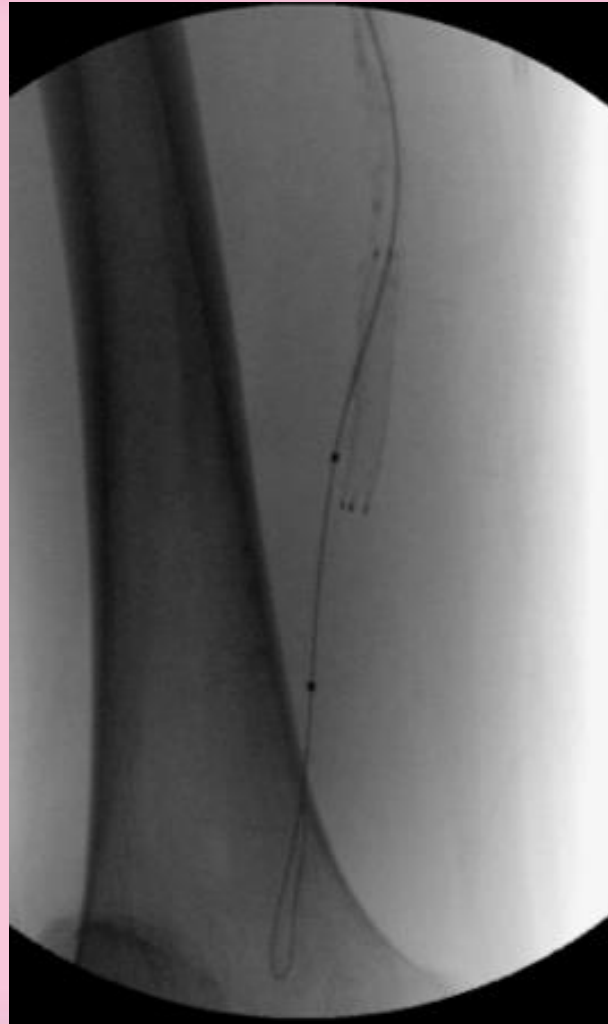
To prevent the elastic recoil and constrictive remodeling



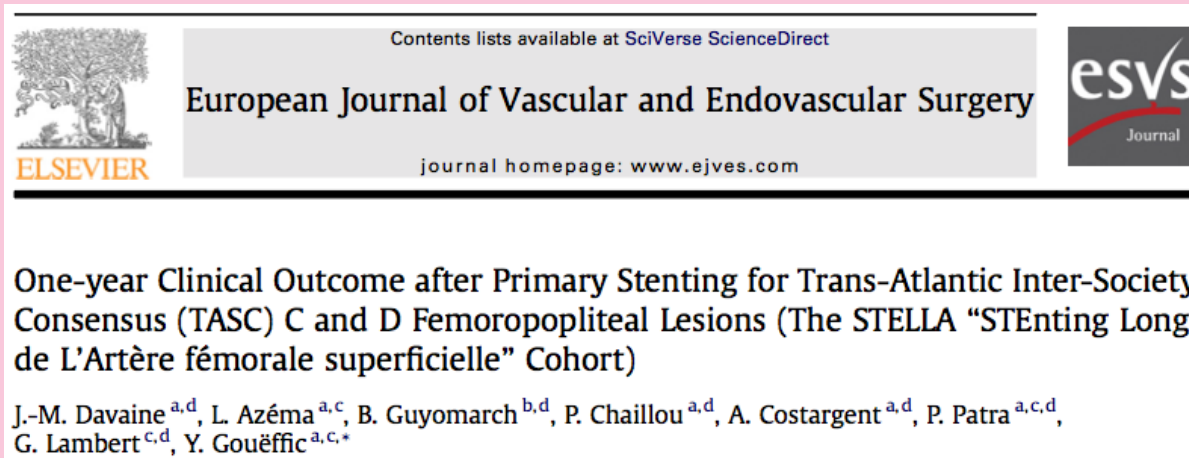
Early reobstruction of the subintimal angioplasty track obtained 2 months after procedure



- The true lumen (●) of the superficial femoral artery is still open at 12 cm distance
- Dissection of the arterial wall located between the internal elastic lamina and the atherosclerotic plaque (●)
- The newly formed route in the arterial wall was filled with thrombus at all levels
- Reobstruction began at the distal part of the artery



Bare metal stents



European Journal of Vascular and Endovascular Surgery xxx (2012)

Results of the Protégé EverFlex 200-mm-long nitinol stent (ev3) in TASC C and D femoropopliteal lesions

Marc Bosiers, MD,^a Koen Deloose, MD,^a Joren Callaert, MD,^a Nathalie Moreels, MD,^a Koen Keirse, MD,^b Jürgen Verbist, MD,^b and Patrick Peeters MD,^b *Dendermonde and Bonheiden, Belgium*

J Vasc Surg 2011;54:1042-50

Demographic and morphologic data

Durability-200

STELLA

N (limbs)	100	62
Mean rutherford stage	3.04	4.05
IC / CLI (%)	71 / 29	40.3 / 59.7
TASC C / D (%)	49/51	62.9 / 37.1
Mean length of treated segment (mm)	242	220

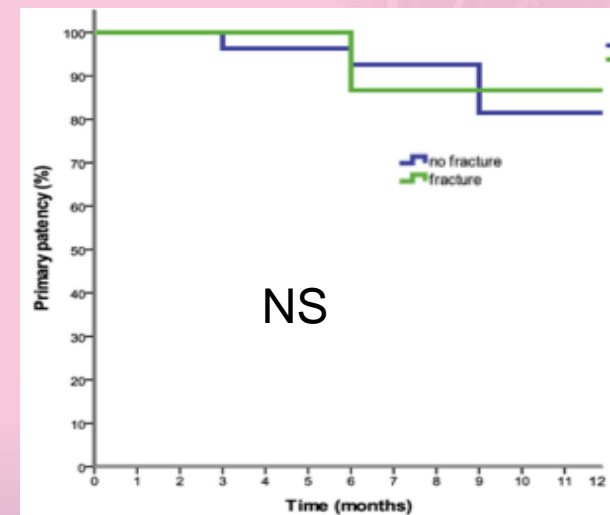
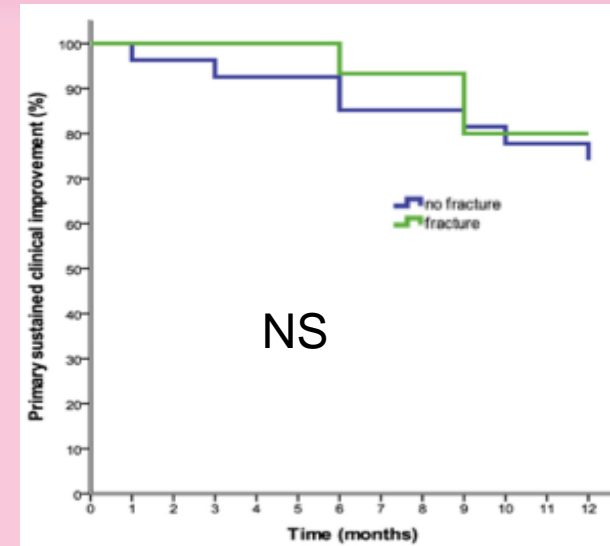
Clinical outcomes @ 1 year

	Durability-200	STELLA
Iry sustained clinical improvement (%)	-	68.6
Mean rutherford stage	0.68	0.71
Asymptomatic (%)	-	64.8
IC / CLI (%)	- / -	29.6 / 5.6
Freedom of TLR (%)	68.2	81.1

Morphologic outcomes @1 year

	Durability-200	STELLA
Primary patency (%)	64.8	66
Secondary patency (%)	-	80.9
In-stent restenosis (%)	24	19.3
In-stent thrombosis (%)	10	11.3
Stent fracture in a limb basis (%)	6	17.7

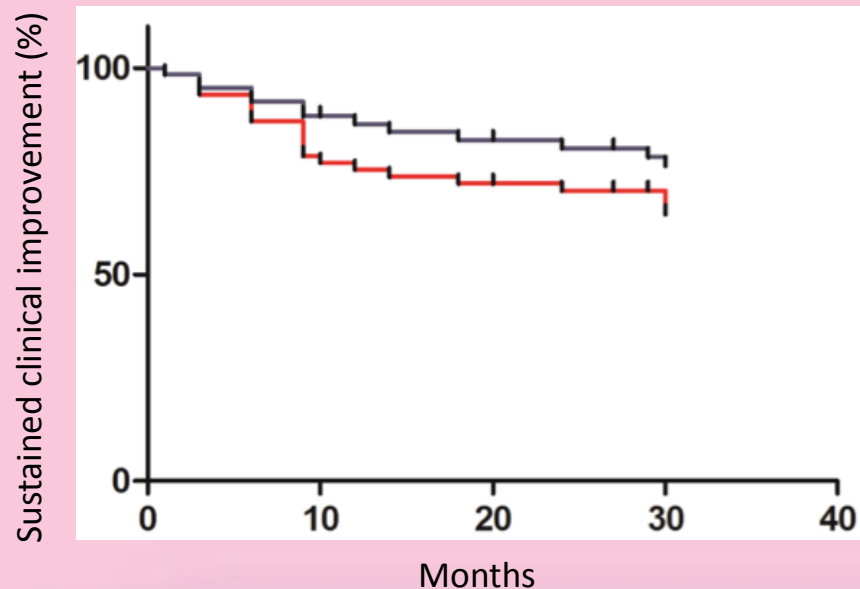
Stent fractures (16/90 - 17.7%)



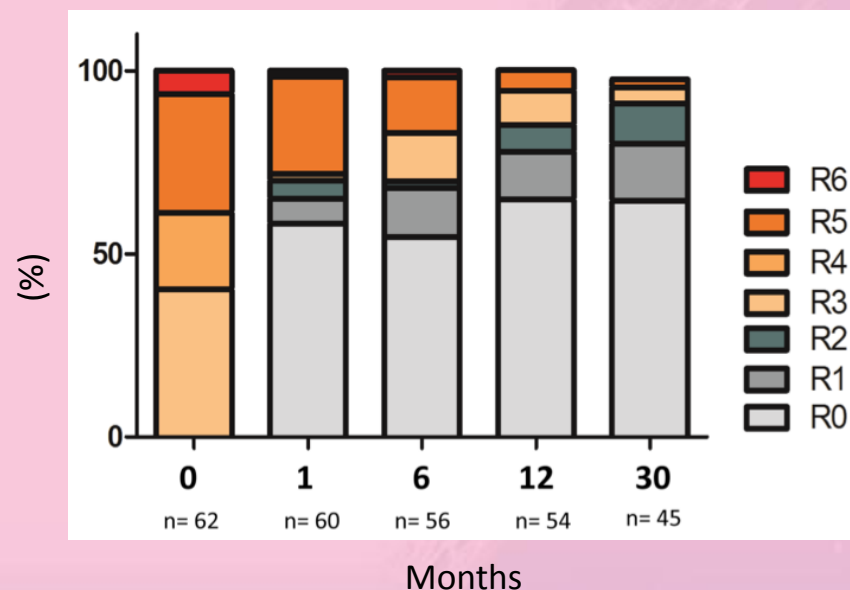
Long term outcomes

@ 30 mo: 55 patients – 58 limbs
 (Baseline: 58 patients – 62 limbs)

**Primary and secondary sustained
 clinical improvement @ 30 mo :
 64.6% and 76.3%**



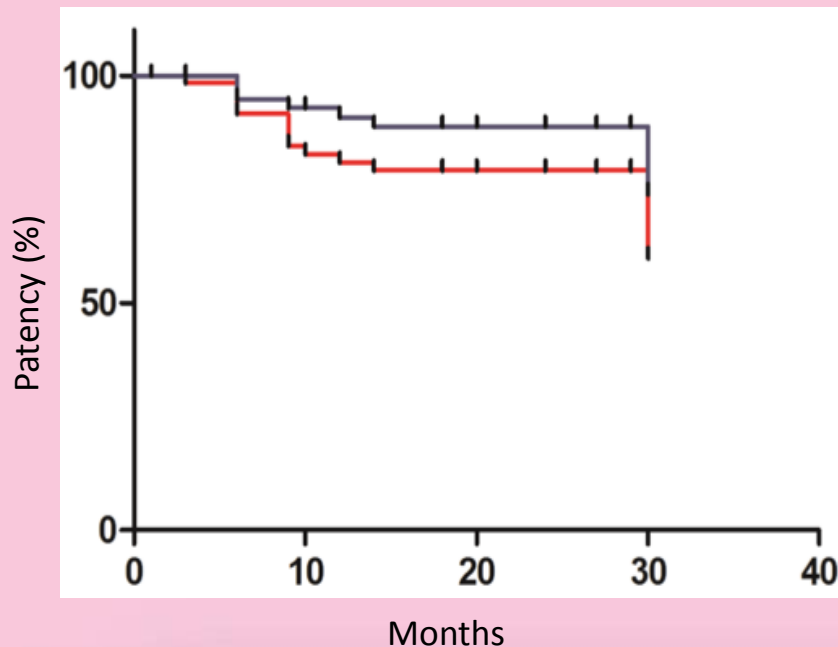
Mean rutherford stage @ 30 mo: 0.6
 (4.1 @ baseline)



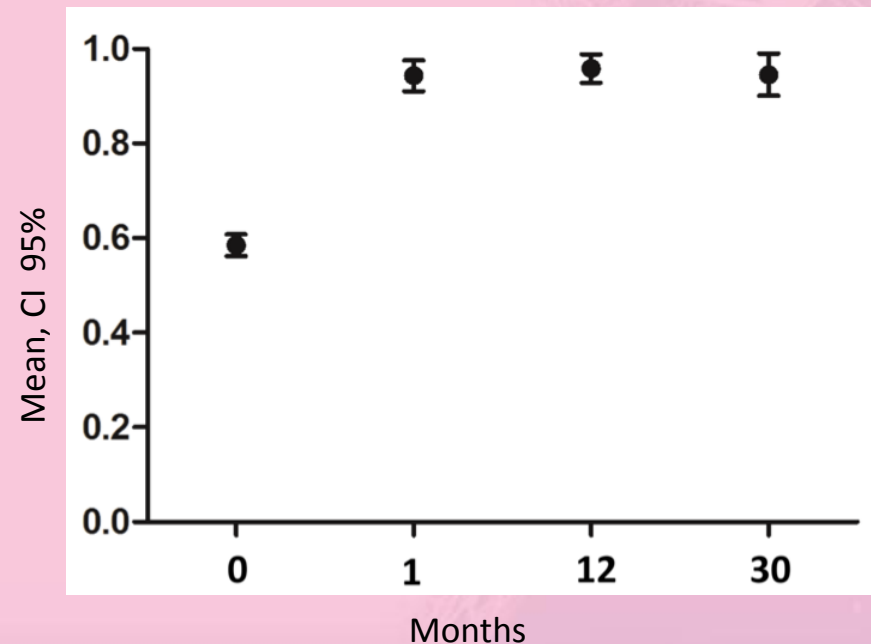
Long term outcomes

@ 30 mo: 55 patients – 58 limbs
(Baseline: 58 patients – 62 limbs)

**Primary and secondary patency @
30 mo: 60% and 74%**



Mean ABI @ 30 mo: 0.95
(0.6 @ baseline)



Messages to take home

- Stenting of TASC C and D femoropopliteal lesions appears to be safe, efficient and durable repair
- Early narrow clinical and duplex scan follow-up of long stents is mandatory to detect potential thrombosis and ISR events
- Primary stenting of TASC C and D lesions needs ongoing surveillance and longer follow-up, given the high rate of CLI
- DES for TASC C and D femoropopliteal lesions ?

STELLA-PTX trial

(released in spring)

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PTA for long femoropopliteal lesions

- ✓ **Median length: 11-cm (2-37)**
- ✓ **Technical success rate: 80% (159 / 200)**
- ✓ **Increase risk of reocclusion:**
 - smoking (x 2.7)
 - each 10 cm of occlusion length increases the risk by a factor of 1.73.
- ✓ **Decrease the risk of reocclusion:**
 - Each run-off artery (/0.54)

