Peripheral Angioplasty why Cardiologists should do it

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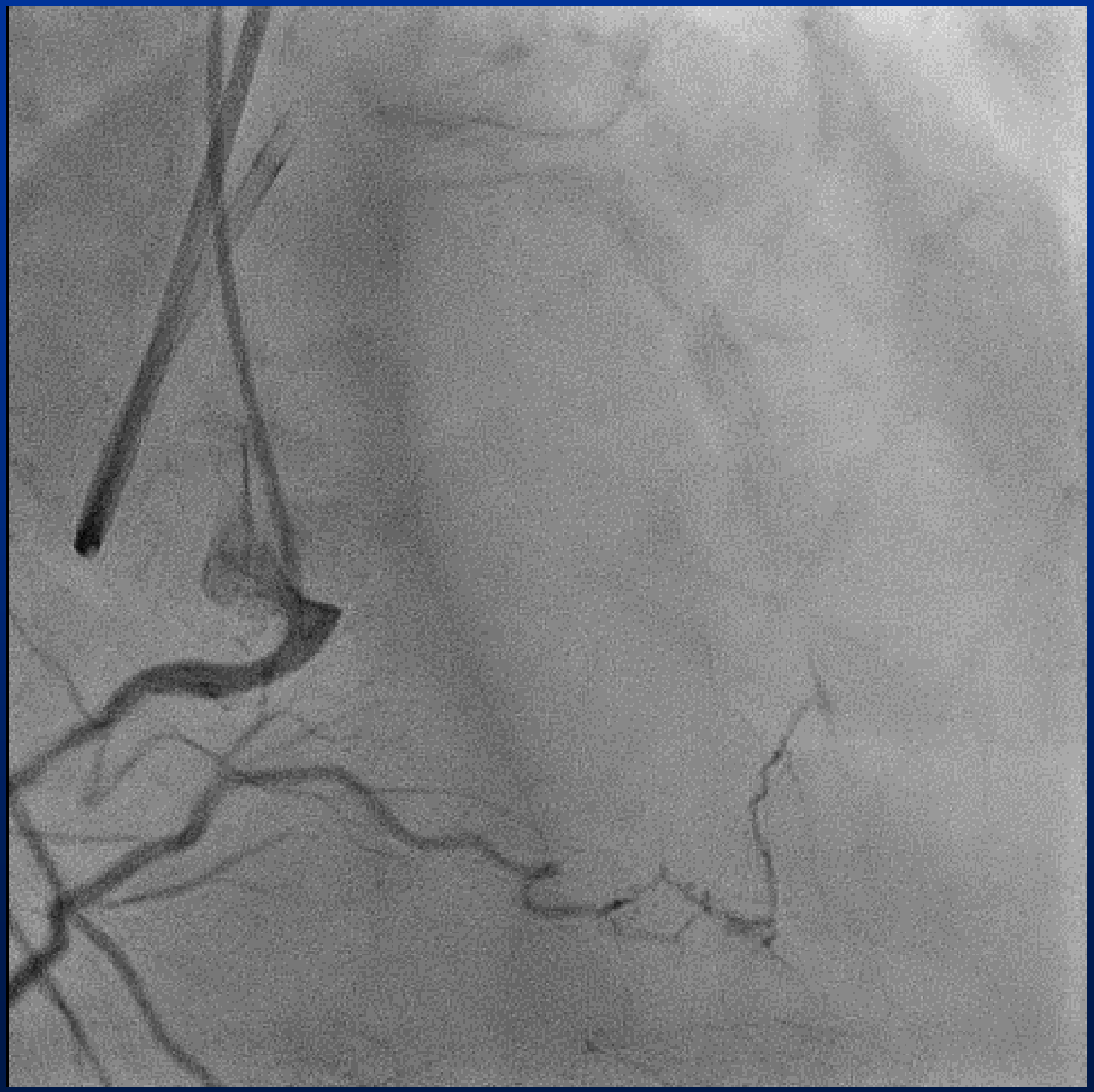
Because

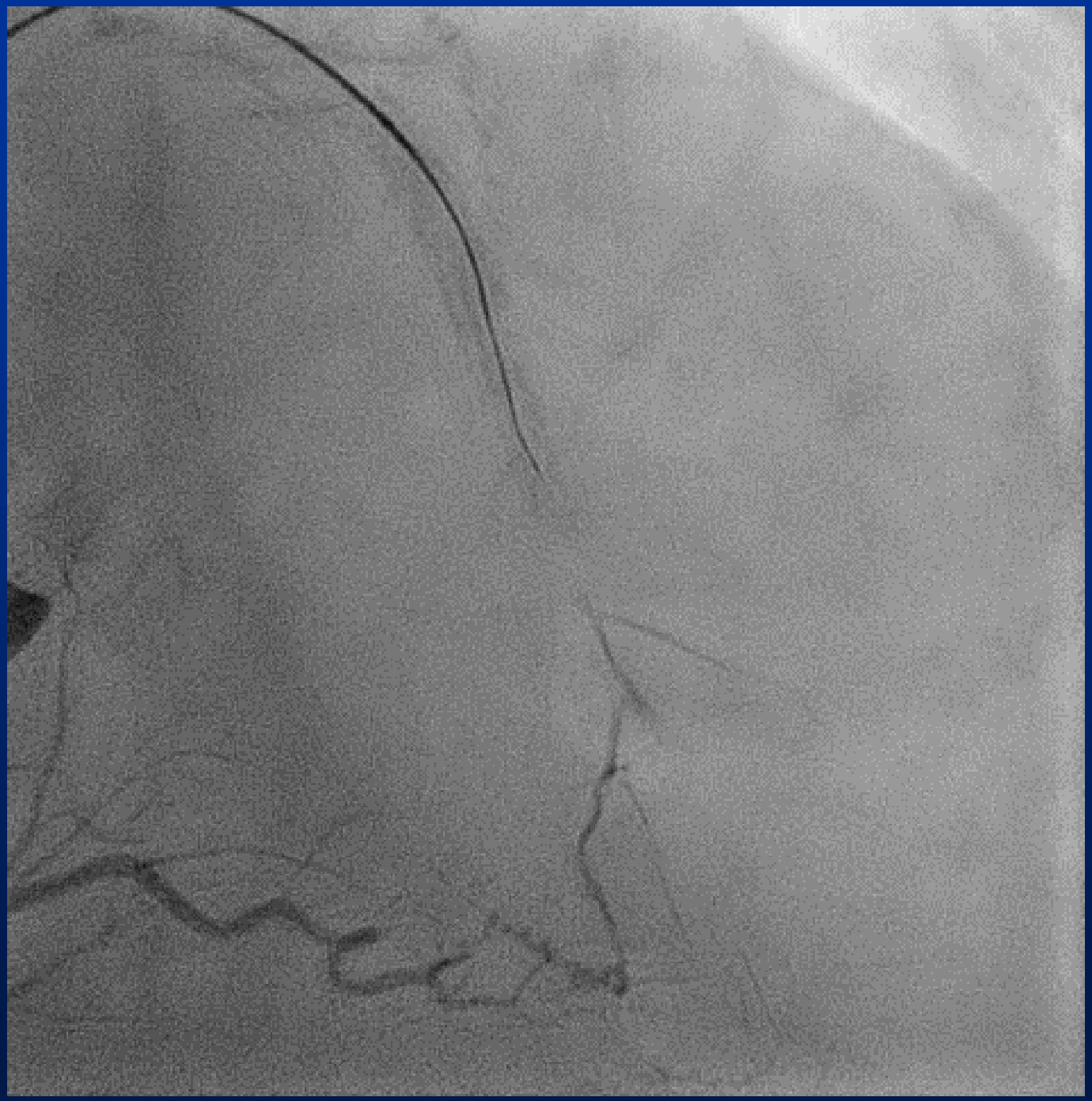
- > 50% are patients with CAD
- We may apply coronary techniques and materieal to open arteries
- Its a field with increasing need for interventions
- Its very gratifying: opening occlusions is saving limbs

My long way to peripheral angioplasty

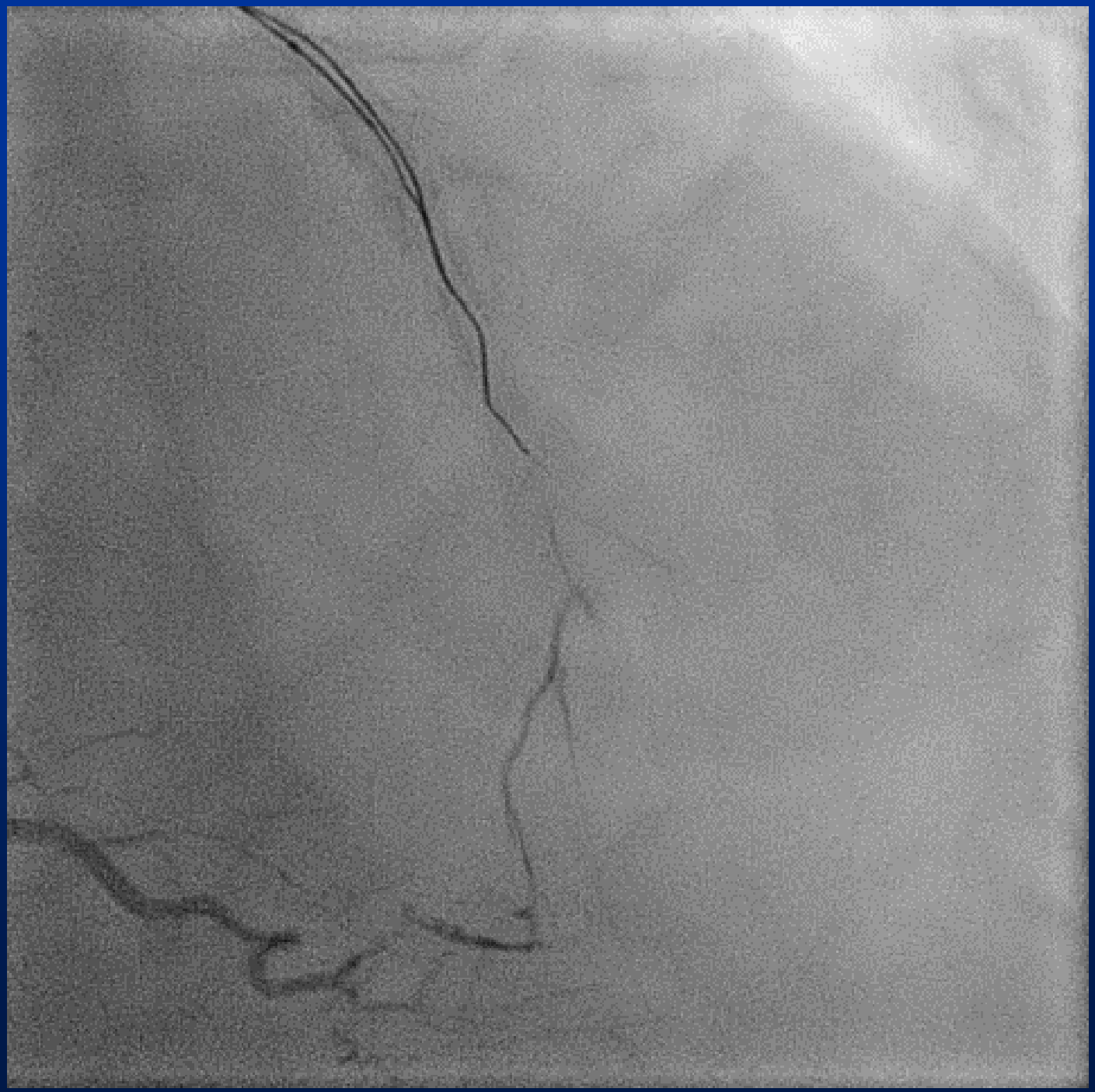
- 1982 first PCI 1985- now about 500 /year
- 1984 renal angioplasty 8/year
- 1994 carotid angioplasty 10/year
- 1998: Jim Margolis: why dont you start peripheral angioplasty
- Since 2005 peripheral program continuously growingn now about 150/year



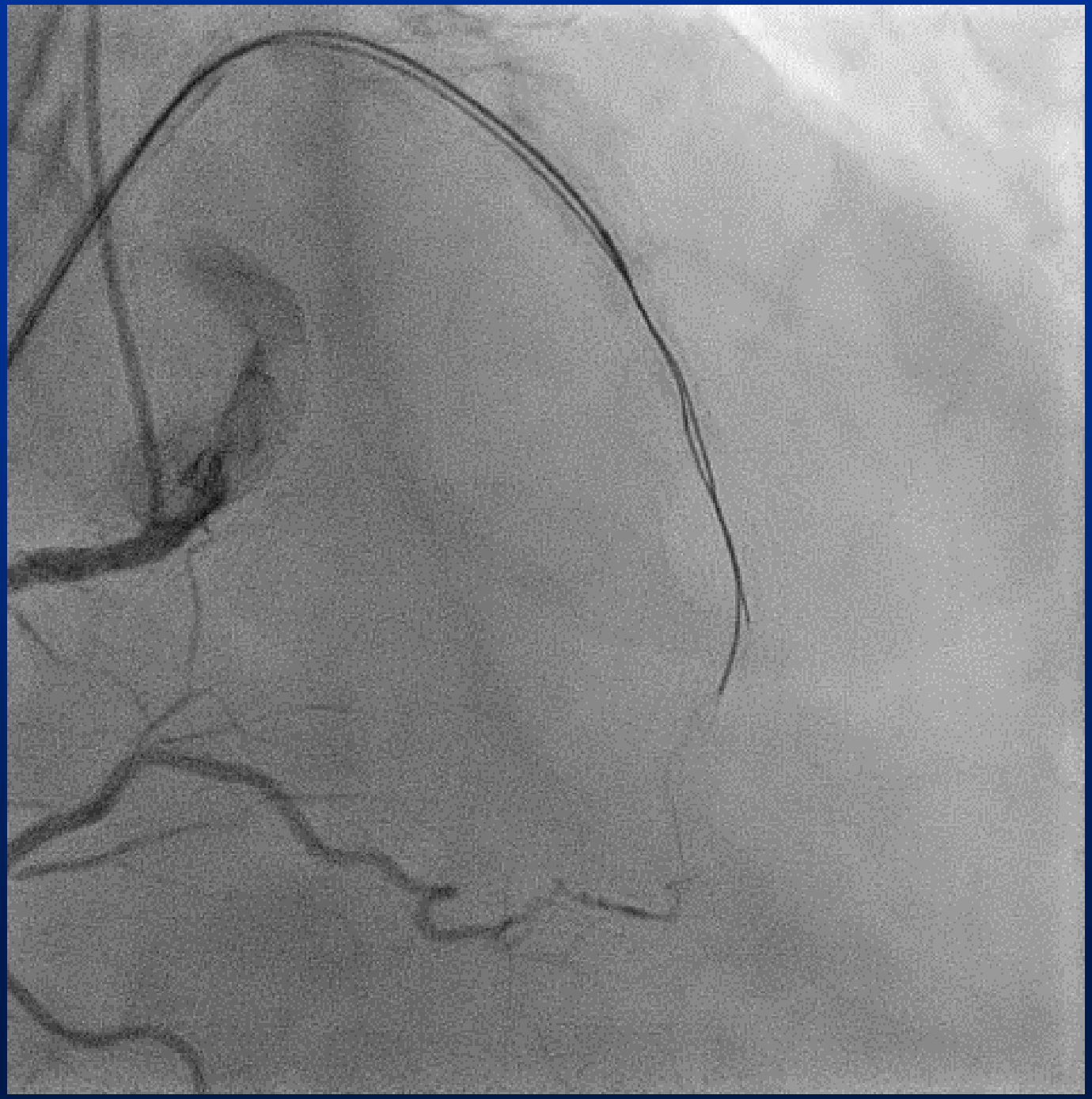
Calcifyed
LAD
occlusion



Corsair
Confianza 9

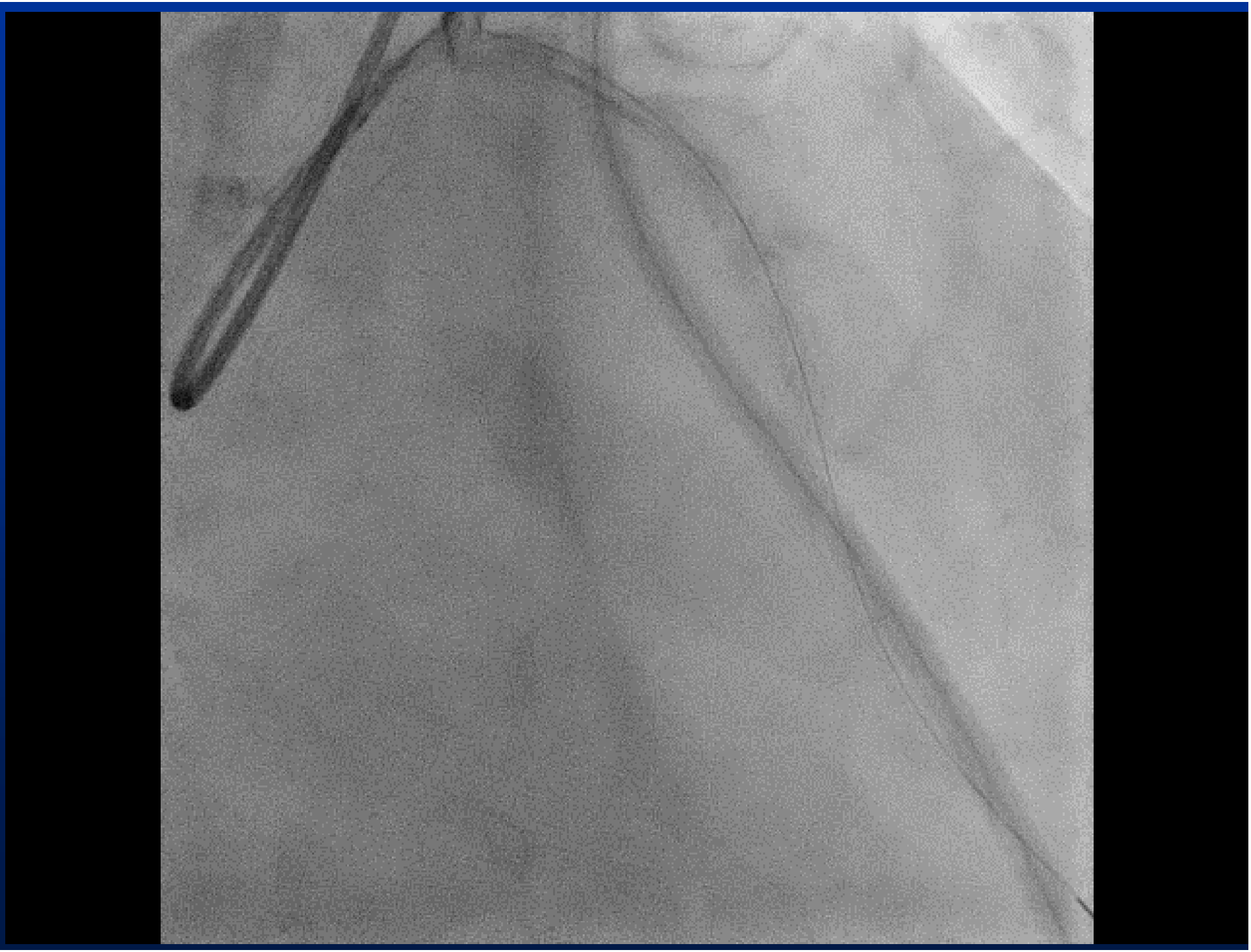


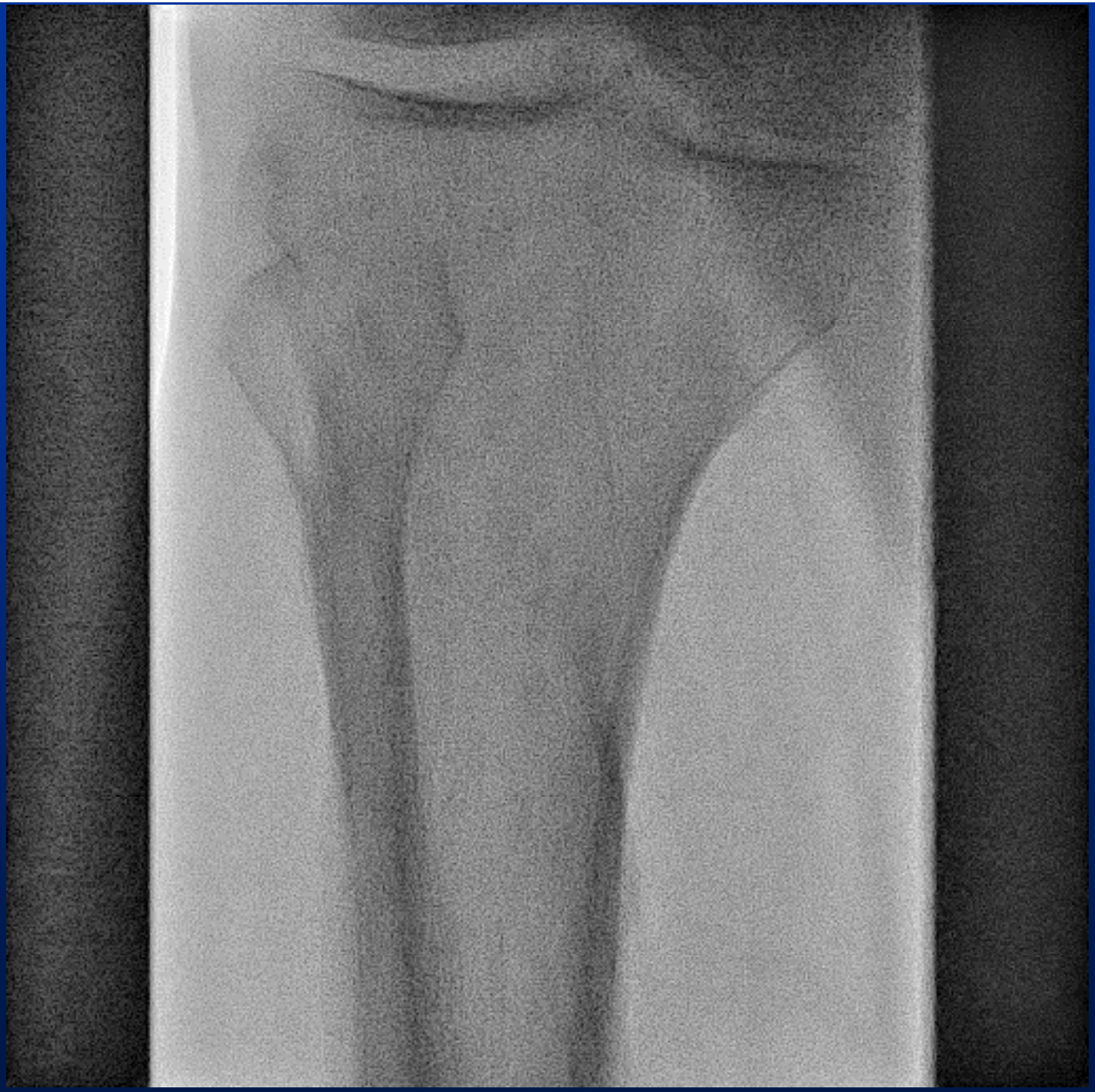
Crusade and parrallel wire (C9)



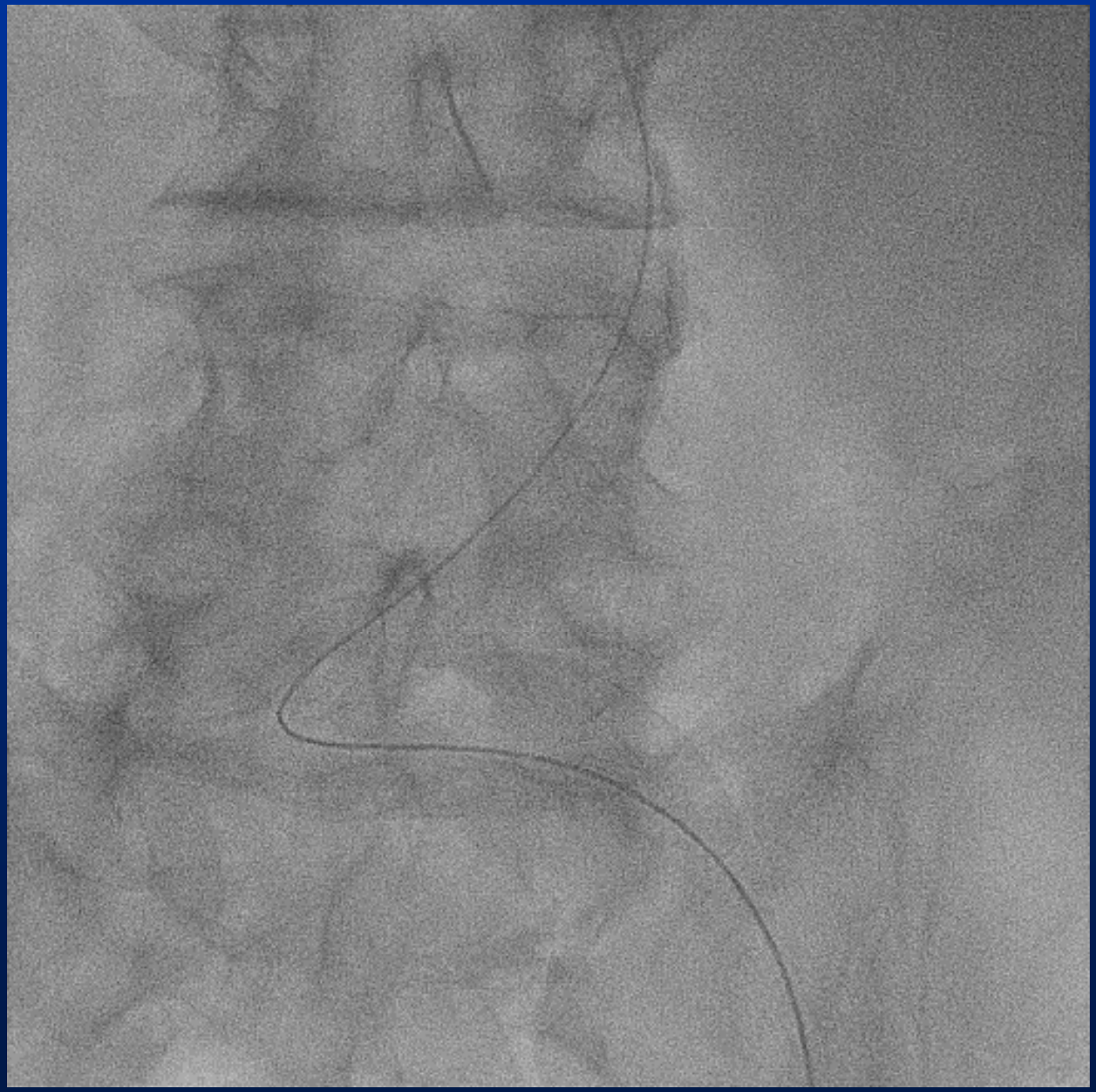
2nd wire enters sidebranch

Soft tapered lubricious 2nd wire via Crusade: Filder XT R

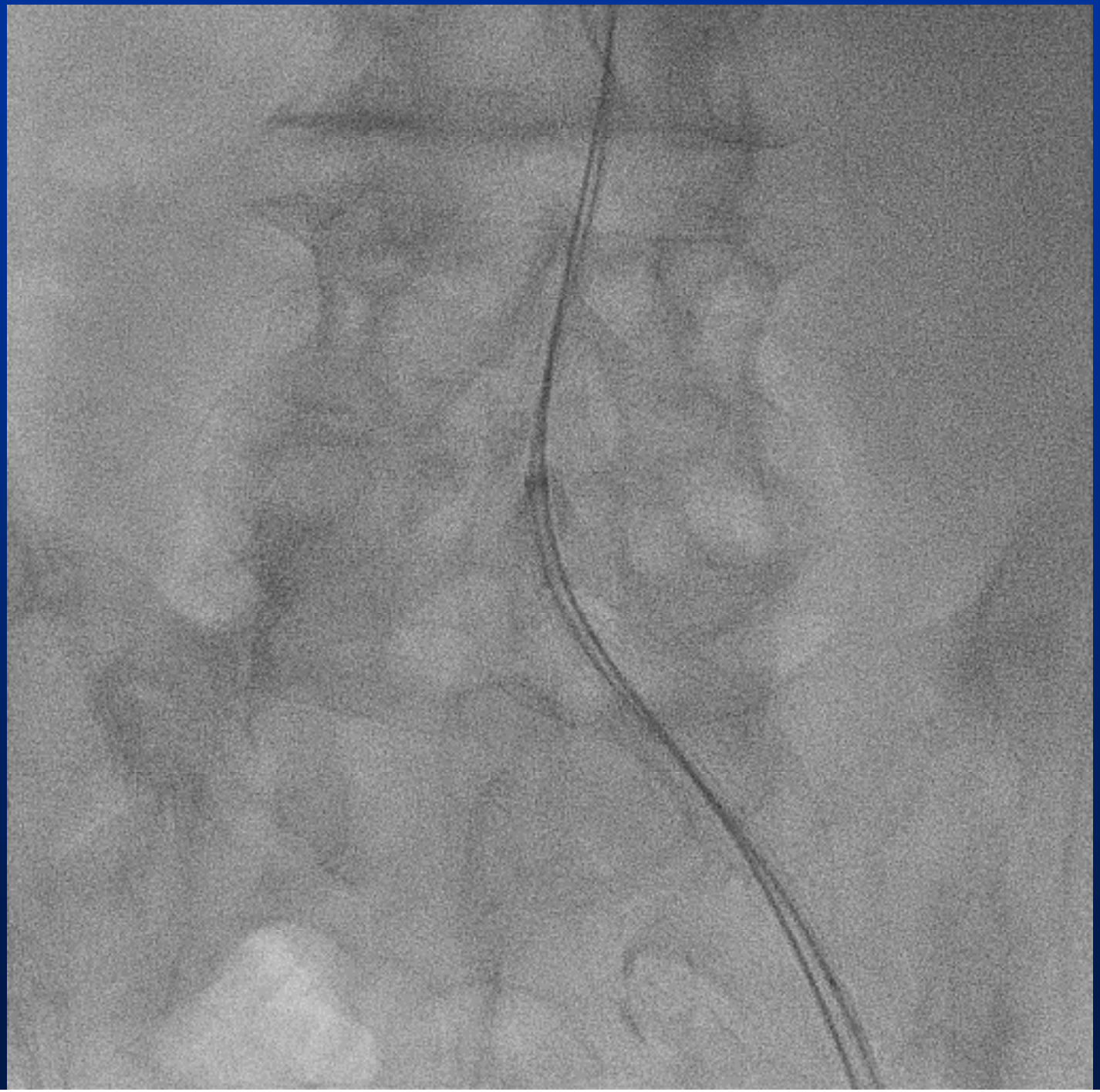




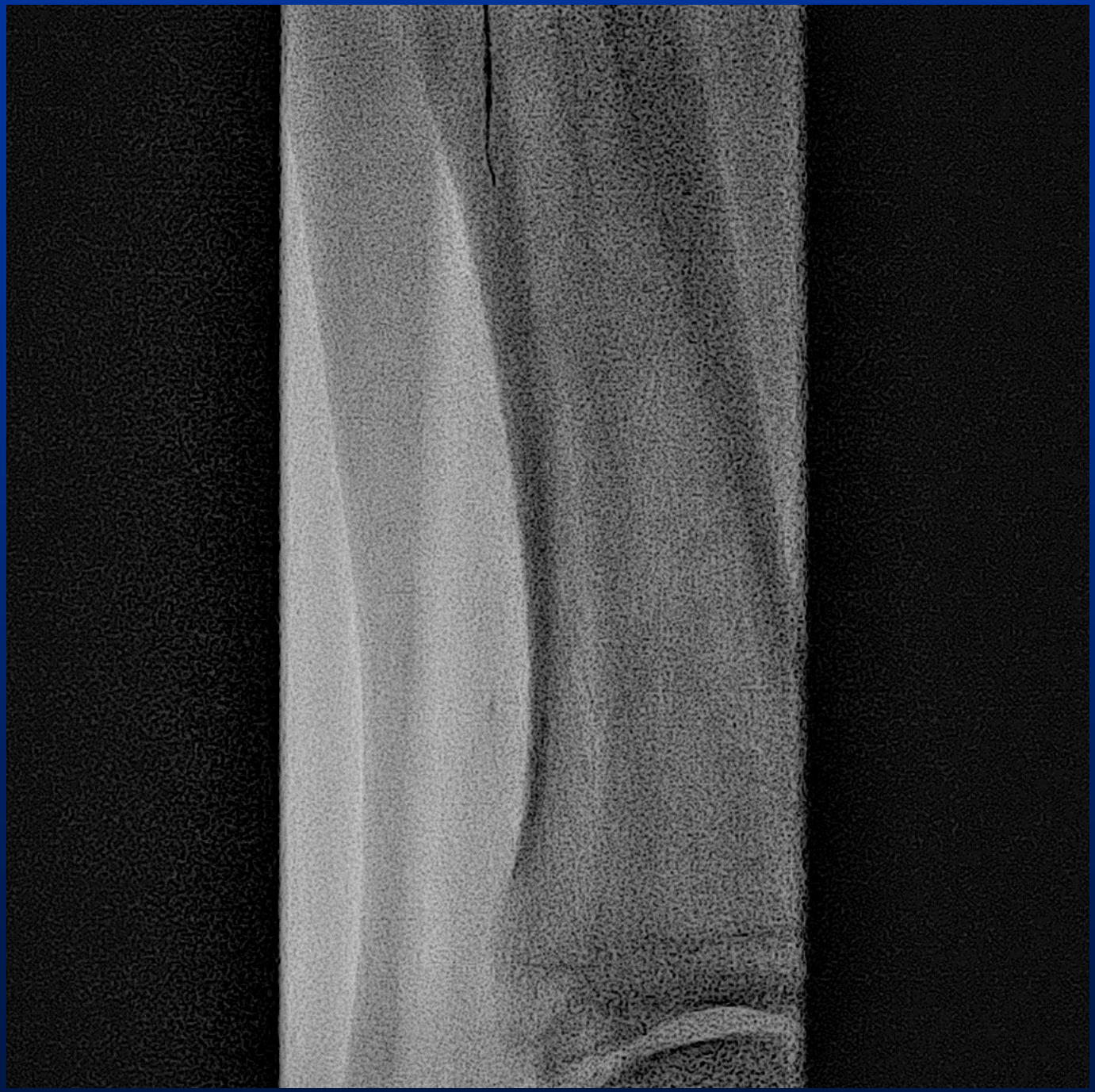
3 vessel occlusion; Long CTO of distal right tibial artery Diabetic foot ulcer toe 1/2



Iliac tortuosity
Crossover difficult
Poor steerability of CTO-wires

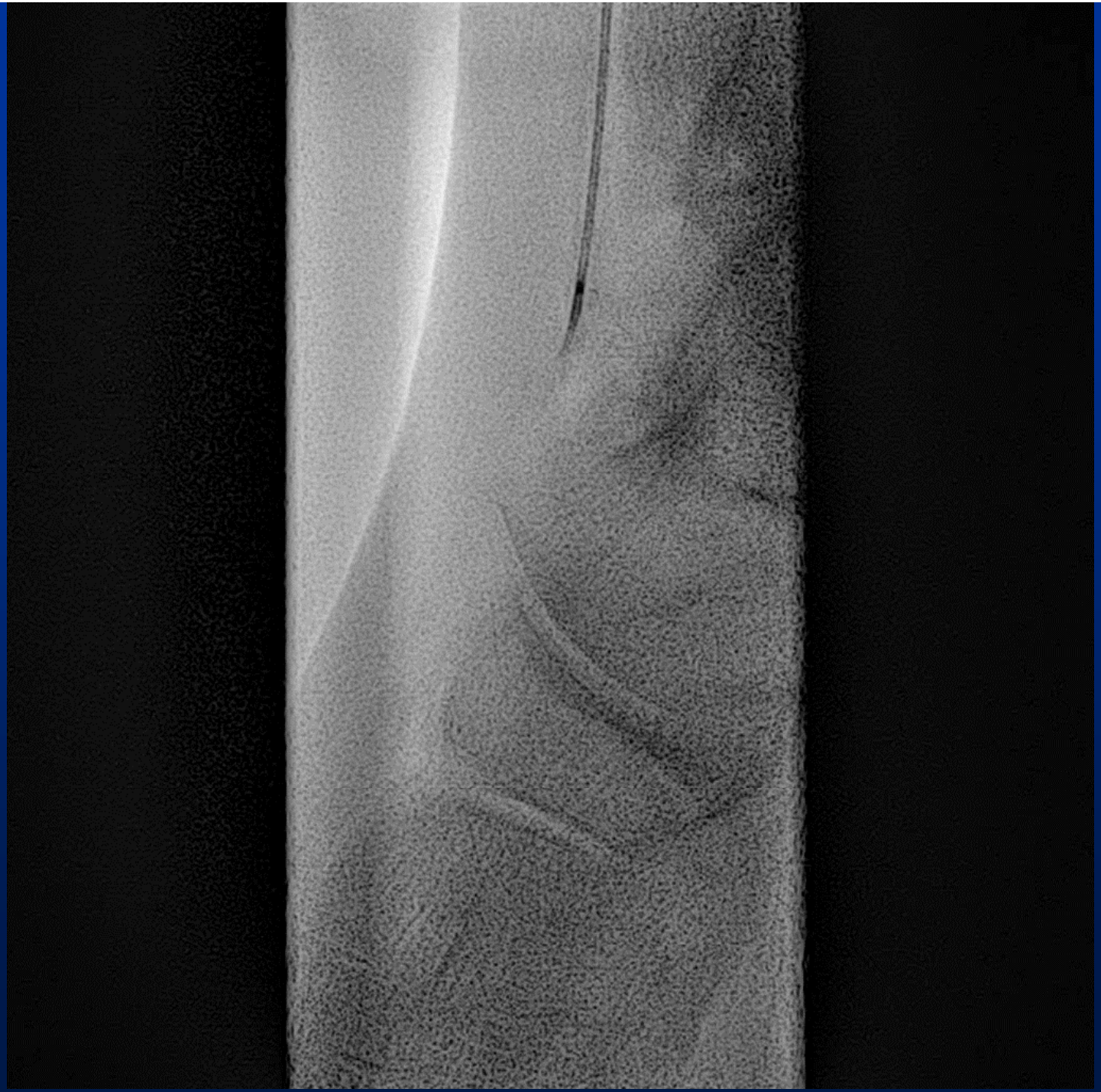


Parrallel sheath technique to straighten the iliac



Corsair,
Confianza
12

Gaia 2
short
knuckle



What Cardiologists do differently

- Crossover aproach (less radiation for operator)
- Use guiding catheters (less friction)
- Try to stay intraluminal (knuckeling as bailout option only)
- Try to stick with 0.0014 wires and balloons

You will need

- CTO experience
- Time and energy to do more cases
- A team that is willing to accept new procedures
- Some more balloons, stents and wires
- X-ray equipment with DSA and Roadmap