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Radial or brachial access as primary choice for CAS in a bovine arch

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Disclosures

The authors don’t have anything to disclose.

CAS in patients without available femoral access

- 6F wire
- Multiple 6F (Stanford, Cook)
- 7F sheath (Lunderquist’s, introducer)
- Angiographic: lateral view to access left innominate ostial artery (75%, 40%)
- Final cut
- Type 3: brachial arch pattern
- No femoral access available
- TR/TB at main arch configuration
- Casual arterial approach

CAS through right TR/TB approach (No way)

CAS in patients with BAAC (with or without available femoral access)

Type 1

Type 2 (A and B)

Type II B

Type III and IV

Tr/Br CAS in LICA+BAAC

Type I & Type II: tips and tricks

Type I (66±24°)
- Manual cath → RJ cath > Sim-1
- Wire deep into ECA
- Guide/IS best below bifurcation

Type II (84±7°)
- Manual cath → RJ cath > Sim-1
- Wire into ECA
- Guide/IS may be seated mid LCCA

High radial artery puncture

Our first choice access in BAAC

Brachial artery exposure and arteriotomy

Brachial artery suture

Brachial artery puncture
In complex arch anatomy many pre-shaped cath. are commonly used by femoral access in BAAC (red circle).

TR CAS with proximal protection in type I BAAC

TR/TB CAS in LICA+BAAC

It is a long way to Tipperary, it is a long way to go...

But you can make a short cut by a brachial access!
TR/TB CAS in LICA + BAAC
Parvoclad experience

Carotid Artery Stenting In Patients With Left ICA Stenosis and Review Arteric Arch: A Single-Center Experience in 60 Consecutive Patients
Right Radial or Brachial Approach

• 60 consecutive patients (2007-2015)
• RvC (41) T (9) (21%)
• Radial approach: 52% (58/110)
• Brachial approach: 48% (51/110)
• Technical success: 95% (105/110)
• Acute stent thrombosis: 0/110 (0%)
• Clinical restenosis: 0/110 (0%)
• Patency: 95/110 (86.4%)

Conclusion
- STA+1.5% in 1st (101)
- Technical success: 95/110 (86.4%)
- Major vascular complications: 2/110 (1.8%)
- Major access complications: 2/110 (1.8%)

CONCLUSION
TR/TB CAS in patients with BAAC
is our first choice because:

- Aortic arch is not touched (shaggy aorta !!!)
- Provides an easy & quick target vessel cannulation
- Gives an ideal anatomic support (the RSA-IA-LCCA pathway)
- Lets choice between two vascular approaches (radial or brachial artery) according to different artery size and hardware to be used
- All standard CAS equipment is allowed, included 8F proximal protection
- Patients early ambulate after CAS

Thank you for your attention!