Tips, Tricks, Equipment And Precautions For Transradial Artery Peripheral And Visceral Interventions

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No Disclosure

Advantage of transradial approach interventions

- reduced access bleeding,
- Lower morbidity,
- early ambulation,
- same-day discharge even on aggressive antithrombotic treatment.

Devices necessary for TRI

- Glide guiding sheath (5F-6F): 90-120 cm anti-kinking long shaft, back-up support, and secure heamostasis
- Diagnostic catheters (4F-5F) and microcatheters: 125/150 cm long diagnostic multipurpose catheters.
- Guide wires: Angle tip hydrophillic 0.035 inch, stiff/super stiff 0.014/0.018 inch (300 cm) guide wires

Brachial artery anotomical variations

Bronchial artery aneurysm: Coilling
Mesenteric and Celiac Truncus stenting

Renal artery interventions
- L RA stenting
- Tx kidney RA stenting

Total occlusions

Complications
- Pseudoaneurysm
- Compartment Syndrome
- Subintimal dissection,
- Laseration,

Radial artery pseudoaneurysm diagnosed by point-of-care ultrasound five days after transradial catheterization: A case report

Surgical management is recommended for large pseudoaneurysms because they may be infected, rupture or source of thromboembolism.

Decompressive fasciotomy required to prevent permanent neurovascular injury when r-pseudoaneurysms cause Compartment Syndrome (CS).

Saccular aneurysm formation after previous coarctation surgery. Sharp angulation of LSCA.

Transradial approach:
Subintimal dissection of LSCA caused by Guiding cath. Plan of using Amplatzer Plug changed to fix the injured artery using more safe coilling via microcath.
Conclusion

Radial artery access has largely replaced the femoral artery as standard access for coronary interventions and peripheral interventions because of its benefits. But we should also be aware of severe complications and ready to fix them.