trunk concluded with excellent results (Figure 3, 4a and 4b). Patient recovered popliteal and pedal pulses.


Fig. 4a


Fig. 4b

DISCUSSION

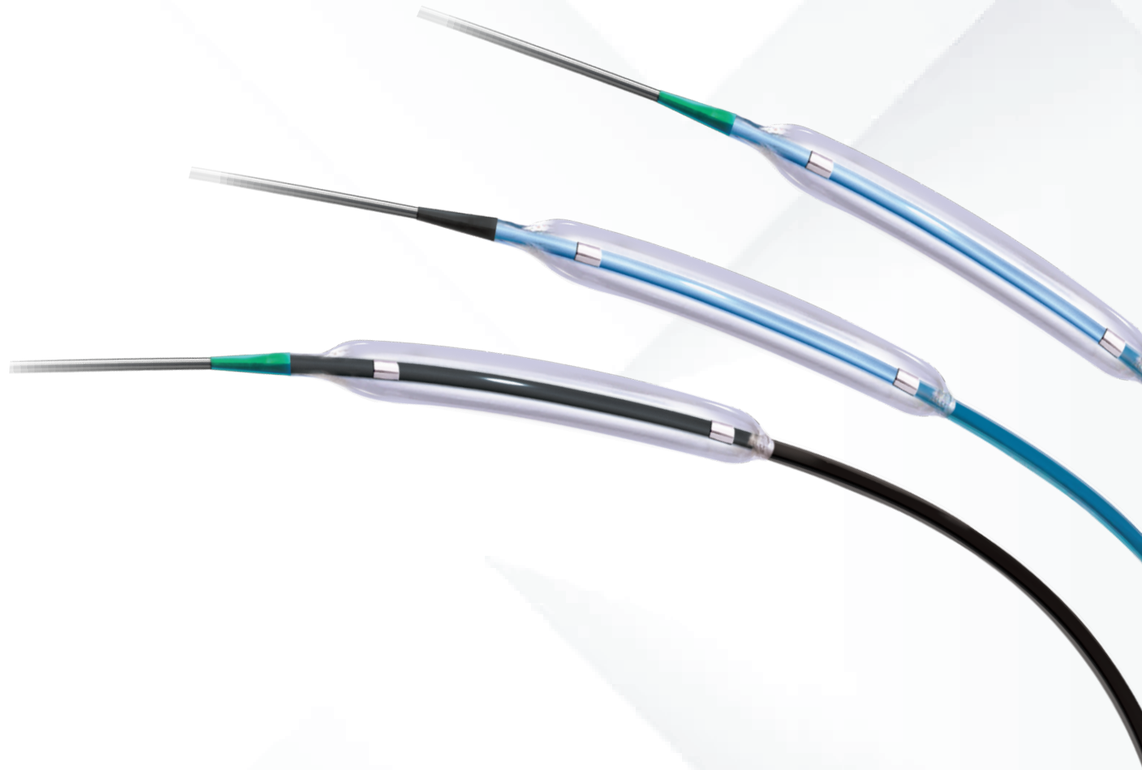
Calcium is probably the greatest enemy when treating patients with CLTI. It is common to find the situation where we manage to recanalize the lesion with our guidewire but after this we are unable to advance with any other device. Both the JADE 0.018 OTW balloon and the JADE 0.014 OTW balloons are great weapons for our armamentarium against calcium. The harder material at the proximal segment gives us really good pushability to allow crossing this calcified lesions, while the distal segment made of a softer material give us the possibility to navigate through tortuous vessels as seen in this case with the transcollateral approach for BTK treatment.

Furthermore, the JADE minimal compliant balloon prevents the “dog-bone” effect during balloon inflating. This way pressure is focused directly on the lesion, avoiding any kind of damage to the healthy vessel at the proximal and distal end of the balloon, minimizing post-PTA dissections and so the need of scaffolding.

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JADE® PTA BALLOON CATHETER



CASE **SPOTLIGHT**

Dr. Pablo Del Canto Peruyera
Vascular and endovascular surgeon
Gijon, Spain

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CASE
SPOTLIGHT

Jade® PTA BALLOON CATHETER



Dr. Pablo Del Canto Peruyera

Vascular and endovascular surgeon
Gijon, Spain

Jade (High-Pressure Minimal Compliant Balloon) for challenging calcified lesions in CLTI

CASE STUDY

CASE DETAILS

82-year-old woman with a history of arterial hypertension and chronic renal failure, presented with necrotic lesions affecting 2nd, 3rd and 4th toes in her right lower limb. Additionally a femoropopliteal obstruction upon physical examination was observed and an ankle brachial index (ABI) of 0.27.

PROCEDURE

A baseline Angio from the common femoral artery with a short 5Fr sheath inserted in an antegrade fashion, was performed. This showed a patent superficial femoral artery, with an occlusion in the P1 segment, patent P2 segment with a diseased P3 segment (Figure 1); distal runoff, a patent anterior tibial artery at its origin but with an occlusion in the first third with a well-developed collaterals network that filled the pedal artery, plus a patent distal peroneal artery that was also filled into the pedal artery (Figure 2a and 2b).

Fig. 1

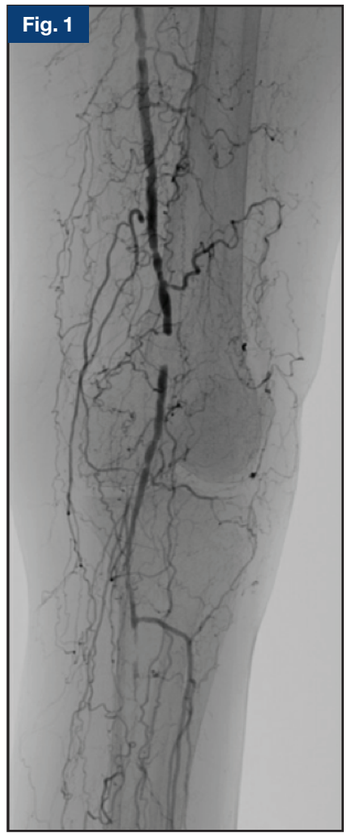


Fig. 2a

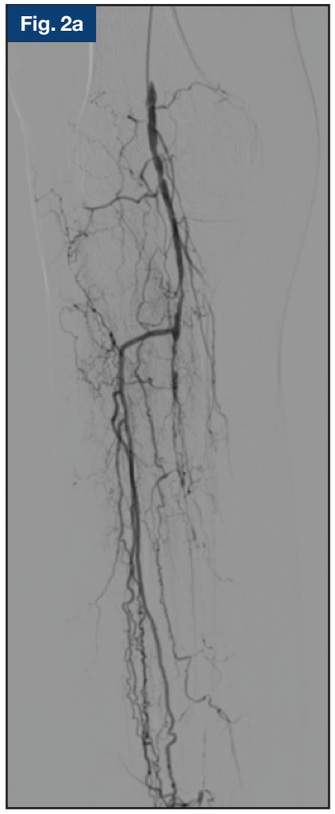
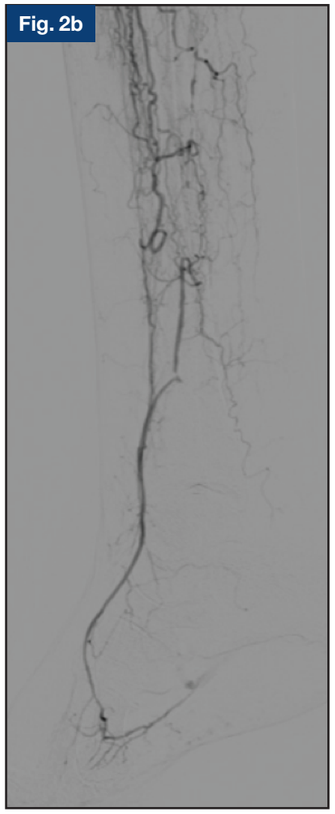


Fig. 2b



A good post-PTA result was achieved. Recanalization of the peroneal artery using a 0.014 guidewire and a microcatheter, in order to have a good guidewire support, followed. Once the guidewire was in the pedal artery, 300 micrograms of selective Nitroglycerine administered and a balloon angioplasty predilatation of the entire peroneal artery (2x80 mm OTW Jade PTA balloon catheter) and finally a 3-minute angioplasty (3x240 mm OTW Jade PTA balloon catheter) from the pedal artery to the tibioperoneal

After systemic heparinization an intraluminal recanalization of the popliteal segment with a 0.018 guidewire and balloon angioplasty (4x80 mm OTW Jade PTA balloon catheter) was performed. For vessel-prep; we completed the procedure with a 3-minute Sirolimus drug coated balloon angioplasty (5x80 mm, Selution SLR).

Fig. 3

