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6th EDITION

ADVANCED STRUCTURAL AND PERIPHERAL INTERVENTION COURSE

ASPIC 2024

Radisson Blu Sisli Hotel

Istanbul

Türkiye

18th - 20th October 2024

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PROGRAM

Z EVENT

SCIENTIFIC PROGRAM

18th October 2024

Hall A

08:15 - 08:30 **Opening Speech**

08:30 - 10:30 **Structural: TAVI**
Moderators: *Dayimi Kaya, Ömer Göktekin*
Panelists: *Levent Korkmaz, Ahmet Yıldız, Şerafettin Demir Emre Altekin, Mahmut Uluganyan*

08:30 Live Case: TAVI
Operators: *Mustafa Karaca, İlker Gül*
Memorial Bahcelievler Hospital

Medintek

09:30 Live Case: TAVI
Operator: *Operators: Won-Keun Kim, Peter Roth*
Universitätsklinikum Gießen und Marburg GmbH, Germany

Online

Tailored Approach for TAVI: Different valves for different anatomies
Roberto Nerla

Hall B

08:30 - 10:30 **Peripheral: Carotid and SFA intervention**
Moderators: *Klaus Mathias, Ertan Vuruşkan*
Panelists: *Aytaç Akyol, Şükrü Ünal,Yavuz Karabag*

08:30 Journey of Carotid Intervention 1977-2024 Klaus Mathias

08:45 Live Case: Carotid Stenting
Operators: *Piotr Musialek, Doğu Kılıç*

Florya Medical Park Hospital

09:30 Live Case: SFA CTO PTA
Operators: *Khusrow Niazi, Unal Gultekin*

Istanbul Cerrahpasa Cardiology Institute Hospital

10:30 - 10:45 **COFFEE BREAK**

SCIENTIFIC PROGRAM

18th October 2024 — Hall A

10:45 - 12:45 **Mitral and Tricuspit Edge to Edge repair**
Moderators: *Sinan Dağdelen, Huseyin Bozbaş*

Panelists: *Özge Özden Kayhan, Ömer Göktekin, Nazif Aygül, Dursun Gündüz*

10:45 Live Case: Mitraclip

Abbott

Operator: *Hakan Uçar, Enes Alic*

Florya Medikal Park Hospital

Imager: *Sinem Özbay Özyılmaz*

11:45 Live Case: Tricuspit TEER

Edwards

Operator: *Dursun Gündüz*

Diakonie Klinikum, Jung-Stilling, Germany

Imager: *Maria Tsiakou*

"The Carillon Mitral Contour System: An Alternative Method for Interventional Mitral Valve Repair."
Dursun Gunduz

SCIENTIFIC PROGRAM

18th October 2024 — Hall B

10:45 - 12:45 **Peripheral : Carotid Stenting**
Moderators: *Jocelyn Brookes, Piotr Musialek*

Panelists: *Yılmaz Güneş, Fatih Güngören, Mustafa Doğduş, Murat Sümbül, Ahmet Anıl Şahin, Ahmet Karagoz*

10:45 Live Case: Carotid Stenting
Operators: *Roberto Nerla, Paolo Sbarzaglia*

Maria Cecilia Hospital-GVM Cotignola, Italy

Live Case: Carotid intervention
Operators: *Çağrı Yayla, Kevser Gülçihan Balcı*

Memorial Bahcelievler Hospital

Difficult scenarios in Carotid Stenting
Piotr Musialek

12:45 - 13:45 LUNCH

SCIENTIFIC PROGRAM

18th October 2024 — Hall A

13:45 - 15:45 **Structural: Complex TAVI**
Moderators: *Oğuz Yavuzgil, Ertan Vuruskan*

Panelists: *Ümit Sinan Yaşar, Ali Nazmi Çalık, Servet Altay, Beste Özben, Yasser Jenap, Mustafa Mehmet Can*

13:45 *Basalica technique for Valve in Valve Rocedure*
Amar Krishnaswamy

Abbott

14:00 Live Case: TAVI
Operators: *Roberto Nerla, Paolo Sbarzaglia*
Maria Cecilia Hospital-GVM Cotignola, Italy

14:45 Live Case: TAVI: BASALICA with TELLTALE electrosurgery system
Operators: *Newell Robinson, George Petrossian*
Imager: *Lin Wang*

New York St Francis Hospital, and Heart Center, USA

Online

16:45 TAVI in complex scenarios
Won Keun Kim

SCIENTIFIC PROGRAM

18th October 2024 — Hall B

13:45 - 15:45 **Peripheral : Aortic-Iliac and SFA intervention**
Moderators: *Sigrid Nikol,Jocelyn Brookes*

Panelsits: *Nazif Aygül, Göksel Dagaşan, Kenan Demir, Elton Soydan, Şahin Kaplan, Okay Abacı*

13:45 Algorithm fort the treatment of SFA
Khusrow Niazi

14:00 Live case:SFA
Operators:Aravinda Najundappa
Cleveland Clinic, USA

14:45 Live Case: Iliac Occlusion

Operators: *Hakki Şimsek, Fatih Özturk, Ahmet Şakir*

Memorial Bahcelievler Hospital

15:30 Shockwave Balloon in peripheral artery disease

Jocelyn Brookes

15:45 - 16:00 COFFEE BREAK

SCIENTIFIC PROGRAM

18th October 2024 — Hall A

16:00 – 18:00 **Mitral and Tricuspit Edge to Edge repair**
Moderators: *Ömer Göktekin, Hakan Ucar*

Panelists: *Sinan Dagdelen, Sinem Özbay Özyılmaz, Murat Ersanlı, Gökhan Ertaş, Cuneyt Kocas*

16:00 Live Case: Triclip

Operator: *Jaffar Khan, Will Chung*

Imager: *Omar Khalique*

New York St Francis Hospital and Heart Center,

USA

Triclip current aprroach
Sinan Dagdelen

SCIENTIFIC PROGRAM

18th October 2024 — Hall B

16:00 – 18:00

Peripheral: CFA and SFA Intervention
Moderators: *Khusrow Niazi, Ahmet Karabulut*

Panelists: *Adnan Kaya, Yunus Emre Gürel, Serdar Akyüz, Fatih Çam, Ömer Köse, Elton Soydan*

16:00 Live Case: CFA Shock Wave
Operators: *Jocelyn Brookes, Mustafa Mehmet Can*

Memorial Bahcelievler Hospital

17:00 Live Case: SFA CTO
Operators: *Hasan Ari, Mehmet Melek*

Istanbul Cerrahpasa Cardiology Institute Hospital

Tips and Tricks for endovascular treatment of flush occlusions of SFA
Ertan Vuruskan

Rotational Thrombectomy: When and How?
Nikol Sigrid

SCIENTIFIC PROGRAM

19th October 2024 — Hall A

08:30 - 10:30 **Structural: TAVI and Tricvalve**
Moderators: *Alp Burak Çatakoğlu, Tahir Durmaz*

Panelists: Derya Tok, Alper Özkan, Hacı Ahmet Kasapkara, Murat Akcay, Kudret Keskin, Mustafa Mehmet Can, Mustafa Yenercag

08:30 Tricus Study
Angel Sanchez Recalde

08:40 Live Case: TAVI

Operators: *İlgar Tahiroğlu, Shahla Agayeva*
Azerbeycan

Medtronic

09:15 Live Case: TAVI
Operators: *Sait Terzi, Göktuğ Savaş*

Meril

Dr. Siyami Ersek Thoracic And Cardiovascular Surgery Education Research Hospital

09:45 Live Case: Tricvalve Implantation

Medix Biomedikal

Operators: *Erdoğan İlkay,*
Angel Shancez Recalde, Ahmet Şakir

Imager: *Emre Ozman*
Memorial Bahcelievler Hospital

How to treat CAD in patients with TAVI
Alper Ozkan

SCIENTIFIC PROGRAM

19th October 2024 — Hall B

08:30 - 10:30 **Peripheral: Subclavian and SFA intervention**
Moderators: *Bashir Hanif, Vecih Oduncu*

Panelists: *Khusrow Niazi, Aydın Yıldırım, Ünal Özturk, Selçuk Pala, Habil Cil, Idris Bugra Celik, Muhammed Keskin*

08:30 Live Case: Iliac CTO

Operators: *Kadriye Kılıçkesmez, Okay Abaci*

Florya Medical Park Hospital

09:30 Live Case: Subclavian CTO PTA

Operators: *Nazif Aygül, Bülent Altunkeser*

KARDİYOMEDİKAL
TEKNİK ve TIBBİ SİSTEMLER İNŞ. SAN. TİC. LTD. ŞTİ

Istanbul Cerrahpasa Cardiology Institute Hospital

AVM Embolisation Jocelyn Brookes

10:30 - 10:45 COFFEE BREAK

SCIENTIFIC PROGRAM

19th October 2024 — Hall A

10:45 - 12:45 **Mitral TEER and TAVI**
Moderators: *Ramazan Özdemir, Ismail Ates*

Panelists: *Hakan Ucar, Hüseyin Bozbaş, Ahmet Yildiz, Nazif Aygul, Angel Sanchez Recalde, Dursun Gündüz*

10:45 Live Case: Mitral TEER
Operators: *Ömer Göktekin, Hakki Simsek*

Imager: *Michael Chrissoheris*

Memorial Bahcelievler Hospital

11:45 Live Case: TAVI
Operators: *Ali Nazmi Calik, M Baran Karatas*

Medtronic

Dr. Siyami Ersek Thoracic And Cardiovascular Surgery Education Research Hospital

How to do Mitraclip: Step by Step
Dursun Gunduz

Imaging for Mitral and Tricuspit TEER
Michael Chrissoheris

SCIENTIFIC PROGRAM

19th October 2024 — Hall B

10:45 - 12:45 **Peripheral: Aortic and SFA/ Intervention**
Moderators: *Ahmet Karabulut, Jocelyn Brookes*

Panelists: *Ahmet Tastan, Serhat Sığırcı, Ersan Oflar, Ahmet Karaduman, Zeydin Acar, Kadri Akboğa*

10:45 Live Case: Leriche Syndrome
Operators: *Nihat Kalay, Umuttan Dogan*

Canon

İstanbul Medeniyet University Göztepe Training and Research Hospital

11:45 Live Case: Iliac CTO
Operators: *Goksel Dagasan, Hasan Ali Barman*

Istanbul Cerrahpasa Cardiology Institute Hospital

Rotational Thrombectomy: When and How
Nikol Sigrid

12:45 - 13:45 LUNCH

SCIENTIFIC PROGRAM

19th October 2024 — Hall A

13:45 - 15:45 **Interventional Congenital&Pediatric Cardiology @ASPIC**
Moderators: *Nazmi Narin, Ömer Göktekin*

Panelists: *Murat Muhtar Yilmazer, Aydın Yıldırım, Metin Sungur, Burak Akçay, Derya Tok*

13:45 Live Case: Pulmonary Valve Implantation
Operators: *İbrahim Halil Demir, Ahmet Çelebi*

Meril

Dr. Siyami Ersek Thoracic And Cardiovascular Surgery Education Research Hospital

Live Case: Large ASD
Operators: *İlker K. Yücel, Ahmet Çelebi*

Dr. Siyami Ersek Thoracic And Cardiovascular Surgery Education Research Hospital

Recent Advances in transcatheter pulmonary valve implantaion
Ender Ödemiş

VSD Closure in Adolescents and young adults
Osman Başpinar

SCIENTIFIC PROGRAM

19th October 2024 — Hall B

13:45 - 15:45 **Peripheral EVAR**
Moderators: *Sigrid Nikol, Firuzan Numan*

Panelists: *Hakan Taşolar, Elnur Alizade, Baran Karatas, Nihat Kalay*

13:45 Live Case: EVAR
Operators: *Ertan Vuruşkan, Gökhan Altunbaş*

Canon

İstanbul Medeniyet University Göztepe Training and Research Hospital

14:45 Live Case: EVAR
Operators: *Elnur Alizade, Hasan Ali Barman*

Istanbul Cerrahpasa Cardiology Institute Hospital

EVAR: Patient Selection, Planning and Techniques
Nikol Sigrid

15:45 - 16:15 COFFEE BREAK

SCIENTIFIC PROGRAM

19th October 2024 — Hall A

16:15 - 17:45 **Interventional Congenital & Pediatric Cardiology @ASPIC**
Moderators: *Kemail Nişli, Baktash Bayani*

Panelists: *Serdar Epcaçan, İbrahim Ece, Tarik Kivrak, Kevser Gulcihan Balci*

16:15 Live Case: Complex ASD Closure
Operators: *Hakan Güllü, Şeref Kul*

META Medikal

Canon

İstanbul Medeniyet University Göztepe Training and Research Hospital

17:15 Live Case: AoC stenting
Operators: *İbrahim Halil Demir, Ahmet Çelebi*

Dr. Siyami Ersek Thoracic And Cardiovascular Surgery Education Research Hospital

Complex ASD closure in adolescents and young adalts
Ali Baykan

Stenting of Aortic Arch: When do we need and how we do it
İlker K. Yücel

SCIENTIFIC PROGRAM

19th October 2024 — Hall B

16:15 - 17:45 **Peripheral: BTK**
Moderators: *Ahmet Hakan Ateş, Bülent Behlül Altunkeser*

Panelists: *İsmail Bolat, Asil Isci, Aydin Nadir, Burak Ayca, Zeki Doğan, Baktash Bayani*

16:15 Live Case: SFA and BTK CTO
Operators: *Ersan Tatli, Mustafa Yilmaztepe*

Florya Medical Park Hospital

Live Case: BTK CTO
Operators: *Yilmaz Gunes, Serhan Özyıldırım*

Istanbul Cerrahpasa Cardiology Institute Hospital

Algorithm fort the treatment of BTK:
Khusrow Niazi

SCIENTIFIC PROGRAM

19th October 2024 — Hall B

17:45 - 18:30 **Peripheral case presentations**
Moderators: *Hakan Ucar, Nihat Kalay*

Panelists: *Mehmet Tugay Yumuk, Lezgin Dursun, Elif Çetin, Abdullah Özçelik*

Alternative access for peripheral vascular interventions
Şevval İlke Güneysu

Successful intervention with CART in a patient with Leriche Syndrome
Abdullah Ömer Ebeoğlu

Successful intervention for peripheral artery perforation
Betül Saribiyik Çakmak

Successful percutaneous treatment of chronic total occlusion of the SMA
Luljeta Allaraj Kurani

Coronary subclavian steal syndrome
Muhammed Emre Güleşir

Giant iliac artery aneurysm
Serhat Günlü

Two-Year Transfemoral TAVR: Outcomes & Complications
Haşim Tüner

SCIENTIFIC PROGRAM

20th October 2024 — Hall A

08:30 - 10:30 **Structural: TAVI**
Moderators: *Engin Bozkurt, Telat Keleş*

Panelists: *Çağdaş Akgüllü, Hakan Erkan, Muhammed Süleymanoğlu, Mustafa Yolcu, Arafat Yıldırım*

08:30 Live Case: TAVI
Operators: *Emre Altekin, Oguz Akkus*

Memorial Bahcelievler Hospital

09:30 Live Case: TAVI
Operators: *Servet Altay, Uğur Özkan*

Florya Medikal Park Hospital

Cusp overlap and commissural alignment technique
Altug Cincin

10:30 - 10:45 **COFFEE BREAK**

SCIENTIFIC PROGRAM

20th October 2024 — Hall A

10:45 - 12:45 **Structural: LAA Closure**
Moderators: *Adnan Abacı, Enver Atalar*

Panelists: *Ersan Oflar, Zafer Küçüksu, Göktuğ Savaş, Selma Kenar Tiryakioğlu*

10:45 Live Case: LAA Closure
Operators: *Şükrü Akyüz, Ceyhan Arkan*

Imager: *Sinem Özbay Özyılmaz*

Florya Medikal Park Hospital

11:45 Live Case: LAA Closure
Operators: *Regaip Zehir, Omer Faruk Baycan*

Imager: *Gonul Aciksari*

İstanbul Medeniyet University Göztepe Training and Research Hospital

LAA closure: Step by step Approach
Emrah Ermis

Abbott
Vamet Medikal
Canon

12:45 - 13:45 **LUNCH**

SCIENTIFIC PROGRAM

20th October 2024 — Hall A

13:45 - 15:45 **Mitral Valvuloplasti and TEVAR**
Moderators: *Ertan Vuruskan, Ahmet Kaya*

Panelists: *İrfan Barutçu,Ekrem Güler, Emine Gazi, Ugur Arslan*

13:45 Live Case: Mitral Balloon Valvuloplasti
Operators: *Mustafa Çalışkan, Şeref Kul*

İstanbul Medeniyet University Göztepe Training and Research Hospital

14:45 Live Case: TEVAR
Operators: *Mustafa Yıldız, Fatih Uzun, Hasan Ali Barman*

Istanbul Cerrahpasa Cardiology Institute Hospita

Paralavular leak closure: Step by step Approach
Ömer Göktekin

Hall A

15:45-16:45 **Structural Case Presentations**
Moderators: *Ömer Göktekin, Bashir Hanif*

Multiple Paravalvular leakage in a candidate for mitral valve in valve
Yasser Jenap

Patient with Complex ASD
Abdullah Tuncez

TAVI and valve in MAC
Enes Alic

Two-Year Transfemoral TAVR: Outcomes & Complications.
Haşim Tüner

SCIENTIFIC PROGRAM

20th October 2024 — Hall A

"From Stroke to Valve Repair: A Case of Neo-LVOT Creation and Mitral Valve.
Enes Alıç

Evaluation of 3 patients with sinus venosus type ASD. *Abdullah Tunçez*

Hall A

16:45 - 17:45 **Peripheral Oral Presentation**
Moderators: *Hakan Uçar, Altug Çinçin*

The Role of Drug-Coated Balloon in Coronary Artery Disease: A Retrospective Report.
Enes Alıç

Our Experiences: Demographic Characteristics And Endovascular Intervention.
Fatih Güngören

Long-term Outcomes and Predictors of Restenosis After Endovascular Treatment.
Ahmet Karaduman

Evaluation of the Relationship Between Late Arteriovenous Fistula Failure
Zeki Cetinkaya

Collaterals and Severe Dissection.
Ibrahım Donmez

The Ocular Manifestation of a Totally Occluded Common Carotid Artery
Güvenç Toprak

17:45 **Closing Ceremony**

Z EVENT

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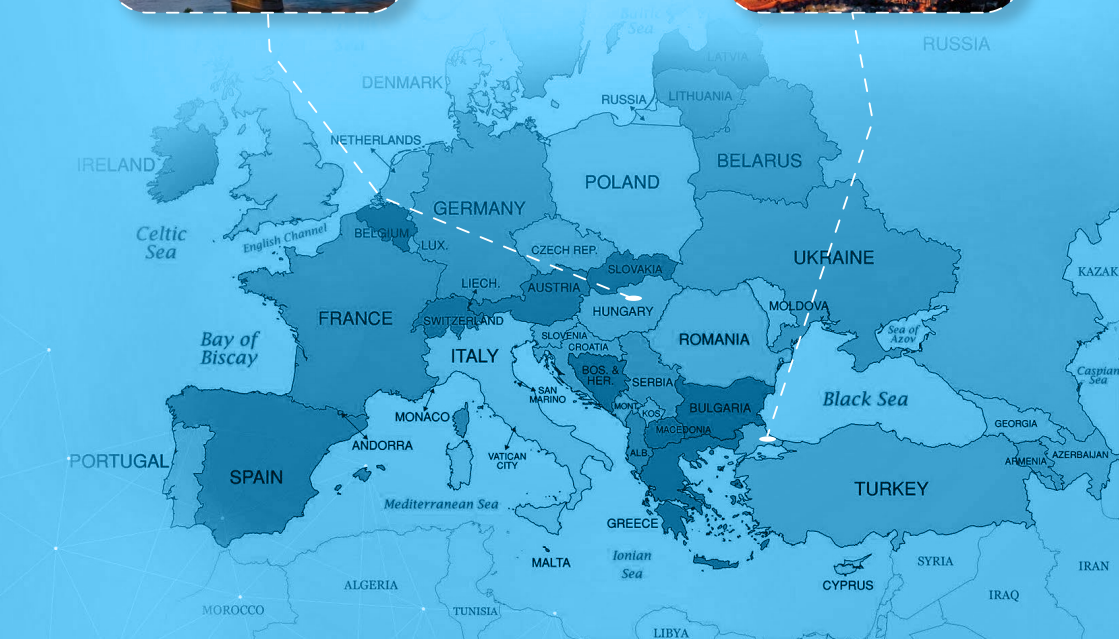

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SB-01

Successful intervention with CART in a patient with Leriche Syndrome

Abdullah Ömer Ebeoğlu[1]

1.İstanbul Cerrahpaşa University- Cerrahpasa Cardiolgy Institute

Leriche syndrome(LS) is also known as aortoiliac occlusive disease and is characterised by chronic occlusion of the abdominal aorta and iliac arteries.Claudication of the lower extremities, absence or reduction of peripheral pulses and erectile dysfunction in men are the main clinical findings of this disease.Surgery is the main treatment modality.Alternative procedures include stented angioplasty and axillary-femoral bypass.

A 60-year-old active smoker with a history of LAD stent 2 years ago presented with exertional dyspnoea (NYHA II), rapid fatigue, progressively increasing back pain and Rutherford I. grade 3-4 claudication for the last 6 months.On physical examination, the femoral artery pulse was weak, and no pulse could be obtained in the popliteal and below-knee arteries.Peripheral angiography showed 100% total occlusion of the distal abdominal aorta from the infrarenal region before the iliac bifurcation.Sheaths were placed in the brachial artery and both femoral arteries. the left side was crossed antegrade with halberd 0.018 wire through the microcatheter.The microcatheter was then externalized from the left femoral and a supracore 0.035 super stiff wire was inserted.Then, the lesion was tried to be crossed antegrade on the right side first with halberd, gaia peripheral and conger wire, but it's failed.we tried to cross the lesion retrogradely with halberd and gaia peripheral wire, but the wire progressed in the subtimal area.Thereupon, the lesion was dilated first with 2.5x15 and then with 5.0x10 apollo coronary balloon to make a cart.passage was attempted with an antegrade conger wire, but again it's failed.cart was repeated with a pilot 200 wire and fell into the true lumen, and the microcatheter was confirmed to be in the true lumen.The microcatheter was externalized from the right femoral with a floppy wire and a supracore 0.035 super stiff wire was inserted.It was predilated by kissing with a 6.0x100 balloon on the right side and a 6.0x80 balloon on the left side.We then implanted a 7.0x120 self-expandable stent on the right side and an 8.0x80 self-expandable stent on the left side.Subsequent images showed that the procedure was successful.He was discharged 3 days later without complications.

LS is a product of atherosclerosis affecting the distal abdominal aorta, iliac arteries and femoropopliteal vessels.It usually affects men over 50 years of age.The lesions are usually confined to the aortoiliac level, the infrainguinal subcurrent bed is usually preserved, the vital prognosis for the lower limbs is rarely involved.Kissing transluminal angioplasty is also gaining importance as first-line treatment and has good immediate results.Limb ischaemia is a potential complication of LS, as well as heart failure, myocardial ischaemia/infarction, gangrene and even death.Without treatment, the prognosis of LS is poor.However, with modern medicine, the results are good.

Although LS is a relatively rare condition, it involves high morbidity and mortality rates.Unfortunately, LS can also be masked by collateral vessel formation that bypasses the occlusion, resulting in asymptomatic progression of the disease years before presentation.Awareness should be raised by physicians as early and effective recognition of the disease is of prognostic importance.

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SB-02

Evaluation of 3 patients with sinus venosus type ASD

Abdullah Tunçez[1]

1.Selçuk University Faculty of Medicine Department of Cardiology

Unrepaired atrial septal defect (ASD) is the second most common adult congenital heart disease. Sinus venosus type atrial septal defect (SVASD) is a non-primium, non-secundum variant that represents only 5% to 10% of all ASD types. Diagnosis of SVASD by TTE is particularly challenging and often requires more advanced studies such as TEE, CMR, cardiac computed tomography (cardiac CT), and occasionally cardiac catheterization. Treatment is largely surgical and requires a thorough understanding of the associated complex anatomic abnormalities to guide an individualized surgical approach. In this case series we want to review and discuss the clinical, electrocardiographic, transthoracic and transeusophageal echocardiographic, radiologic findings and treatments that applied these patients.

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SB-03

Long-term Outcomes and Predictors of Restenosis After Endovascular Treatment

Ahmet Karaduman[1]

1.Kartal Koşuyolu Eğitim ve Araştırma Hastanesi

Objective: Endovascular therapy (EVT) continues to be a prominent treatment for infrarenal aorta occlusions (IAO) with advancements in techniques and technology. Despite its effectiveness in early and mid-term outcomes, the long-term outcomes and predictors of restenosis remain inadequately studied. This study aims to evaluate the extended long-term outcomes of EVT in patients with IAO.

Methods: A total of 72 consecutive patients (age, 59.2±7.2 years; 68.5% male; 44% critical limb ischemia) from a single-center database, undergoing EVT for IAO disease between January 2011 and March 2022 were retrospectively analyzed. The outcome measures included primary patency rate and amputation-free survival, calculated using the Kaplan–Meier method. Independent predictors of restenosis were assessed with the Cox proportional hazards regression model.

Results: Technical success was achieved in 65 patients (90.3%). In total, 245 stents (84 self-expandable stents, 81 balloon-expandable stents) were implanted. During a follow-up period of 39.8±30 months, 9 patients experienced loss of patency. Primary patency rates were 95%, 81%, and 73% at 1, 3, and 5 years, respectively, and amputation-free survival rates were 100%, 88%, and 79% at 1, 3, and 5 years, respectively.

Conclusion: This study's extended follow-up period confirms that EVT for infrarenal aorta total occlusions provides favorable long-term outcomes. However, the rates of primary patency and amputation-free survival slightly decline over time. Further studies are warranted to identify predictors of restenosis and improve patient selection and treatment strategies.

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SB-04

Successful intervention for peripheral artery perforation

Betül SARIBIYIK ÇAKMAK[1], *Ahmet Can ÇAKMAK, Emre EYNEL, Fahrettin TURNA*
1.Sakarya Eğitim ve Araştırma Hastanesi

Peripheral artery perforation refers to the partial or complete rupture or puncture of peripheral arteries, which typically occurs during invasive medical interventions. Perforation usually occurs during interventional procedures such as angiography, arterial stent placement, or catheterization. It can happen in a weakened area of the arterial wall or after a traumatic intervention. Typically, a tear or hole forms in the inner layer of the artery, allowing blood to leak out of the vessel. This leakage can result in perivascular hematomas, the development of arteriovenous fistulas, or, in more severe cases, the formation of aneurysms or pseudoaneurysms. Perforation may also cause ischemia in surrounding tissues by reducing blood flow to distal areas.

Small perforations may heal with compression and conservative management, while larger perforations may require surgical repair or endovascular intervention via angiography. Early intervention is crucial to prevent complications. Peripheral artery perforation is a significant complication in interventional cardiology and vascular surgery practices, requiring a multidisciplinary approach for diagnosis and treatment.

A 60-year-old male patient with a history of smoking but no known chronic diseases presented to the Cardiovascular Surgery Clinic with pain in his right leg. Doppler ultrasound of the lower extremities revealed a 70% stenosis in the left superficial femoral artery (SFA) and a 100% occlusion of the right SFA. The patient was subsequently referred to our clinic for peripheral angiography. During the angiography, a 100% occlusion was observed in the right SFA at the ostium, and an 80% stenosis was noted in the left SFA(Figures1-2). Antegrade passage through the total occlusion of the right SFA was unsuccessful despite microcatheter support. Retrograde access was obtained through the anterior tibial artery (ATA), followed by antegrade access. The lesion was dilated with a peripheral balloon(Figure3),

resulting in successful recanalization with good distal flow. However, a perforation was observed in a side branch of the SFA(Figur4). The patient began experiencing swelling and pain in the affected leg, and perforation closure was planned. To address this, a 2.0x20 mm balloon was modified by trimming. The balloon membrane was stripped, and the guidewire lumen was cut. The modified balloon was placed over the outer surface of a 2.25x15 mm stent. To prevent the balloon from slipping off the stent, a surgical knot was tied around the stent. The balloon was then advanced to the perforated branch over a 0.014 wire and implanted at 14 atm. Final imaging confirmed that the perforation was completely sealed(Figure5-6).

The patient’s pain subsided, and the procedure was successfully completed.

Peripheral angiography is a commonly used invasive procedure in the diagnosis and treatment planning of peripheral artery disease. However, complications can occasionally arise during this procedure. Successful management of these complications depends on early recognition and timely intervention. When a complication occurs after peripheral angiography, rapid intervention based on the severity of the complication and the patient's overall condition can positively impact the prognosis. Therefore, the presence of a multidisciplinary team and the availability of appropriate interventional tools during the procedure are of utmost importance.

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SB-05

From Stroke to Valve Repair: A Case of Neo-LVOT Creation and Mitral Valve

Enes Alıç[1]
1.Istanbul Aydın Uni Medikal Park Florya Hospital

Case Presentation: 81-Year-Old Female – Complex Valve Intervention

Medical History: An 81-year-old female with a history of PCI 10 years ago. She is on ASA, Norvasc, Beloc, and Glifor.

Admission: The patient was admitted to the neurology clinic for an ischemicstroke. She was managed with heparin infusion, and no interventional procedure was performed.

Echocardiographic Findings: Severe mitral stenosis (22/11 mmHg gradient), moderate-to-severe mitral regurgitation, and moderate aortic stenosis. Due to high Wilkins score and moderate mitral regurgitation, percutaneous mitral balloon valvulaplasty was deemed unsuitable.

Treatment Plan: Given the narrow angle between the aortic and mitral valvesand the risk of LVOT obstruction by the mitral valve implant, it was decided to perform a staged approach: first, a TAVI for the aortic valve to create a neo-LVOT.

Aortic Valve Implantation: A Myval aortic valve was successfully implantedvia the right femoral artery, and the access site was closed with Proglide.

Mitral Valve Implantation: The left femoral vein was accessed, followed byseptostomy via the postero-superior septum. After dilating the septum with a 12 mm baloon, the Confida wire was advanced to the left upper pulmonary vein. Using FlexCath, the wire was directed to the LV apex, and balloon dilatation was performed. However, initial attempts to deploy the Myval valve were unsuccessfull.

Complication: During further attempts, the wire perforated the LV apex, causing pericardial effusion. Rapid balloon dilatation was performed again, allowing the valve to be positioned correctly in the mitral location andsuccessfully implanted. The pericardial effusion was evacuated.

Surgical Intervention: The patient was promptly referred for surgery, whereperica rdial drainage and LV apex repair were performed.

Outcome: The patient recovered well and was discharged one week later.

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SB-06

The Role of Drug-Coated Balloon in Coronary Artery Disease: A Retrospective

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This study retrospectively evaluates the clinical and laboratory outcomes of 34 patients treated with a drug-coated balloon (DCB) for coronary artery disease (CAD). The study aims to assess the efficacy of DCBs in maintaining vessel patency and their impact on different patient subgroups. Findings suggest that DCBs could serve as an effective treatment strategy, particularly in bifurcation lesions and anatomically challenging areas, reducing the need for stent implantation.

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SB-07

Our Experiences: Demographic Characteristics and Endovascular Intervention

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Introduction: The prevalence of peripheral arterial disease (PAD) was estimated to be 4.6% in the general population. Endovascular treatment modality is become main treatment method for PAD. Although the results of endovascular treatment are generally great, it may vary from center to center. In this study, we aimed to share the baseline characteristics and procedure-related features of our patients with PAD who underwent intervention.

Tools and Method: A total of 58 patients who underwent endovascular treatment were included in this study. Baseline characteristics, laboratory results and angiographic images of patients were evaluated retrospectively.

Results: Baseline characteristics, laboratory findings and prosedural features of the patients are given in Table 1 and Table 2. The mean age of the patients was 63.2 ± 10.3 and 63.8 % of the patients were male. 82.8% of the patients were hypertensive, 69% were diabetic, and 55.2% were hyperlipidemic.5 patients had iliac artery lesions, 37 patients had pheomoropopliteal artery lesions and 16 patients had lesions below the knee. 82.8% of all endovascular interventions were successful, 12.1% were partially successful and 5.1% were unsuccessful. The complication rate was determined as 20.7%. 4 patients had intimal dissection with timi 2 flow, 2 patients had timi 1 flow, 1 patient had acute occlusion, 2 patients had acute renal failure, and 3 patients had access site complications.

Discussion: Although the success rate of endovascular approach in PAD varies among centers, it is performed with high success rates in our country. Some adverse events may occur during endovascular treatments. In this study, we have presented the endovascular treatments, success rates and complication rates that we have performed in our clinic for 1 year.

Table 1: Baseline characteristics and laboratory parameters

	Study group (n = 58)
Age (years, SD)	63.2 ± 10.3
Diabetes Mellitus (n, %)	40 (69)
Hypertension (n, %)	48 (82.8)
Hyperlipidemia (n, %)	32 (55.2)
Coronary artery disease (n, %)	39 (67.2)
Tobacco use (n, %) Smoker Ex smoker Never	 30 (51.7) 17 (29.3) 11 (19)
Gender (n, %) Male Female	 37 (63.8) 21 (36.2)
Urea (mg/dL)	34 (27-40)
Creatinine (mg/dL)	1.04 ± 0.2
Hemoglobin (g/dL)	12.4 ± 1.4
Platelet (10^3//mm^3)	280 ± 50
Ejection fraction (%)	52.8 (45-60)

Table 2: Procedural features

Patients (n = 58)	
Lesion location (n, %)	
Iliac artery	5 (8.6)
Superficial femoral artery	37 (63.8)
Blow the knee	16 (27.6)
Procedural success (n, %)	
Successful	48 (82.8)
Partially successful	7 (12.1)
Unsuccessful	3 (5.1)
Technique (n, %)	
Drug-eluting balloon	49 (84.5)
Stent	9 (15.5)
All complications (n, %)	12 (20.7)
Complication type (n, %)	
Intimal dissection with timi 2 flow	4 (7)
Intimal dissection with timi 1 flow	2 (4)
Acute occlusion	1 (2)
Acute renal failure	2 (4)
Access site complications	3 (5)

Intervention localization (n, %)	
Femoral	53 (91.4)
Brachial	2 (3.4)
Popliteal	3 (5.2)
Presented symptom (n, %)	
Claudication	41 (70.7)
Unhealed wound	12 (20.7)
Critical limb ischemia	2 (3.4)
Asymptomatic	3 (5.2)

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SB-08

The Ocular Manifestation of a Totally Occluded Common Carotid Artery

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Introduction: Amaurosis fugax is typically defined as sudden and transient vision loss in one eye, which resolves spontaneously within a short period (usually within one hour). This condition arises due to temporary reduction in blood flow to the retina or optic nerve. The most common cause is the occlusion of the retinal artery by small emboli or thrombi. Amaurosis fugax often signals underlying vascular pathologies such as carotid artery stenosis or atherosclerosis, and serves as a significant clinical warning for individuals at risk of stroke or myocardial infarction. Therefore, patients presenting with amaurosis fugax should undergo comprehensive cardiovascular evaluation to assess for potential underlying vascular conditions.

Case Presentation: A 72-year-old male patient with a history of hypertension and aortic root dilatation (measuring 4.2 cm on echocardiography) is followed by the cardiology clinic. The patient is on dual antihypertensive therapy and reports occasional headaches radiating from the nape of the neck, along with borderline hypertensive readings. Based on these complaints, a calcium channel blocker was added to his treatment regimen. After starting the new medication, the patient reported a reduction in headache frequency, but also described episodes of balance problems and a sudden need to sit down. Additionally, over the past month, he experienced two episodes of transient vision loss in his right eye, each lasting 3-4 hours before resolving spontaneously.

The patient was referred to ophthalmology and neurology clinics for further evaluation. Ophthalmologic examination revealed full visual function, with normal findings in both fundus examination and fluorescein angiography. However, due to the prolonged duration of vision loss, retinal vascular occlusion was considered in the differential diagnosis. Concurrently, the patient reported balance disturbances and measured his blood pressure during these episodes, noting readings around 100/60 mmHg. In neurology, brain MRI was performed to rule out ocular migraine

or intracranial etiologies, and the results were normal. Following this evaluation, the patient was referred back to ophthalmology.

Despite the atypical presentation of amaurosis fugax, carotid ultrasonography was requested by the ophthalmologist. The ultrasound revealed a total occlusion of the right internal carotid artery (ICA). The patient was once again referred to neurology, where a CT angiogram confirmed complete occlusion of the right common carotid artery (CCA), with retrograde filling of the right ophthalmic artery from the contralateral side, potentially explaining the ocular symptoms. A cardiovascular surgery consultation determined that surgical intervention was not indicated. The patient was advised that the balance issues were likely due to compromised ocular and cerebral perfusion, and the calcium channel blocker was discontinued from his treatment plan.

Conclusion: Although it is traditionally understood that amaurosis fugax typically resolves within one hour, it is important to consider that symptoms may last longer. Furthermore, such symptoms may arise not only from carotid plaques but also from total carotid occlusion. This case underscores the necessity of performing carotid artery evaluation in all patients presenting with symptoms of amaurosis fugax, even in atypical presentations.

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SB-09

Two-Year Transfemoral TAVR: Outcomes & Complications

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Introduction: Transcatheter Aortic Valve Replacement (TAVR) is a widely accepted treatment for severe aortic stenosis, particularly in patients at high or intermediate surgical risk. This study presents a two-year single-center experience, focusing on procedural success, complications, and overall outcomes.

Methods: From January 2022 to January 2024, a total of 106 patients (aged 60-95 years, mean age 79) underwent transfemoral TAVR. Both balloon-expandable (95 patients) and self-expandable (11 patients) valves were used. Data on demographics, procedural details, and outcomes were collected and analyzed.

Results

1. Patient Demographics

Parameter	Value
Age	60-95 years (mean 79)
Gender	68 males, 38 females
Comorbidities	40 with Diabetes Mellitus (DM)
	71 with Hypertension (HT)
	59 with Coronary Artery Disease (CAD)
	18 post-CABG

Parameter	Value
Renal Function	27 had elevated creatinine (>1.3 mg/dL)
Hemoglobin Levels	23 had hemoglobin <10 g/dL

2. Procedural Details

Parameter	Value
Access	104 right femoral, 2 left femoral
Valve-in-Valve Procedures	2 cases
Anesthesia	101 managed with deep sedation, 5 intubated, 4 sent to internal care unit (ICU)
Post-Dilatation	32 patients required post-dilatation
Blood Product Use	27 needed erythrocyte suspension transfusion

3. Complications

Complication	Details
Aortic Regurgitation (AR)	16 mild, 4 moderate
Paravalvular Leak (PVL)	5 mild, 1 moderate

Complication	Details
Iliac Artery Complications	6 cases; 4 managed with balloon tamponade, 2 required graft stents
Pericardial Tamponade	1 case due to temporary pacemaker lead, resolved without sequelae
Pacemaker Requirement	1 patient required a permanent pacemaker
Ischemic Stroke (SVO)	2 cases, fully recovered without sequelae

4. Outcomes

Outcome	Value
Procedural Success	100% (no annular perforation, coronary occlusion, or valve mismatch)
Post-Procedure Care	101 patients monitored in cardiac care unit (CCU); 5 intubated, 4 sent to ICU
Mortality	No in-hospital deaths; 2 deaths within one month, 8 total within one year
Surgical Conversion	None required

Discussion: This study demonstrates the high procedural success and safety of transfemoral TAVR, with a 100% success rate and no in-hospital mortality. Similar findings were reported in major studies like the PARTNER 3 trial, where procedural success rates also exceeded 95%, and in-hospital mortality was low. The post-dilatation in 32 patients highlights the importance of valve sizing and positioning, especially for patients with pre-existing conditions like AR.

Comparison to Similar Studies: The incidence of paravalvular leak and iliac artery complications was comparable to other registries and clinical trials, demonstrating effective procedural management. The relatively low rate of permanent pacemaker implantation (1 case) and the full recovery of patients with ischemic strokes indicate advancements in procedural techniques and patient care.

Conclusion: Our two-year experience with transfemoral TAVR reaffirms its effectiveness and safety for patients, even those with significant comorbidities such as renal impairment and anemia. Future studies should continue to focus on optimizing patient selection, procedural techniques, and post-procedure care to improve outcomes further.

Keywords: TAVR, Transfemoral Approach, Procedural Success, Complications, Renal Impairment, Anemia, Single-Center Experience.

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SB-10

Collaterals and Severe Dissection

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Introduction: Collateral vessels develop from pre-existing arterioles in response to shear stress from arterial stenosis and mechanosensor activation. Animal studies suggest that these vessels increase in number and size after arterial occlusion, potentially offering a natural bypass and protection against critical limb ischemia. Efforts to enhance collateral vessel growth aim to improve walking performance in peripheral arterial disease (PAD). Factors influencing collateral vessel formation include plaque accumulation, tissue components, and comorbid conditions. Balloon angioplasty is a primary treatment for PAD but often leads to vessel dissection, with severe dissections linked to reduced long-term patency and requiring additional treatments. The relationship between collateral vessel characteristics and dissection severity remains unexplored.

Materials and Methods: This retrospective study analyzed endovascular treatments for femoropopliteal chronic total occlusion (FP-CTO) in 824 limbs of 706 PAD patients from January 2018 to May 2023. Exclusion criteria included prior treatments, severe aortoiliac and common femoral artery disease, and deep femoral artery disease. The final cohort comprised 410 limbs from 387 patients. Data on risk factors, lesion characteristics, and procedural details were collected. Collateral vessels were assessed by grade and number, and vessel dissection was categorized from Type A to Type F. Multivariate logistic regression identified predictors of severe dissection.

Results: Severe dissection was more frequent in TASC II C/D lesions and in patients with longer FP-CTO lengths, CTOP class-4 plaque morphology, flush ostial CTO, severe calcification, and large or numerous collateral vessels. Significant predictors of severe dissection included end-stage renal disease, FP-CTO length, CTOP class-4, flush ostial CTO, severe calcification, and large collateral vessels.

Discussion: Longer CTO lengths and complex plaque characteristics increase the risk of severe dissection during balloon angioplasty. Large and numerous collateral vessels are associated with severe dissection.

Severe dissection is more common in complex lesions and those with end-stage renal disease. The findings suggest that plaque compliance and collateral vessel characteristics are crucial in assessing dissection risk, highlighting the need for further research with larger cohorts and advanced imaging techniques.

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SB-11

Successful percutaneous treatment of chronic total occlusion of the SMA

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Chronic mesenteric ischaemia; occlusion of the mesenteric arteries that causes acute mesenteric ischaemia occurs over a longer period of time, resulting in chronic impairment of intestinal nutrition. Instead of vascular occlusion due to sudden clotting, causes such as atherosclerosis, vasculitis, radiation, aneurysm and congenital abnormalities are more prominent in chronic ischemic status. Although these causes do not always lead to chronic mesenteric ischaemia, these causes lead to chronic mesenteric ischaemia more frequently in patients who smoke, have atrial fibrillation (AF), diabetes mellitus, hypertension and hyperlipidaemia. The most common symptom of chronic mesenteric ischaemia is abdominal pain that starts 30-60 minutes after a meal and lasts for 1-2 hours, is usually mild to moderate and is usually felt around the umbilicus. The patient becomes reluctant to eat in order to avoid this pain and starts to lose weight accordingly. In some patients, abdominal pain is not prominent and chronic diarrhoea, extreme weakness, anaemia, weight loss and hypoalbuminemia-related ascites and pretibial oedema may be more prominent. In these patients, stenosis occurs in the small intestine due to chronic ischaemia and ileus symptoms such as bloating, nausea and vomiting may occur due to this stenosis. Treatment consists of reducing metabolic demand in the mesenteric bed, treatment of atherosclerosis and endovascular or operative revascularisation. Percutaneous mesenteric artery stenting is usually the predilated with Artimes 1.5x20mm and 5.0x30mm semicompliant balloons. Then Omnilink 6.0x29mm stent was placed from the lesion level. Optimal patency was achieved.

There were no complications during the procedure. At the 1st month follow-up, it was confirmed that the patient's complaints decreased and weight gain started.

Chronic total occlusions of mesenteric arteries are rare and require interventional treatment and endovascular treatment may be the only option for some patients.

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SB-12

Are distal protection devices always beneficial in carotid procedures?

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Are distal protection devices always beneficial in carotid procedures? A rare complication is the deformation of the stent by the protection device and its entanglement with the stent.

Background: In patients with carotid artery disease who have experienced a cerebrovascular event (CVE) or transient ischemic attack (TIA) within 6 months, and have more than 70% carotid stenosis (but not total occlusion), carotid endarterectomy or carotid artery stenting is considered in addition to medical treatment.

One of the most significant complications of carotid procedures is a erebrovascular event. Accepting a stroke risk of up to 5% during these procedures is considered a reasonable risk. Various methods are recommended to reduce the risk of cerebrovascular events in carotid procedures. Embolic protection devices are one such method recommended to reduce the risk of cerebrovascular events. The ESC 2017 peripheral artery disease guidelines include a class 2a recommendation stating that “the use of embolic protection devices should be considered in patients undergoing carotid artery stenting.”

Case Presentation: A 77-year-old male patient with known hypertension, diabetes mellitus, and non-critical coronary artery disease. The patient’s ECG shows sinus rhythm. The patient’s regular medications include: Matofin 500, Klogel-A 75/75, Pravachol 40, Cantab Plus 32/12.5, Tiopati 600, Dutapros 0.5, and Esom 40.

Following a transient ischemic attack (TIA), carotid vertebral ultrasonography and carotid computed tomography were requested, revealing a significant lesion in the right internal carotid artery (ICA). Digital subtraction angiography (DSA) was performed for confirmation and potential treatment.

Carotid DSA: There is 70-80% stenosis in the right ICA, with plaques in the right common carotid artery (CCA) and external carotid artery (ECA). The left CCA, ICA, and ECA also have plaques. Following DSA, a procedure was planned for the right

ICA. A Spider device filter was placed in the right ICA, followed by the implantation of an 8x10x30 mm Balton stent (self-expandable). During the removal of the filter, it got entangled with the stent and could not be removed. When forced, the stent collapsed, and the procedure was terminated. The patient's neurological examination during the procedure was normal, but surgical removal of the stent-filter complex was deemed necessary. The patient was transferred to the cardiovascular surgery intensive care unit for surgical removal and atherectomy. The surgery was performed, and the patient's neurological examination remained normal during follow-ups.

Discussion: While the use of filters in carotid procedures is recommended, it is essential to be aware of the complications associated with the filter itself and to proceed with caution considering these potential complications.

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SB-13

Coronary subclavian steal syndrome

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An important entity in patients scheduled for CABG, as important as preoperative valve assessment: Is the subclavian artery optimally evaluated in every patient where LIMA will be used?

Background: Coronary artery bypass grafting (CABG) is a treatment method commonly applied in patients with multiple coronary artery diseases. In CABG, the left internal mammary artery (LIMA) and saphenous vein grafts are used as grafts. LIMA is a branch of the subclavian artery, and it is recommended to evaluate the subclavian artery before using LIMA (1). This case describes graft insufficiency and the procedure performed on the subclavian artery due to subclavian stenosis in a patient where LIMA was used for LAD.

Case Presentation: A 59-year-old female patient with known hypertension and diabetes mellitus (DM) who underwent CABG in 2019 has been experiencing exertional dyspnea for 1 month. Her ECG showed sinus rhythm, and her echocardiogram revealed an EF of 55. Based on her complaints, coronary angiography (CAG) was performed. A 6F sheath was placed in the left radial artery, and diagnostic CAG was performed. The CAG report was as follows: LMCA: Normal, LAD: In-stent osteal 70-80%, in-stent mid-region 60%, CX: Distal 60-70%, RCA: Mid plaque, aortic saphenous CX open, left subclavian osteal 90%, LIMA open but not filling the LAD antegradely, LAD filling from LIMA - Subclavian (coronary subclavian steal). After diagnostic CAG, a decision was made to proceed with a subclavian procedure. Due to the need for support and ease of material passage, it was decided to perform the procedure from the femoral artery. A 7F sheath was placed in the right femoral artery, and an 8.0x38 mm DES was placed in the left subclavian osteal region with a 7F JR4 catheter at 12-18 atm. LIMA - LAD started to fill antegradely. Post-dilatation was not performed as sufficient patency was achieved. The patient's medication regimen was adjusted to include acetylsalicylic acid, pitavastatin 4 mg, metoprolol 50 mg, proton pump inhibitor, and 3 oral

antidiabetic drugs, along with the addition of clopidogrel 75 mg. At the 1-month follow-up, it was observed that the patient's complaints had resolved and her exercise capacity had increased.

Discussion: Evaluating the subclavian artery in every patient scheduled for CABG, especially when LIMA will be used, can prevent potential graft insufficiency in the near future.

Keywords: Coronary subclavian steal syndrome, Subclavian stenosis, Subclavian stenting.

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SB-14

Giant iliac artery aneurysm

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A 82 -year-old male patient was admitted to emergency service with urinary incontinence, abdominal pain and claudication. During the physical examination of the patient with a history of coronary artery disease (CABG), chronic atrial fibrillation, heart failure (EF 35%), diabetes mellitus type 2, blood pressure was 138/82 mmHg and heart rate was 122/min. In the emergency department, the pH value of blood gas was 7.24 with hgb of 13.2 and creatine value of 1.1 mg/dl. A giant tandem aneurysms (CIA;87 mm and IIA;55 mm) were detected on contrast-enhanced lower abdominal tomography. Bilateral common femoral artery aneurysm (14 mm) was also observed.The patient's Health care records indicated hat he experienced urinary incontinence and abdominal pain emergency department treatment three times in the past month. The patient's ASA score (4) indicated a high risk for surgery. The council decided to perform endovascular intervention.

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SB-15

Prostate artery embolization in benign prostatic hyperplasia

Serhat Günlü[1]
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82 -year-old male patient was admitted to emergency service with urinary retension attack. During the physical examination of the patient with a history of coronary artery disease (<70% stenosis), chronic atrial fibrillation, heart failure (EF 35%), blood pressure was 138/82 mmHg and heart rate was 122/min. In the emergency department, the pH value of blood gas was 7.21 with hgb of 10.2 and creatine value of 4.2 mg/dl (previous baseline value was 1.32). The patient's health care records indicated that he experienced urinary retention attacks and sought emergency department treatment three times in the past month. The patient's ASA score (4) indicated a high risk for surgery. The council decided to perform endovascular intervention with previous baseline creatine value due to the absence of response to medical treatment (finasterid+doksazosin) over the past three months, severe IPSS (>18), PVR > 143 ml, and prostate size > 80 gr. Foleycatheter was placed as a marker before procedure. A 5-Fr vertebralcatheter was used to engage the hypogastric artery ostium with 0.035-inch stiffglidewire (Zipwirestiff, Boston). Then, the prostate artery was visualized with digital substraction angiography (30-45 degree ipsilateraloblique) after selective microcatheterization (Corsair Pro XS, ASAHI) over the wire of 0.014 inches (BMW, Abbott). 200 mcg nitroglycerin was administered for each side. Prostate artery was embolized with 300-500 µm microspheres (Embosphere, Merit) (Figure1). The patient complained of mild retropubic pain, which was treated with non opioid analgesic. He had no fever or hematuria and was discharged 3 days after PAE. He urinated spontaneously upon urethral catheter removal 2 hours after the procedure.

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SB-16

Alternative access for peripheral vascular interventions

Şevval İlke GÜNEYSU[1]

1.ISTANBUL CERRAHPAŞA UNIVERSITY, INSTITUTE OF CARDIOLOGY

The prevalence of peripheral artery disease(PAD) has increased in relation to an ageing population with chronic disease. Up to 1 in 10 patients with PAD have the most severe form of the disease, chronic limb threatening ischemia(CLTI). The treatment of CLTI includes medical therapy and timely revascularization. Peripheral vascular interventions(PVIs) for infrainguinal disease are traditionally conducted via the common femoral artery(CFA), either antegrade on the ipsilateral limb or retrograde via the contralateral limb. However, femoral artery access has several limitations, including limited push-ability for infrapopliteal lesions and challenging access in total complete occlusions of the CFA. Therefore, the use of safe and effective alternative access sites for PVI is crucial in the management of PAD and for limb salvage.

A 64-year-old man with hypertension and congenital (secondary to atrophy) single kidney presented to our outpatient clinic with an open wound on his foot. Physical examination revealed a necrotic wound starting from the 3-4-5. toes of the left foot and spreading proximally. The patient was decided to intervene. A catheter was placed in the right femoral artery for intervention of total stenosis in the distal left superficial femoral arter (SFA). Poseidon and cenger wires were tried to be passed, but retrograde intervention was decided upon subintimal progression of the wires. First 4f and then 6f sheat was placed in the left dorsalis pedis artery. Retrograde lesion was crossed with a floppy wire. The wire was externated. Then a 5.0x150mm balloon was applied to the distal SFA. Then 2.5x120mm balloon was applied to tibialis anterior artery. Complete opening was achieved at the end of the procedure.

The transpedal approach was first described in 1990 by Iyer et al. as an incision in the posterior tibial artery to facilitate endovascular revascularisation of occluded tibial arteries where conventional antegrade techniques have failed. Since then, this approach has been reproduced in multiple small studies. A large prospective cohort study evaluating the

outcomes after a transpedal retrograde approach for infrainguinal disease demonstrated that technical success did not differ significantly between those with prior failed antegrade attempts and those with a primary tibiopedal attempt. The major advantage of this approach is the ability to perform complex interventions retrogradely which decreases procedure time compared to the combined retrograde-antegrade technique. In addition, it avoids cutdown access, which may increase procedure time and the potential for infection. The major limitation of this technique is the sheath size that can be used. Larger sheath sizes cause vasospasm which can cause pain during the procedure and could result in potential postprocedure complications. calcium channel blockers and nitroglycerin can be used to reduce the risk of vasospasm.

Depending on user preference and familiarity with these techniques, alternative access sites can be used judiciously as either first-line approaches for infrainguinal disease or additional strategies for limb salvage. Although additional studies are needed to evaluate the long-term patency rates and outcomes transpedal access, the current literature reports acceptable technical success, amputation-free survival, and low access site complications with these techniques for the management of CLTI.

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SB-17

Alternative access for peripheral vascular interventions

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Periferik arter hastalığının (PAD) yaygınlığı, kronik hastalığı olan yaşlanan bir popülasyonla ilişkili olarak artmıştır. PAD'li hastaların 10'da 1'ine kadarında hastalığın en şiddetli formu olan kronik uzuv tehdit edici iskemi (CLTI) vardır. CLTI'nin tedavisi tıbbi tedavi ve zamanında revaskülarizasyonu içerir. İnfrainguinal hastalık için periferik vasküler müdahaleler (PVI'ler) geleneksel olarak ortak femoral arter (CFA) yoluyla, ipsilateral uzuvda antegrad veya kontralateral uzuvdan retrograd olarak gerçekleştirilir. Ancak femoral arter erişiminin, infrapopliteal lezyonlar için sınırlı itme kabiliyeti ve CFA'nın tam tıkanıklıklarında zorlu erişim dahil olmak üzere çeşitli sınırlamaları vardır. Bu nedenle, PVI için güvenli ve etkili alternatif erişim noktalarının kullanımı, PAD'nin yönetiminde ve uzuv kurtarmada çok önemlidir.

Hipertansiyonu ve konjenital (atrofiye sekonder) tek böbreği olan 64 yaşında erkek hasta ayakta açık yara şikayetiyle polikliniğimize başvurdu. Fizik muayenesinde sol ayak 3-4-5 parmaklarından başlayıp proksimale doğru yayılan nekrotik yara tespit edildi. Hastaya müdahale kararı verildi. Distal sol süperfisyal femoral arterdeki (SFA) total stenozun müdahalesi için sağ femoral artere kateter yerleştirildi. Poseidon ve cenger telleri geçirilmeye çalışıldı ancak tellerin subintimal ilerlemesi üzerine retrograd müdahale kararı alındı. Sol dorsalis pedis arterine önce 4f sonra 6f sheat yerleştirildi. Retrograd lezyon floppy telle geçildi. Tel çıkarıldı. Daha sonra distal SFA'ya 5.0x150mm balon uygulandı. Daha sonra tibialis anterior artere 2.5x120mm balon uygulandı. İşlem sonunda tam açıklık sağlandı.

Transpedal yaklaşım ilk olarak 1990 yılında Iyer ve arkadaşları tarafından konvansiyonel antegrad tekniklerin başarısız olduğu tıkalı tibial arterlerin endovasküler revaskülarizasyonunu kolaylaştırmak için posterior tibial arterde bir kesi olarak tanımlanmıştır. O zamandan beri, bu yaklaşım çok sayıda küçük çalışmada yeniden üretilmiştir. İnfrainguinal hastalık için transpedal retrograd yaklaşımdan sonraki sonuçları değerlendiren büyük bir prospektif kohort çalışması,

teknik başarının daha önce başarısız antegrad girişimleri olanlar ve birincil tibiopedal girişimi olanlar arasında önemli ölçüde farklılık göstermediğini göstermiştir. Bu yaklaşımın en büyük avantajı, kombine retrograd-antegrad tekniğe kıyasla işlem süresini azaltan karmaşık müdahaleleri retrograd olarak gerçekleştirme yeteneğidir. Ek olarak, işlem süresini ve enfeksiyon potansiyelini artırabilecek kesi erişimini önler. Bu tekniğin en büyük sınırlaması, kullanılabilen kılıf boyutudur. Daha büyük kılıf boyutları, işlem sırasında ağrıya neden olabilen ve olası işlem sonrası komplikasyonlara yol açabilen vazospazma neden olur. Vazospazm riskini azaltmak için kalsiyum kanal blokerleri ve nitrogliserin kullanılabilir.

Kullanıcı tercihine ve bu tekniklere aşinalığına bağlı olarak, alternatif erişim noktaları infrainguinal hastalık için birinci basamak yaklaşımlar veya uzuv kurtarma için ek stratejiler olarak akıllıca kullanılabilir. Uzun vadeli açıklık oranlarını ve transpedal erişim sonuçlarını değerlendirmek için ek çalışmalara ihtiyaç duyulmasına rağmen, mevcut literatür CLTI'nin yönetimi için bu tekniklerle kabul edilebilir teknik başarı, ampütasyonsuz sağkalım ve düşük erişim noktası komplikasyonları bildirmektedir.

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Radisson Blu Sisli Hotel
Istanbul-Türkiye
18th - 20th October 2024

SB-18

Evaluation of the Relationship Between Late Arteriovenous Fistula Failure

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Amaç: Arteriovenöz fistül yetmezliğinin (AVFF) gelişimi, inflamatuar yanıttan önemli ölçüde etkilenir. Sistemik immün-inflamasyon indeksi (SII), farklı hastalıkları olan hastaların klinik deneylerinde nasıl performans göstereceğini belirtmek için kullanılabilecek yeni bir inflamatuar belirteçtir. Bu çalışmanın amacı, yüksek SII düzeylerinin AVFF ile nasıl ilişkili olduğunu değerlendirmektir.

Gereç ve Yöntemler: Toplamda 108 hasta vardı (70 AVFF'li ve 38 AVFF'siz). SII'yi hesaplamak için trombosit sayısı x nötrofil sayısı / lenfosit sayısı kullanıldı. Klinik veya hematolojik verilerin geç AVFF ile ilişkili olup olmadığına bakıldı.

Bulgular: AVFF'li hemodiyaliz hastaları daha yaşlıydı ve daha fazla HT ve KAH'ye sahipti. (sırasıyla p=0,02, p= 0,009 ve p=0,01). AVVF'li hasta grubunda C-reaktif protein (CRP), SII ve nötrofil/lenfosit oranı (NLR) ortalamalarının istatistiksel olarak anlamlı şekilde daha yüksek olduğu gösterildi. (tümü için 28,4 ± 23,4; 575,2 ± 169,44 ve 3,6 ± 1,7, p<0,001) Tek değişkenli çalışmada hastalığın gelişimi ile bağlantı gösteren yaş, hipertansiyon, koroner arter hastalığı, CRP, NLR, SII ve hipertansiyon değişkenleri çok değişkenli lojistik regresyon analizinde kullanıldı. Çok değişkenli lojistik regresyon analizi, yalnızca SII'nin AVFF'yi etkileyen bağımsız faktörler olduğunu ortaya koydu. SII için geç AVFF'nin bağımsız öngörücülerinin var olduğu gösterildi. (p = 0,003, [OR] 1,006, %95 CI 1,001-1,013)

Sonuçlar: SII'nin öngörü değerleri AVFF'li hastalarda AVFF'siz hastalara göre daha yüksekti. Çalışmamız AVFF'li hastalarda sistemik immün-inflamasyon indeksi adı verilen yeni, kolay erişilebilir, düşük maliyetli ve tekrarlanabilir bir inflamatuar belirtecin klinik faydasını ortaya koydu.

Anahtar kelimeler: Sistemik immün-inflamasyon indeksi, Arteriovenöz fistül yetmezliği, Hemodiyaliz hastaları