**RARE PATIENT WITH INFRAINGUINAL STENT RESTENOSIS**

**A COMPLICATION: ATERECTOMY DEVICE FRACTURE**

**Abstract**

 Excisional atherectomy alone or followed by balloon angioplasty in patients with infra-inguinal peripheral artery disease is an acceptable and appropriate treatment strategy. In this article, a case study of a 67-year-old man who had an intravenous foreign body removed due to aterectomy device fracture while performing atherectomy due to peripheral arterial disease in the Cardiovascular Surgery Unit of our hospital is presented. The foreign body was demonstrated by invasive imaging examination. The superficial artery was found with an incision made on the anterior 1/3 of the right thigh, and the broken atherectomy part was excised. Surgical intervention may be required to remove intravascular foreign body that is broken during peripheral artery atherectomy.

**Keywords:** *Peripheral artery disease, Atherectomy, Foreign Body*

**Introduction**

 Peripheral artery disease (PAH) is a clinical condition that has been increasing in recent years; In addition, although it has various clinical variations for itself, the majority of patients suffer from claudication, which affects their lifestyle (1). In addition to the medical and surgical approach, angiographic treatment methods, especially infrainguinal atherectomy and additional balloon angioplasty, have been widely used (2). Cilostazol, which has clearly proven efficacy in medical treatment, can’t be used in patients with left ventricular failure. That is why we use endovascular methods like angioplasty, atherectomy, or a combination of these in patients with infra-inguinal peripheral artery disease (3). Performing angioplasty alone, especially of the femoral artery, is generally an inadequate treatment. It is characterized by a high degree of calcification of the superficial femoral artery and the widespread involvement of the disease and a much higher prevalence of occlusion than stenosis (4). There are a number of atherectomy devices for SFA disease, including rotational atherectomy, orbital atherectomy, and excisional, and no comparison has been made between available atherectomy devices in randomized studies (5). There is no clear signal of superiority among these treatment modalities in observational studies. Thus, the choice of device is left to the experience and expertise of the surgeon.

 We present a case of a 67-year-old male, who was previously treated with an infra inguinal stent in an external center, and whose stents were claudicated due to total occlusion, who were planned to be treated with excisional atherectomy and balloon angioplasty.

 In this case the blood vessel was occluded within 3 months following stenting.

It is unique in that the atherectomy catheter is broken in the patient scheduled for atherectomy treatment.

In this case report, the mechanism and management of the complication are discussed.

**Case**

 A 67-year-old male patient was admitted to our clinic with the complaint of right calf claudication, which has been progressive for the last 4 weeks and restricted his lifestyle. There was no history of ischemic rest pain or non-healing wounds. On the right he had an ABI(Anke Brachial Index) of 0,6.

 His past medical history was remarkable in terms of coronary artery disease, tobacco use, and femoro popliteal bypass above the knee with PTFE graft to the same extremity and peripheral artery stenting below the inguinal ligament. Diagnostic angiography showed extensive right iliac artery disease, total occlusion in the common femoral artery and right SFA, and old nitinol stents totally occluded in both the common femoral and distal of the SFA. After consultation with the patient, it was decided to continue endovascular treatment of the right external iliac, CFA and SFA.

 The left common femoral artery was entered without any complications. A long angiographic sheet was placed into the left iliac artery and it was advanced in a retrograde way untill it reached the external right iliac artery. Lesions in the external iliac and femoral arteries were crossed with a 0.18mm nitinol wire. We advanced it with the wire of the atherectomy device. Occlusions within common femoral artery and distally to the external iliac artery were successfully passed with atherectomy. **(İMAGE 1-2)** When the distal of the SFA was reached, the atherectomy catheter was broken in the old nitinol stent, which was understood to be subintimal after the procedure.



 The patient was operated under general anesthesia under emergency conditions. Under fluoroscopy, the tip of the atherectomy catheter was found and marked. The skin was passed subcutaneously, SFA was found and returned. Transverse arteriotomy was performed after 1 cc heparinization. The broken end of the atherectomy device (18 cm) was grasped with forceps and taken out. Proximal and distal embolectomy was performed. Inflow and run off current was seen. The artery was primarily repaired with 0,6 prolene. (**IMAGE 3**).



**Discussion**

 There are other potential complications of atherectomy, but fracture is rare. There are studies in the literature in which the guide wires were broken independently of atherectomy (6). The most unique feature of our case is that it did not contain the total occlusion of the old nitinol stents before atherectomy, and unfortunately, the old stent placed by another hospital  was positioned out of the lumen.

Contact between the incisor of the atherectomy device and the subintimal stent, might be among the factors contributed to this complication, because of loss of structural strength. Various methods have been reported for retrieving broken devices using techniques such as catheter use, biopsy forceps, and balloon inflation (7). In our case, the use of a trap atherectomy catheter was not appropriate because the severed piece was quite long (18 cm). In addition, it was thought that the pressure balloon inflation technique was not applicable due to the risk of rupture of the vessel wall by the very hard foreign body. Although the guidewire technique is theoretically possible to retrieve the split end, the capture guidewires will not always be entangled. With endovascular methods and the use of infra-inguinal stents there is a success rate above 95 percent. However, because of the nitinol stent structure, the risk of subintimal placement and the movements of the limbs, the chance of success decreases to 50% (8). Because of these risks, atherectomy and balloon angioplasty are thought to be more appropriate in stents in the infra inguinal artery(9).

Results

The use of atherectomy should be reconsidered in cases with infrainguinal stent implantation due to the subintimal location of the SFA stent and the risk of more risky complications of the atherectomy device.

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