

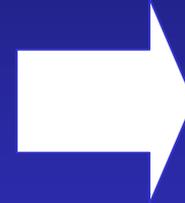
# **B T K Stents**

## **Fallvorstellung und Diskussion**

Gunnar Tepe



# Case 1

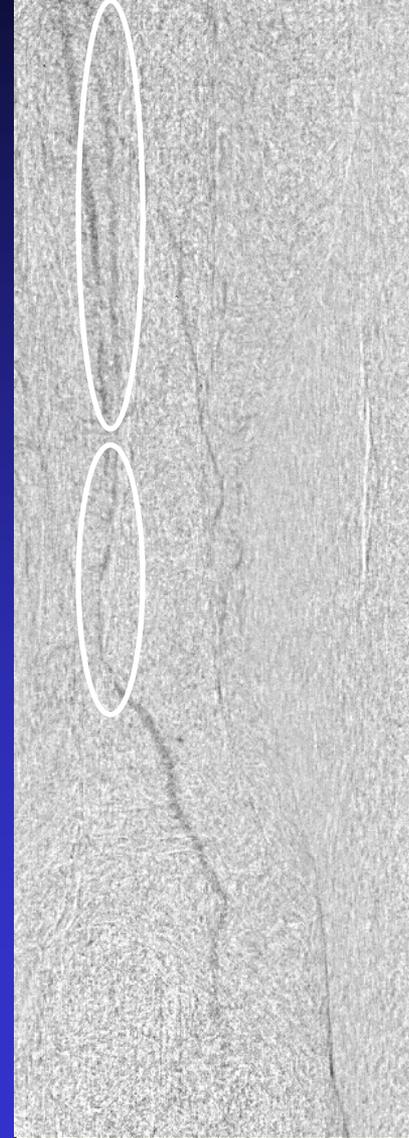


# Learning objectives

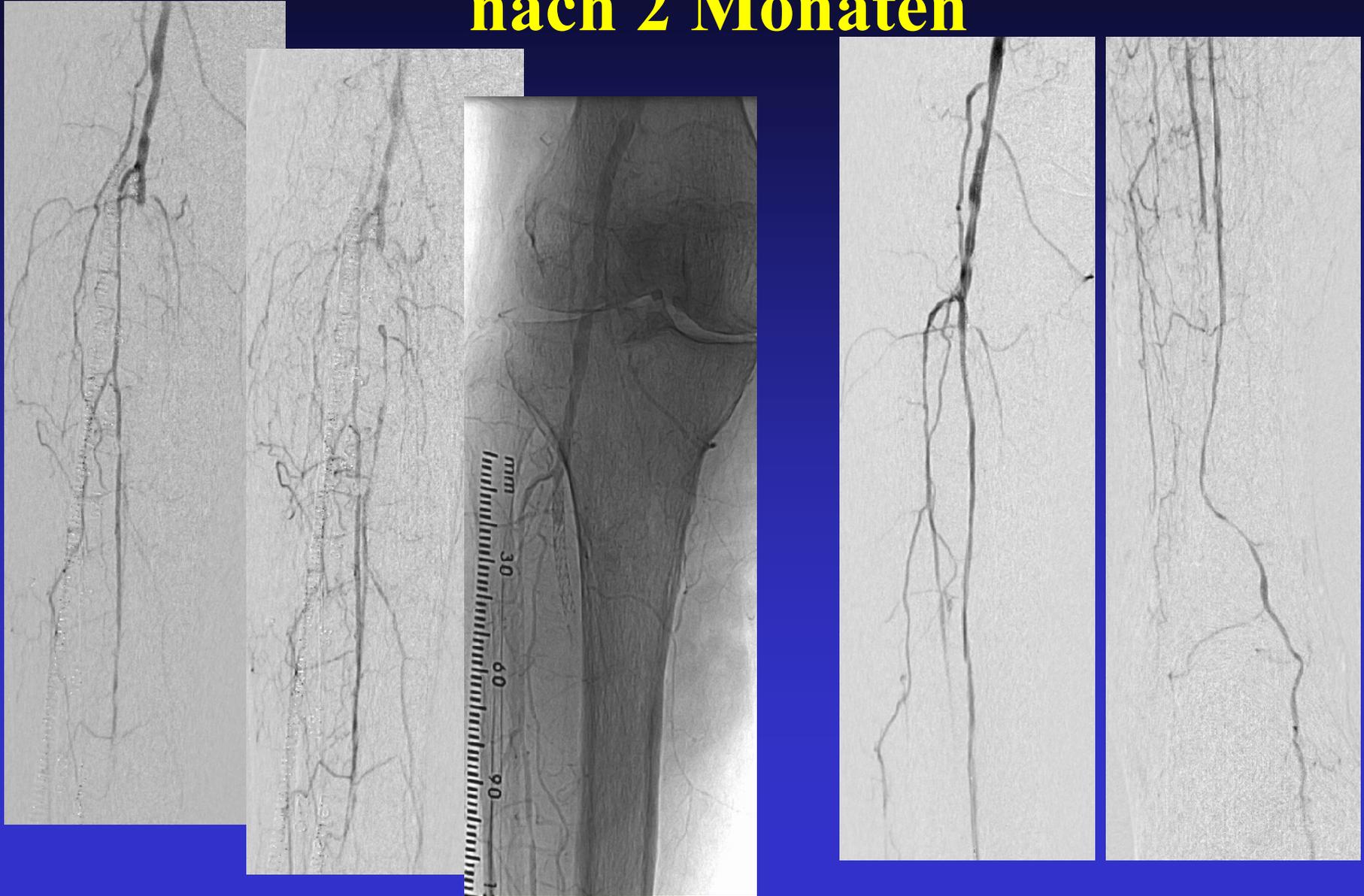
- PTA ohne Stentapplikation kann einen guten technischen Erfolg haben
- sogar nach 2 Monaten höhere Restenoserate (zusätzliche Gründe: vessel recoil, subacute Thombose)

# Case 2

# BELOW - PTA/Cypher/ReoPro



# BELOW - PTA/Cypher/ReoPro nach 2 Monaten

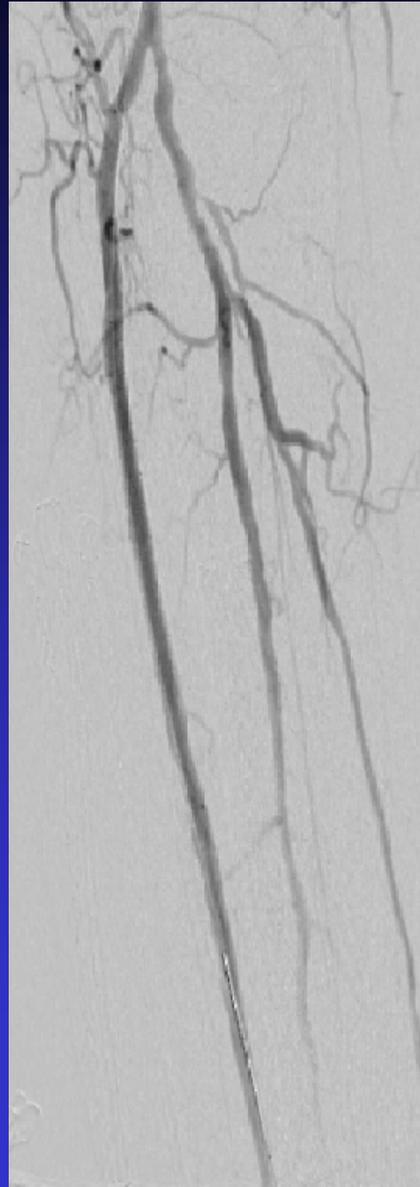
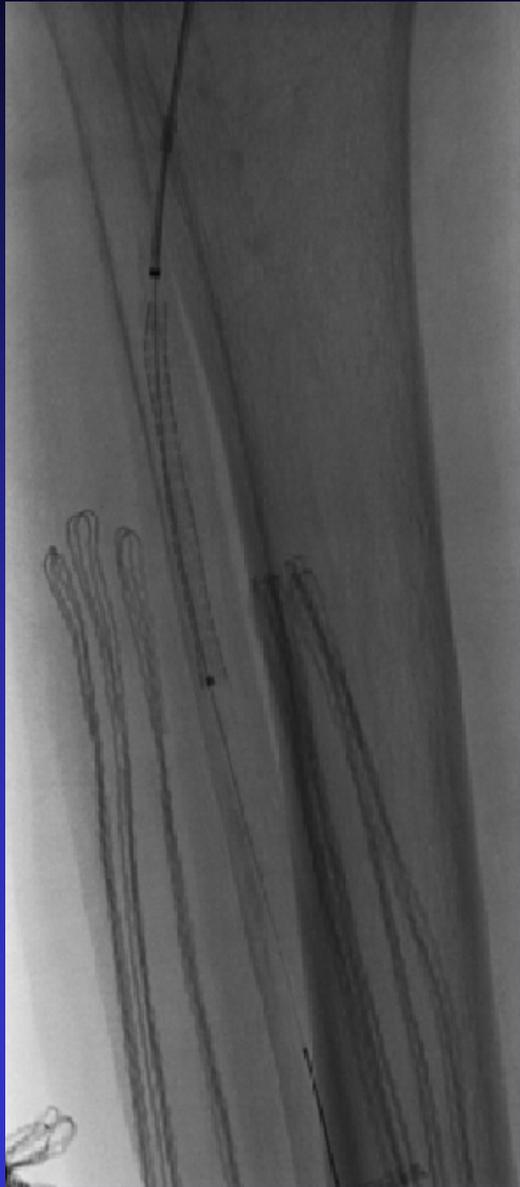


# Learning Objectives

- DES können thrombosieren (besonders wenn der Ausstrom limitiert ist)
- Der frühe Widerverschluss muss nicht mit einer neuen Symptomatik vergesellschaftet sein
- Wenn DES wieder eröffnet: Restenose kann entstehen

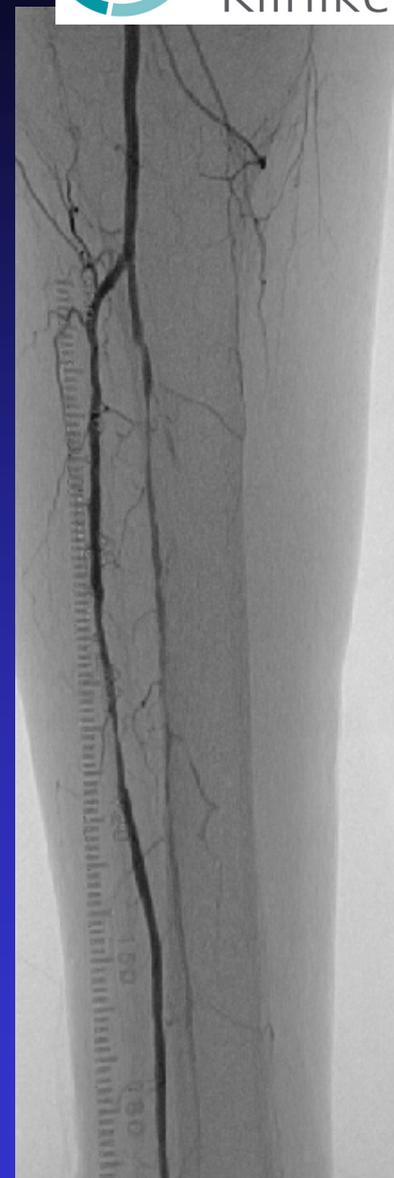
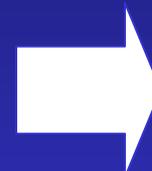
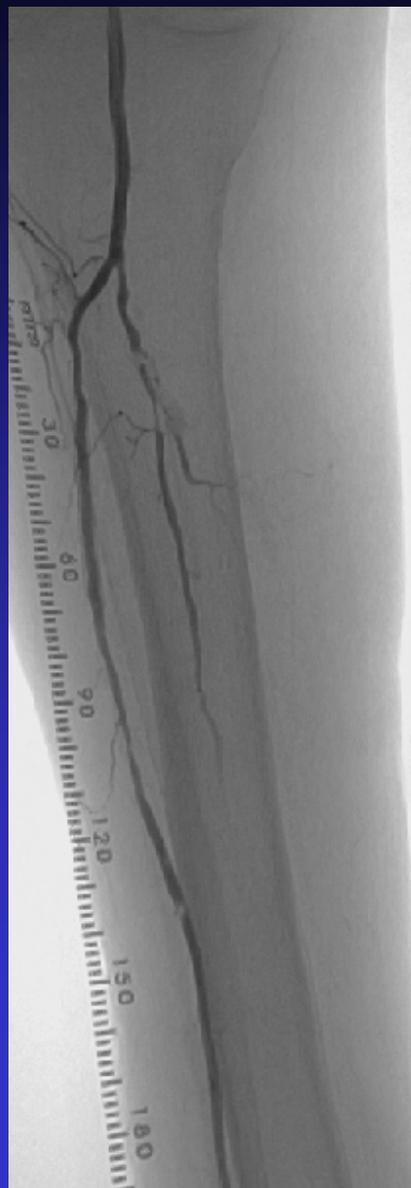
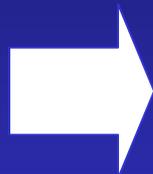
# Case 3

# Vor „BELOW“

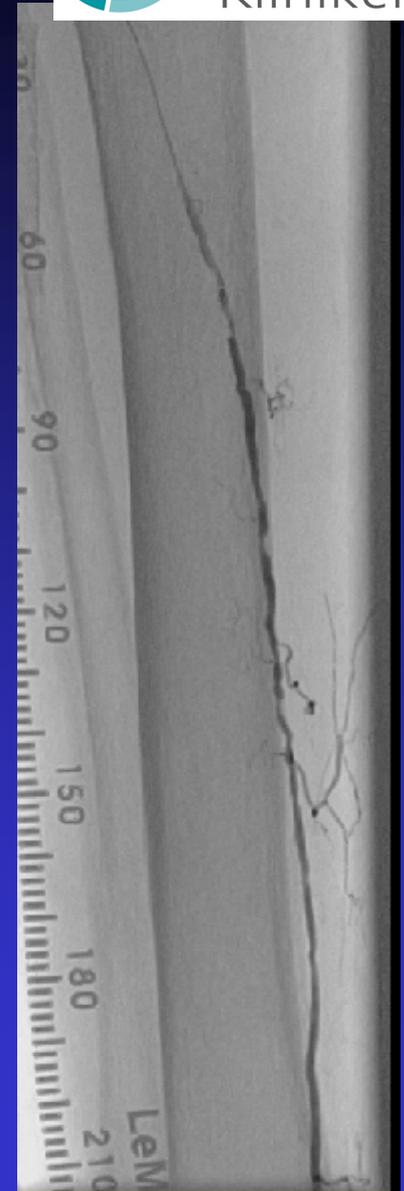
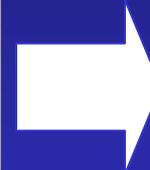
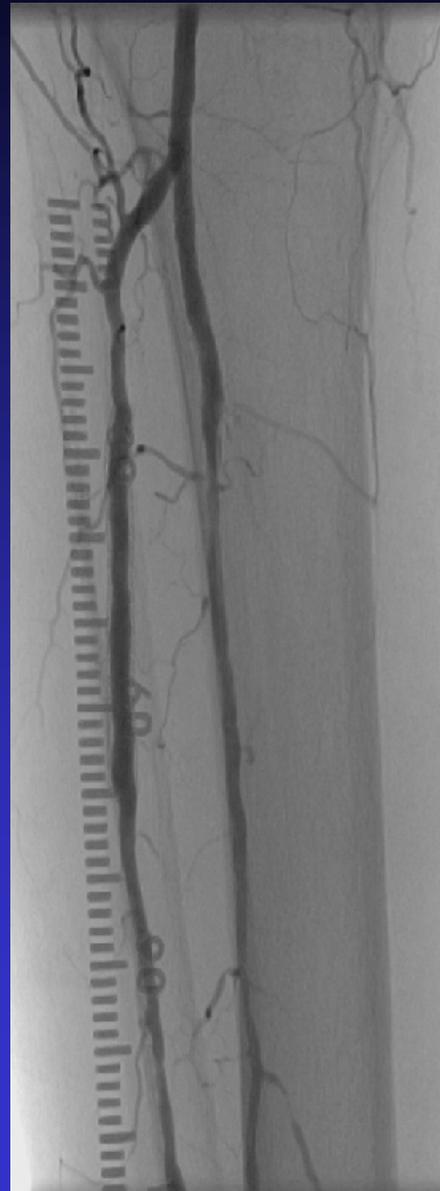
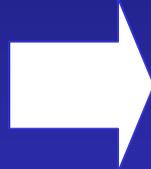
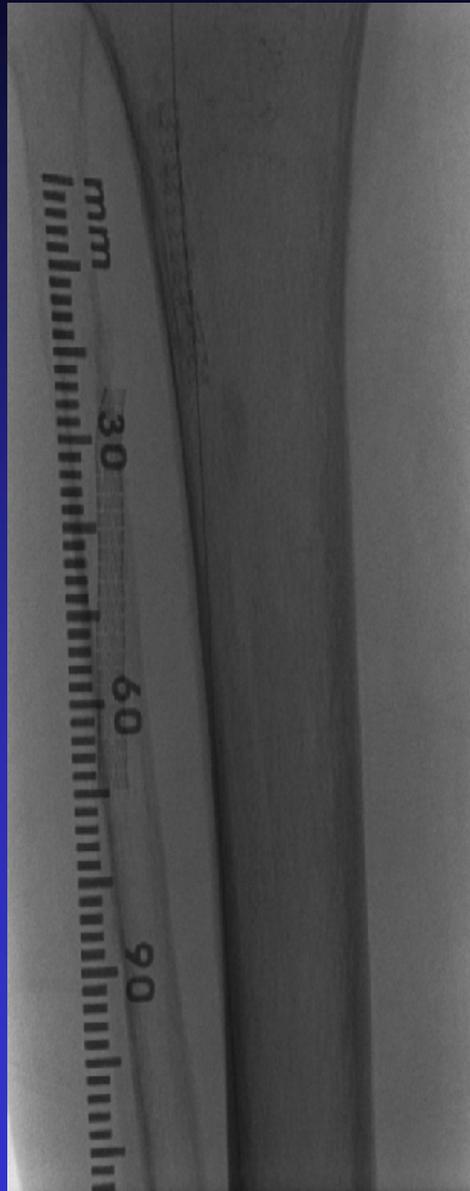


# BELOW – Cypher/ReoPro

6 Mo



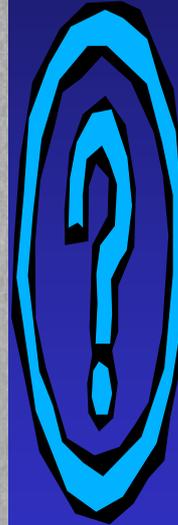
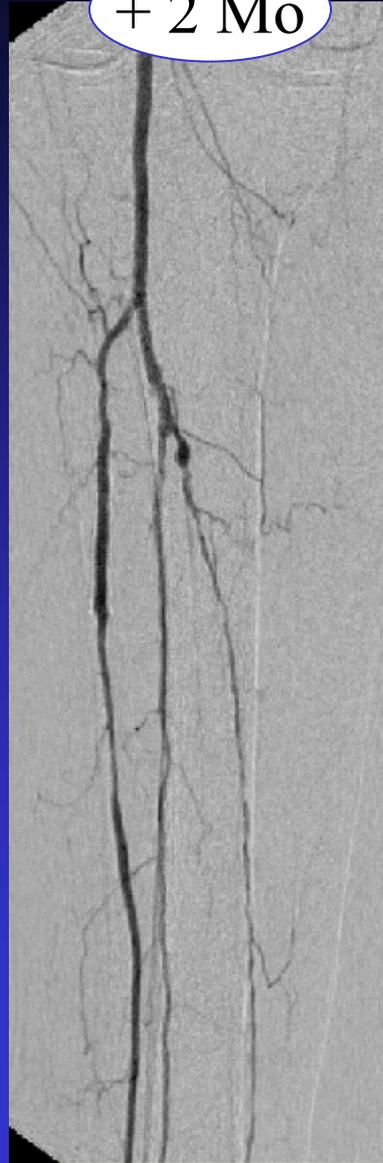
# BELOW – Cypher/ReoPro



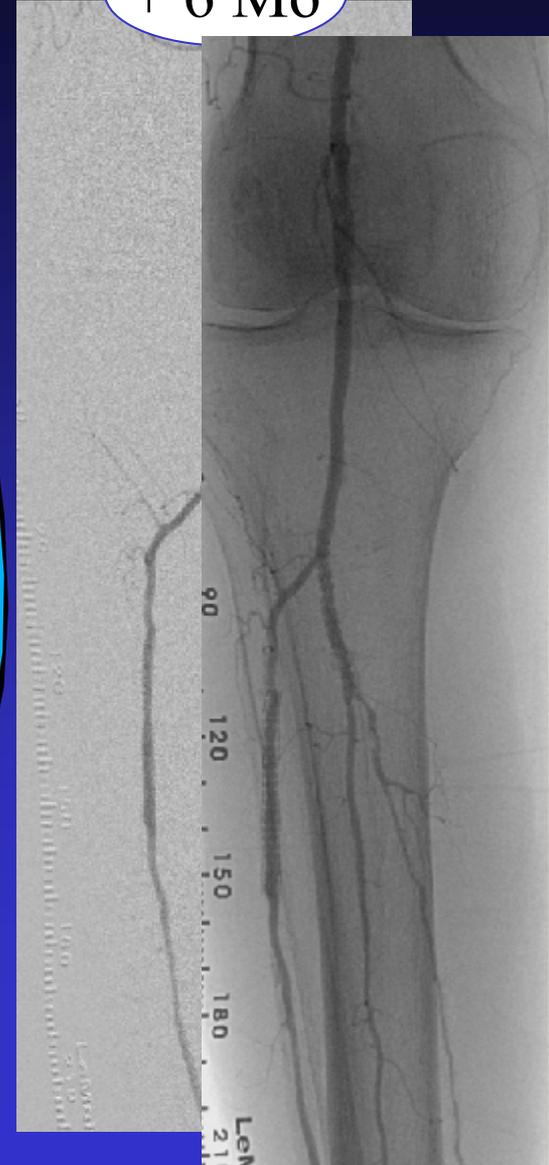
# BELOW – Cypher/ReoPro



+ 2 Mo



+ 6 Mo

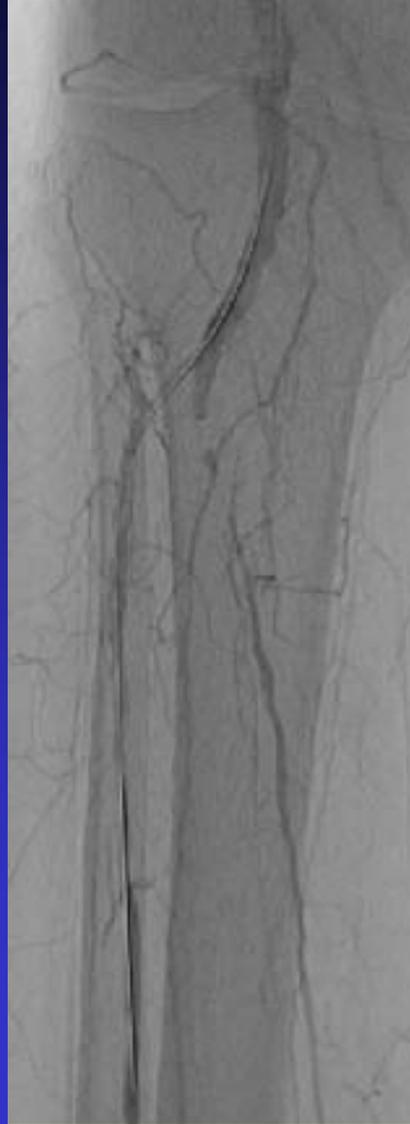
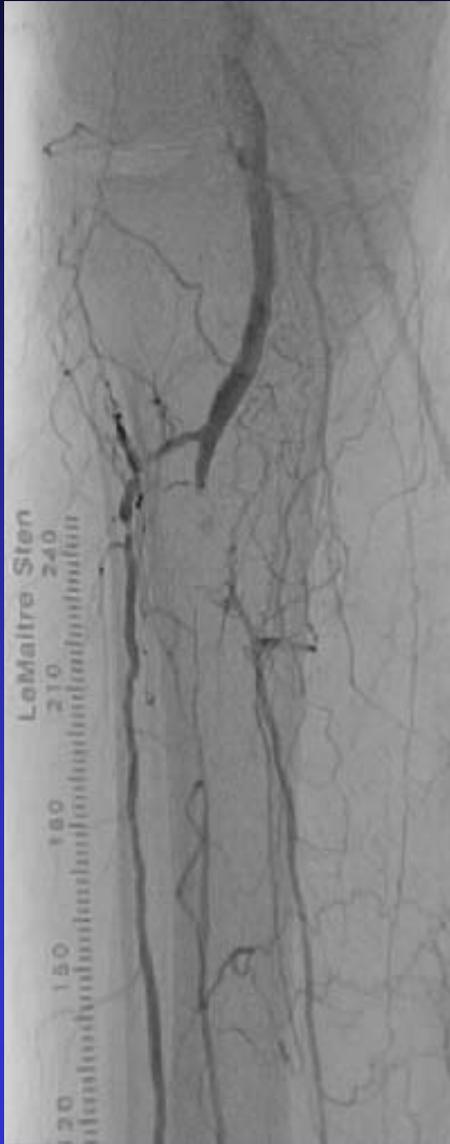


# Learning Objectives

- Selbstexpandierender Stent mit guter Langzeitoffenheit
- DES ohne Restenose nach 6 Monaten

# Case 4

# BELOW – Bare Stent/ReoPro



# BELOW – Bare Stent/ReoPro

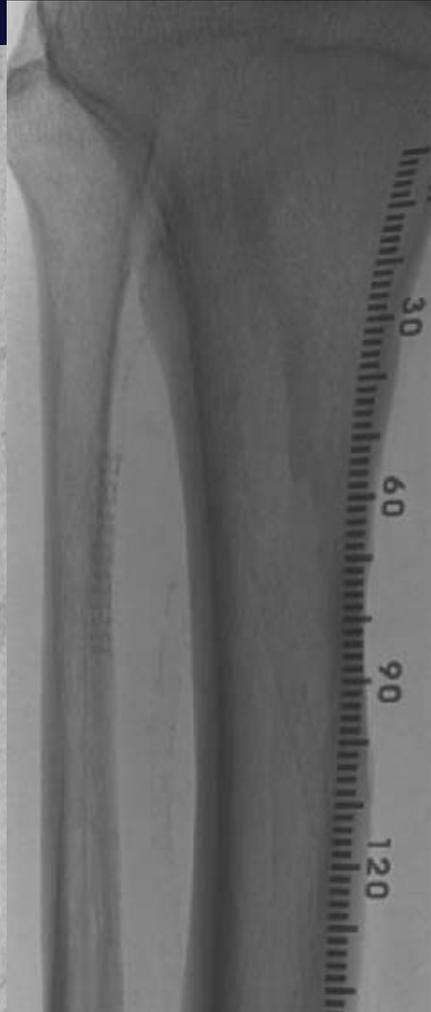
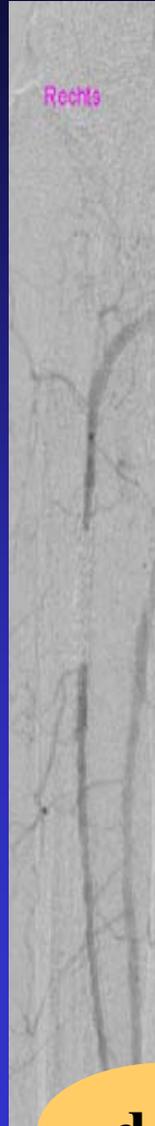
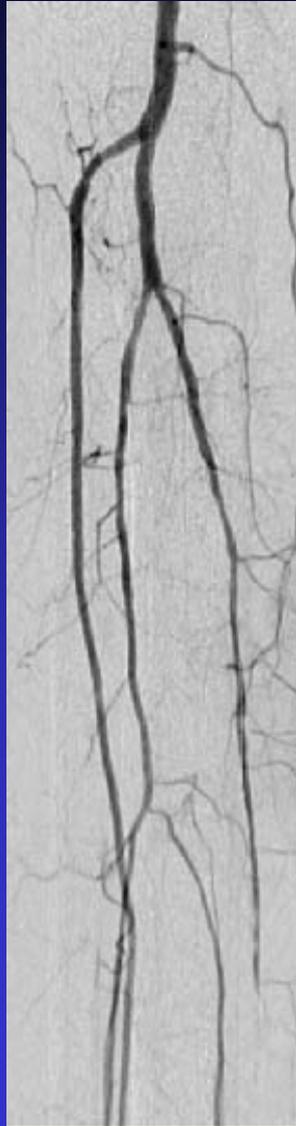


# Learning Objectives

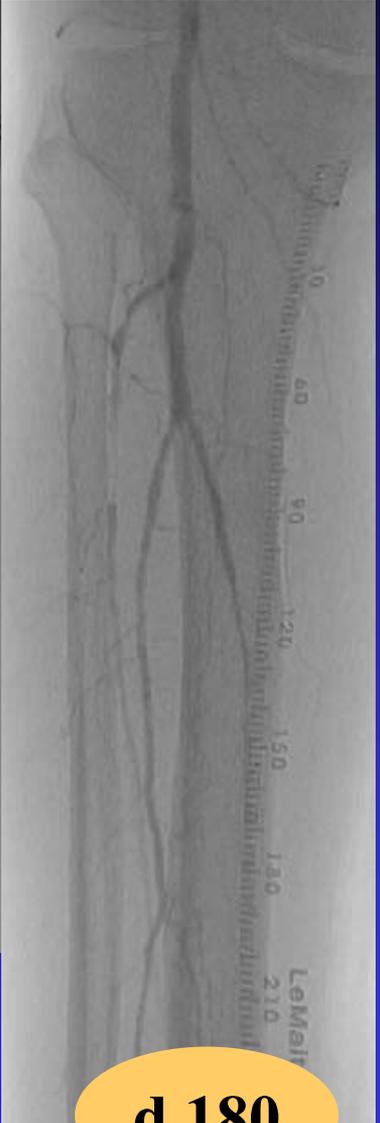
- PTA alleine oftmals nicht ausreichend um technischen Erfolg zu erzielen
- “Alle” Läsionen sollten therapiert werden

# Case 5

# BELOW – Bare Stent/ReoPro



d 60

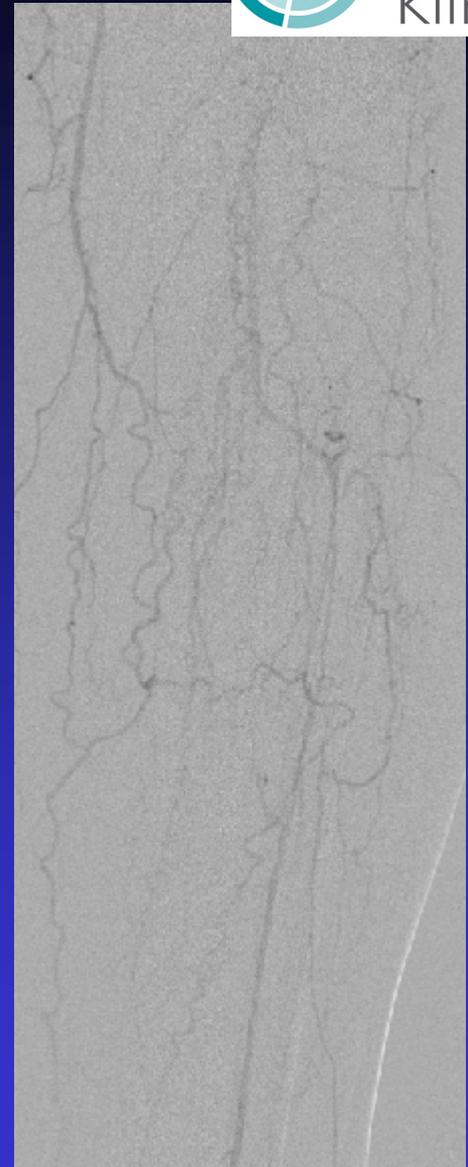
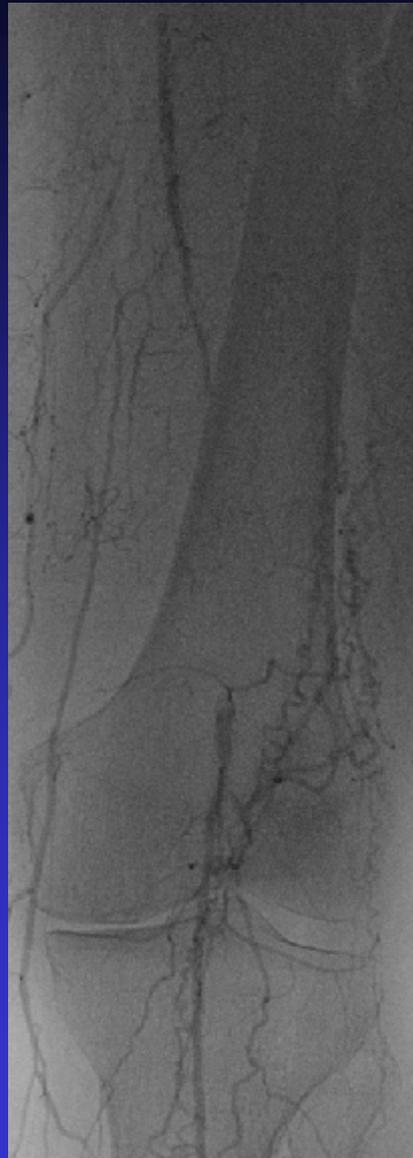
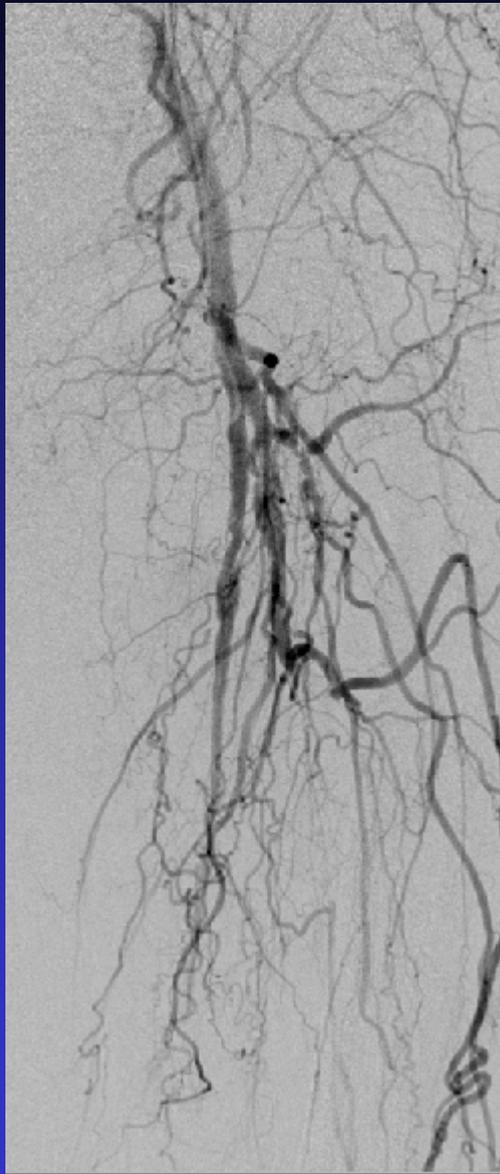


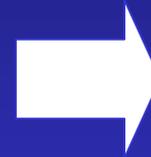
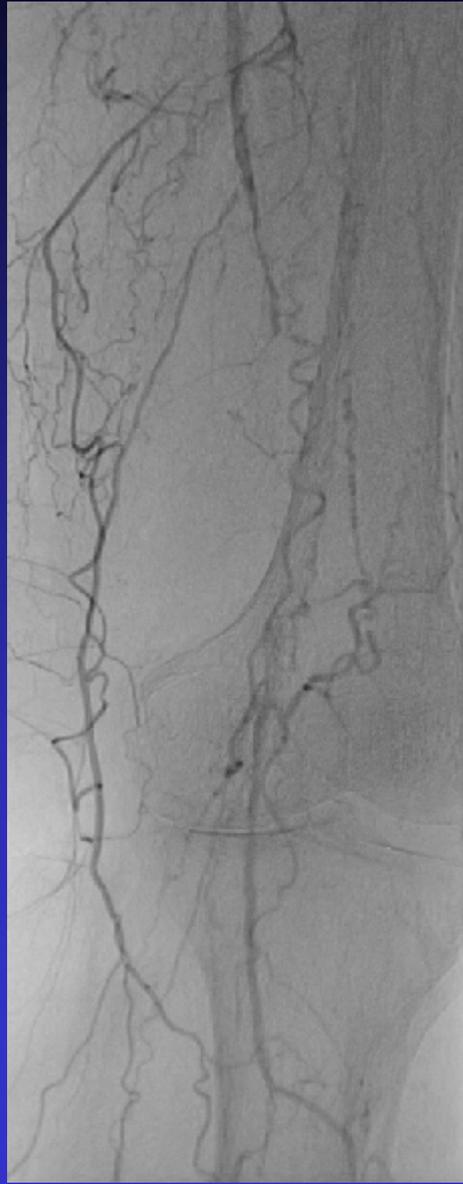
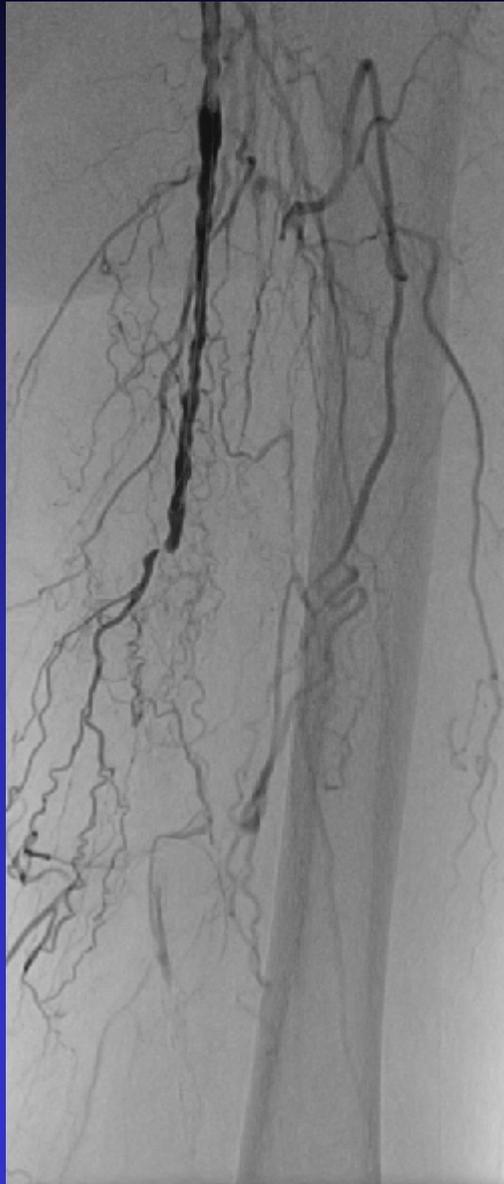
d 180

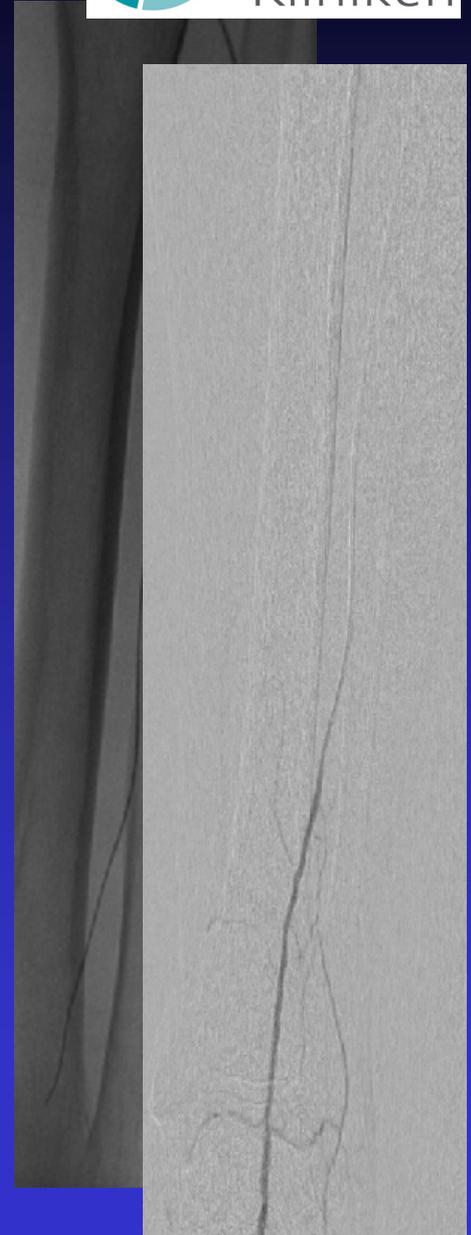
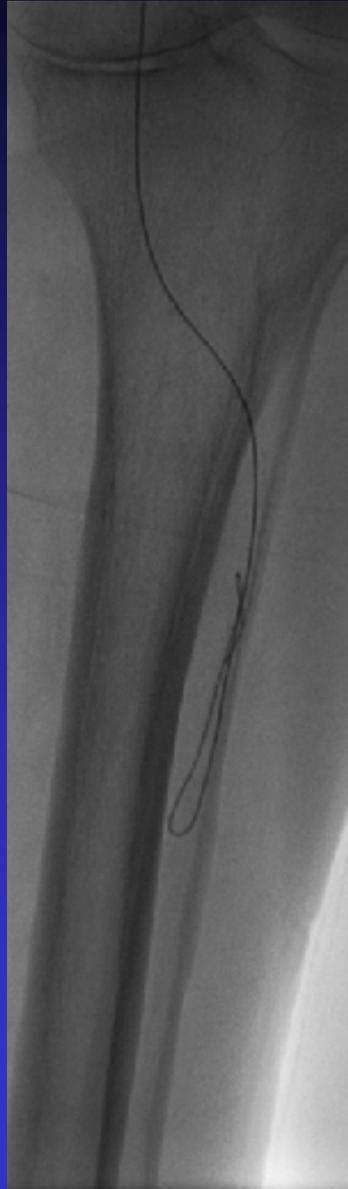
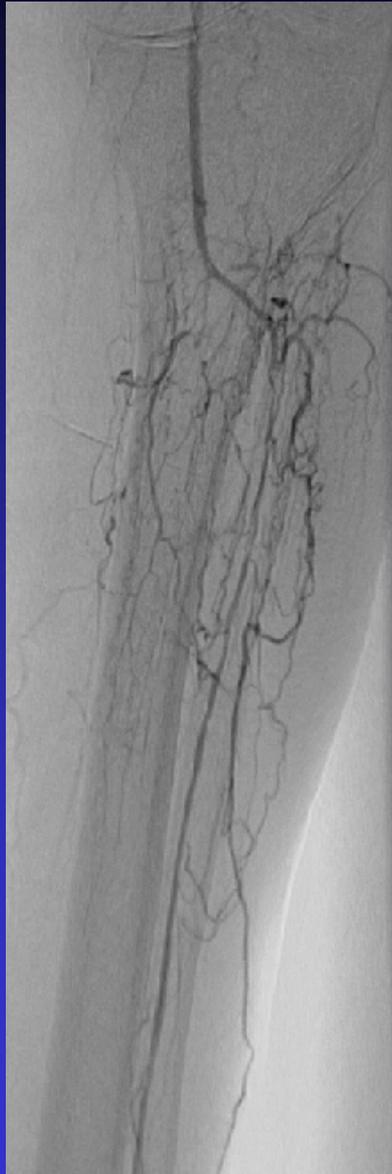
# Learning Objectives

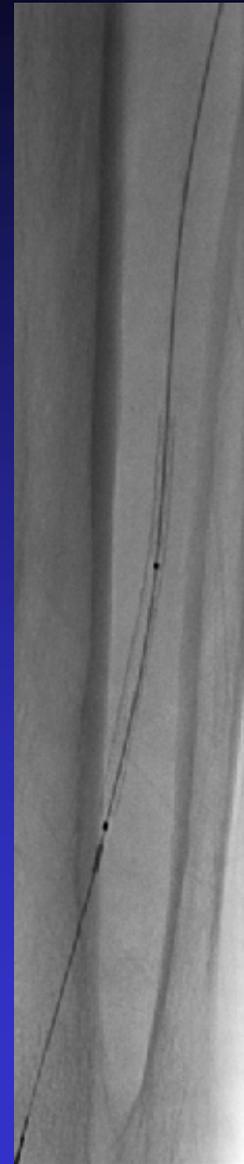
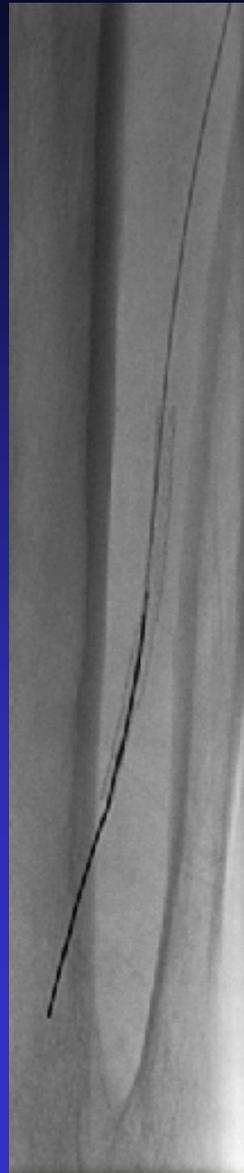
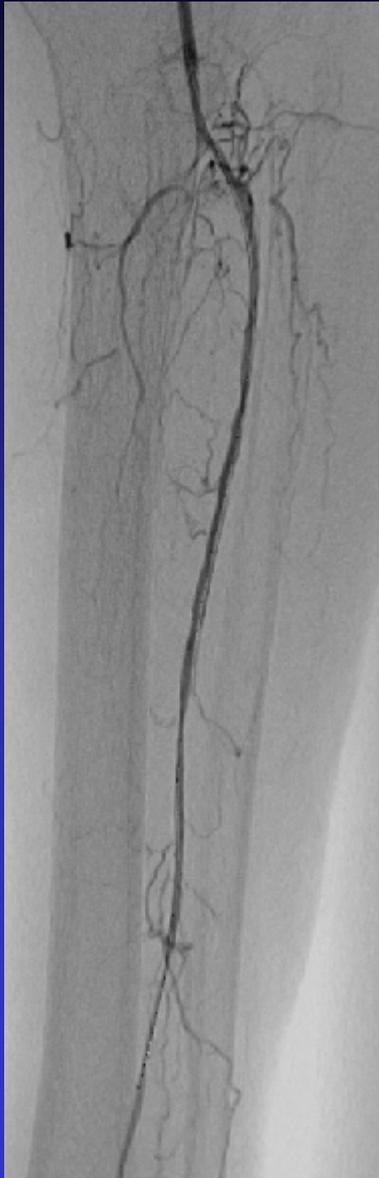
- Stents (auch nicht DES) sind thrombogen und können sich subakut verschließen
- Klinisches Bild geht nicht mit Gefäßstatus einher (inbes. bei pAVK IV) –  
hier: Besserung trotz Frühverschluß

# Case 6





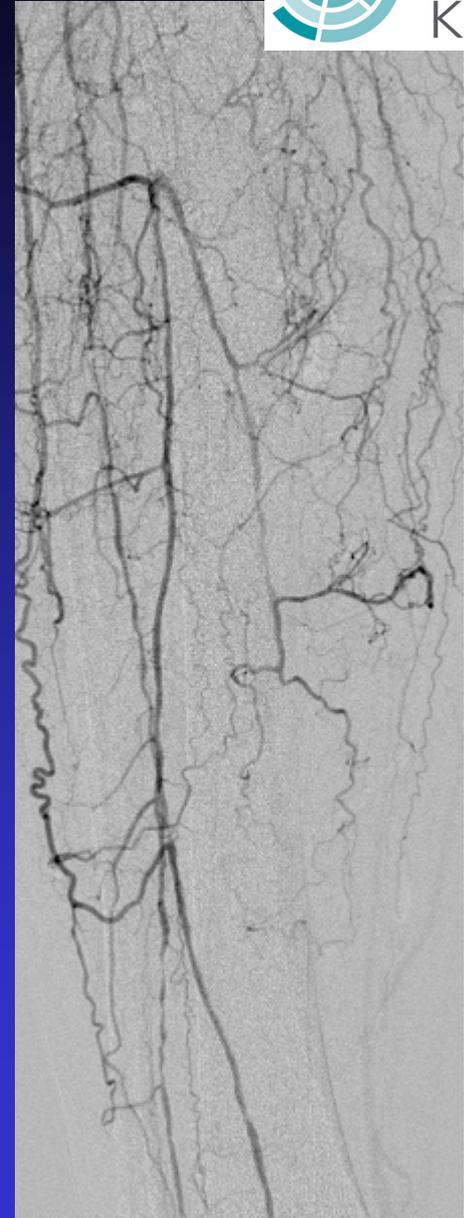
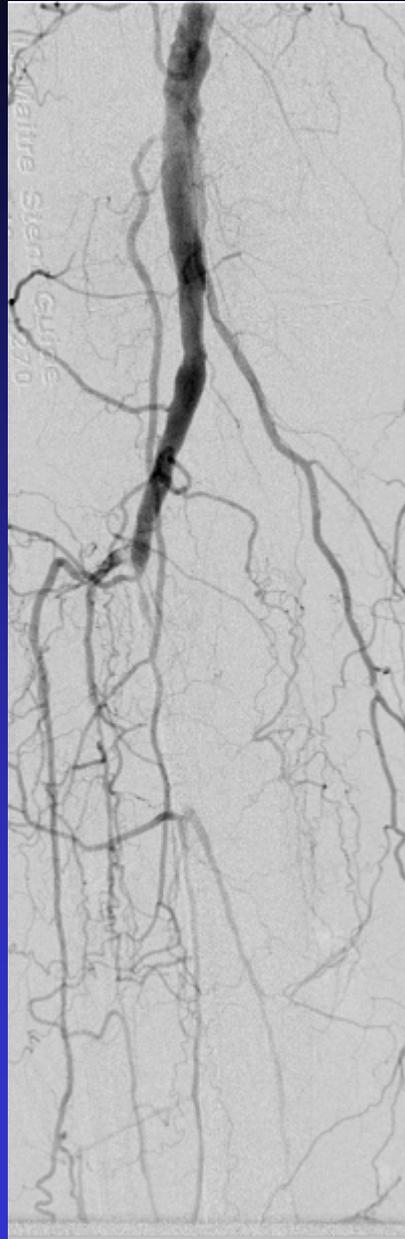


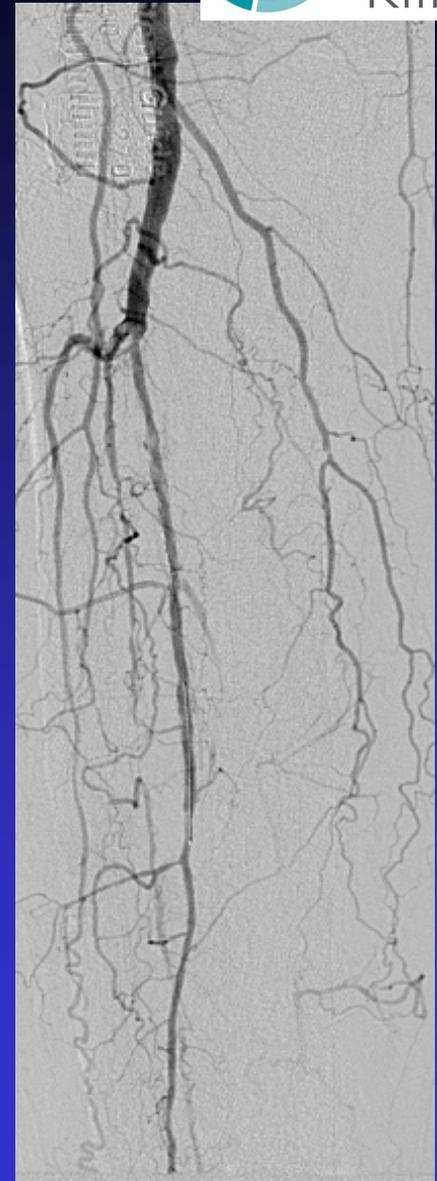
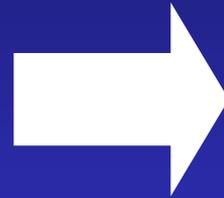
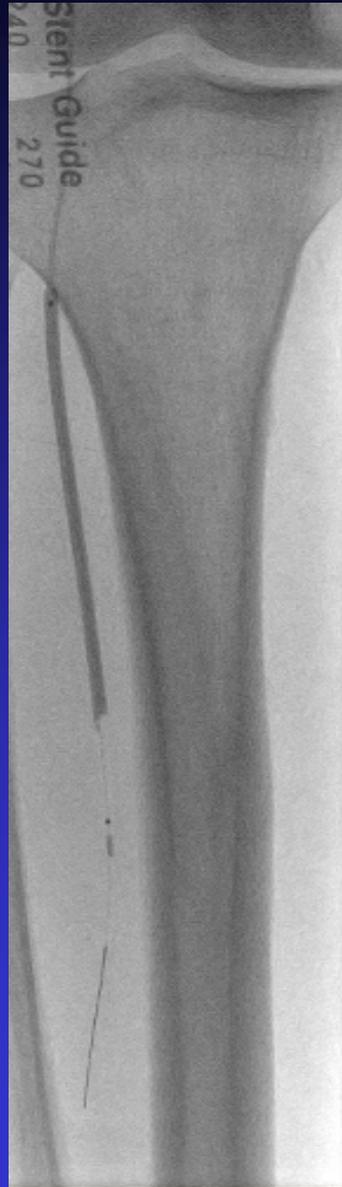


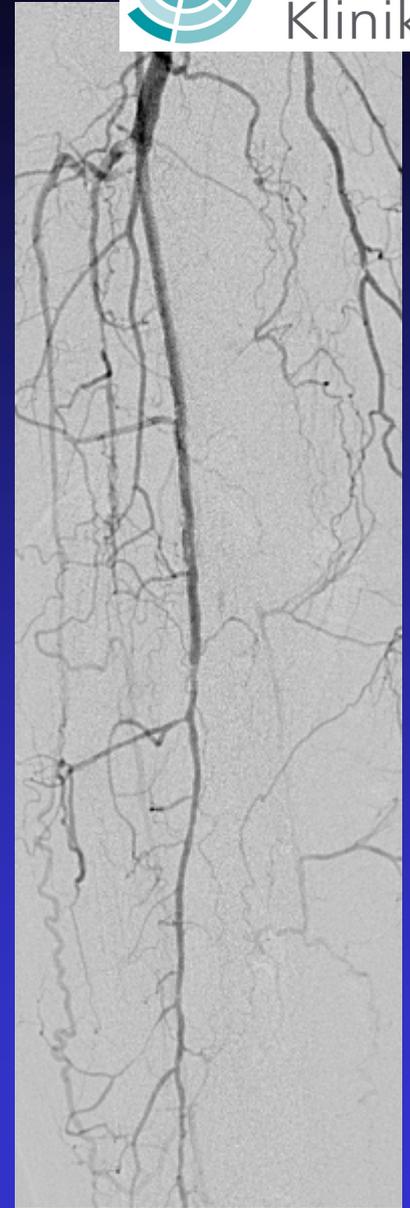
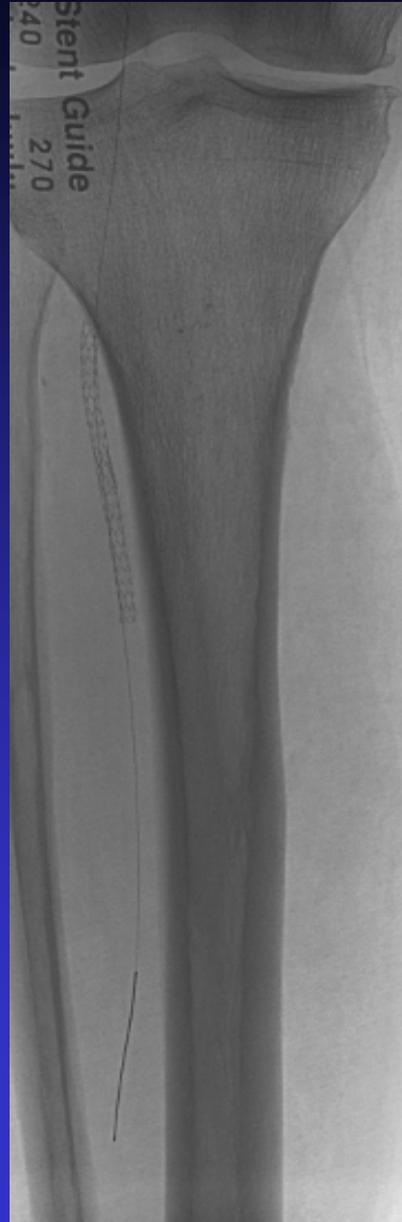
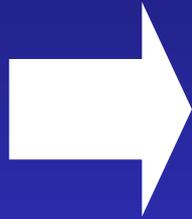
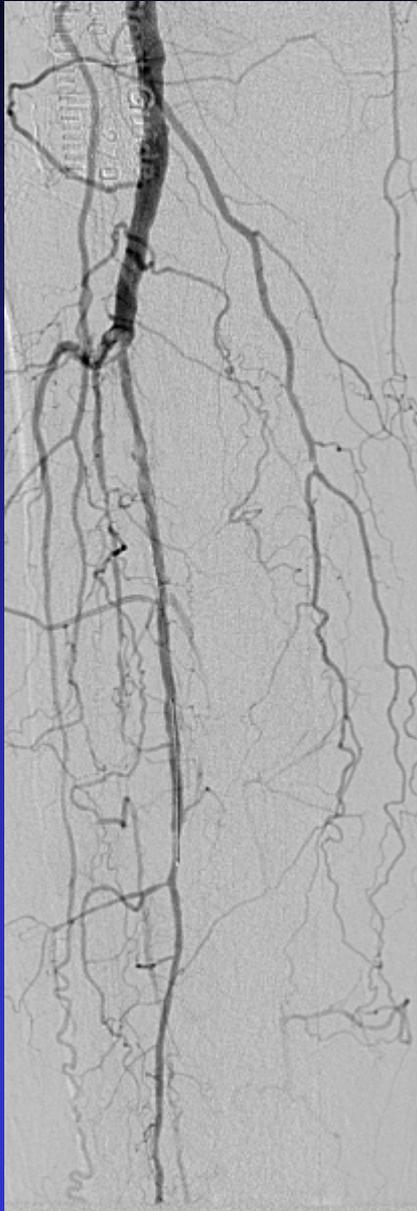
# Learning Objectives

- Auch “inflow-Läsionen”  
müssen therapiert werden
- Subintimal PTA im BTK-Bereich ist möglich:
  - Stenting in diesem Fall notwendig  
aber
  - Stenting reentry/ gesamte Läsion?

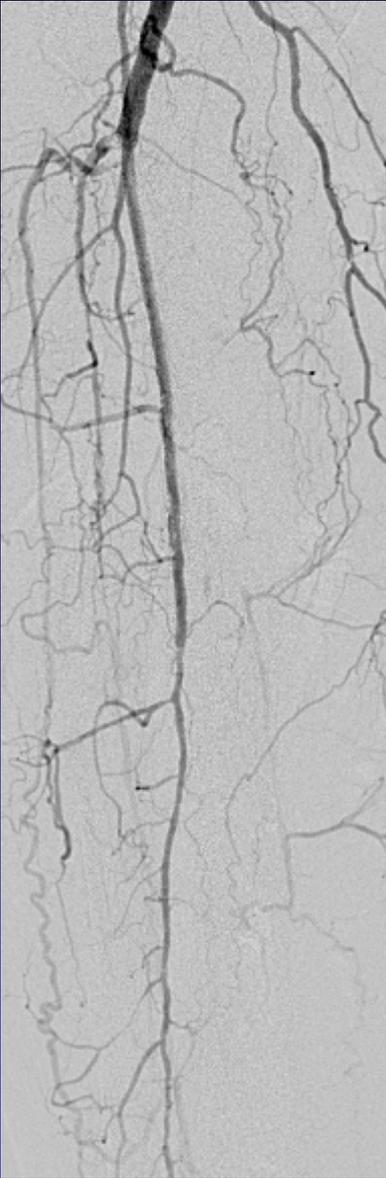
# Case 7



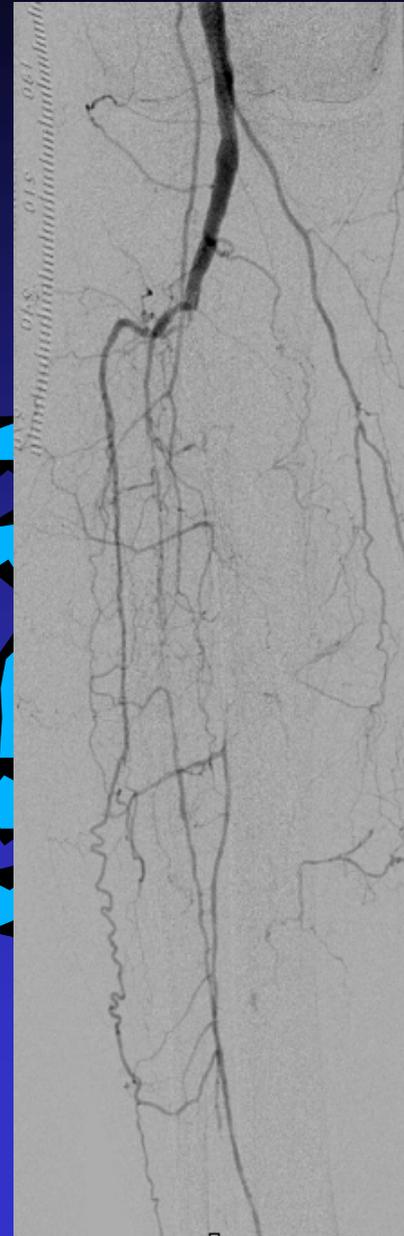
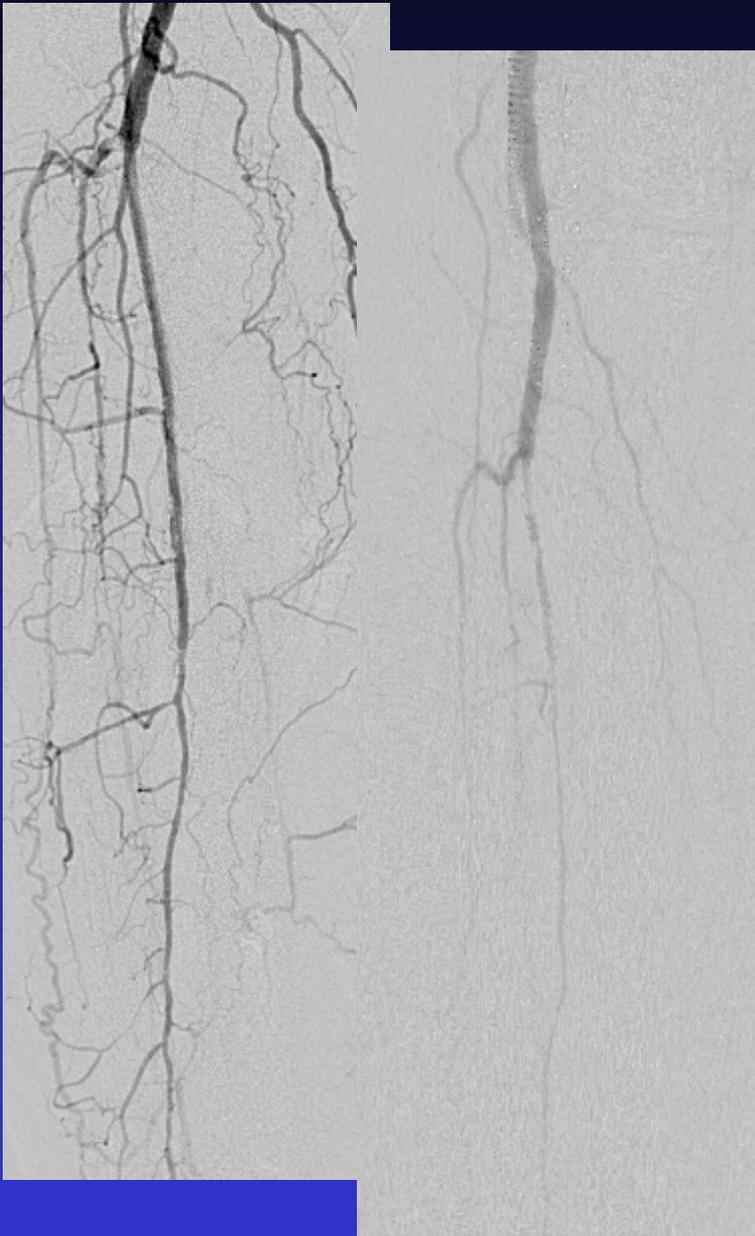




nach 3 Monaten



nach 9 Monaten



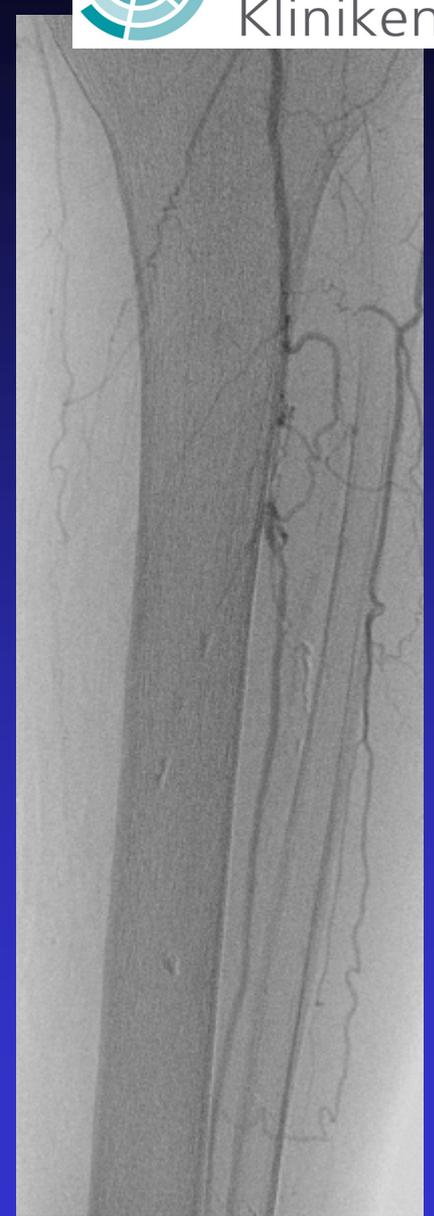
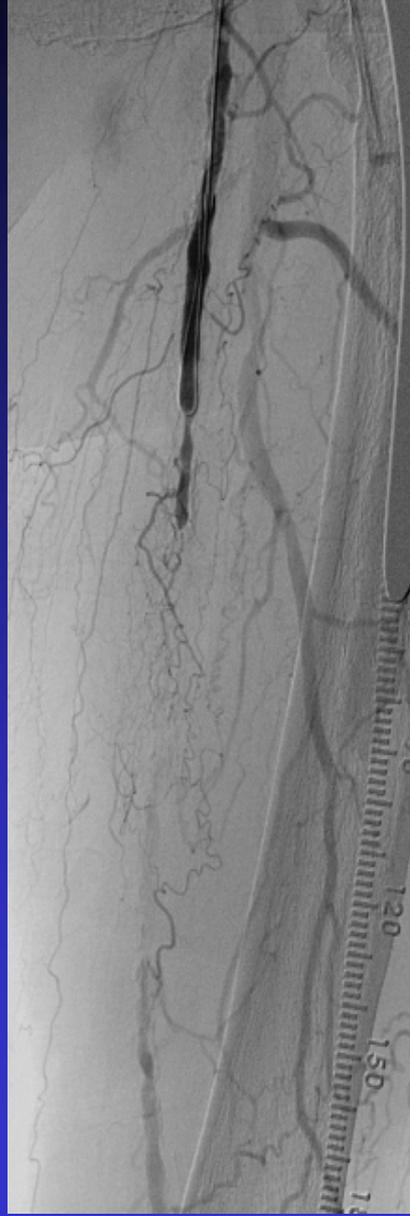
# Learning Objectives

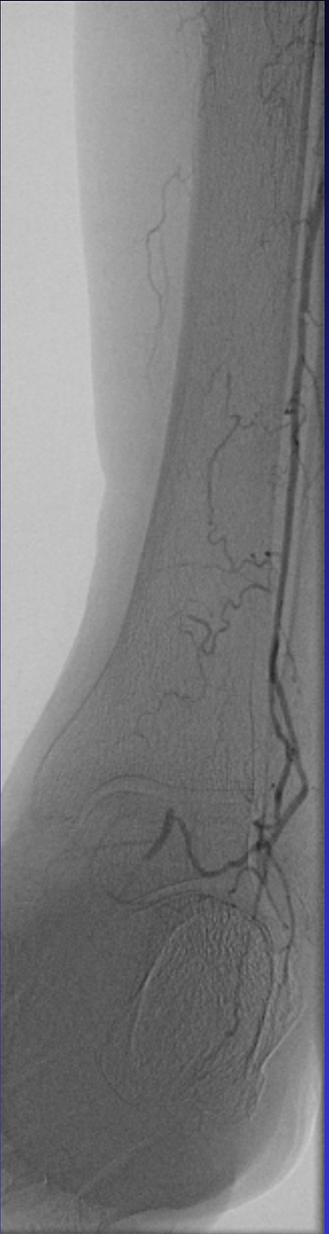
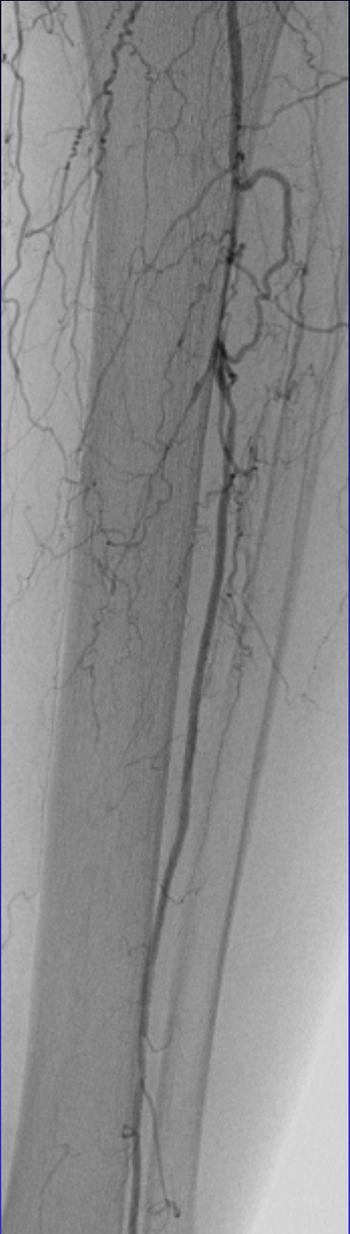
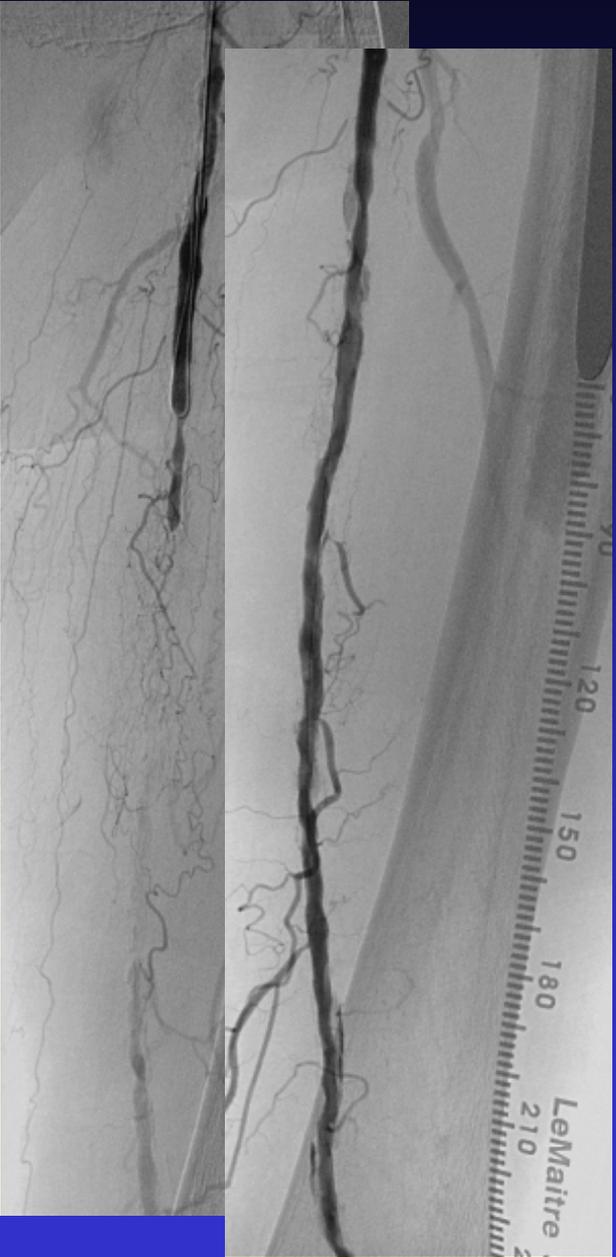
- Nach PTA verbleibt möglicher Weise eine Reststenose
- Nach bare stents: Restenose möglich
- Nach PTA im Unterschenkel: Stenting der gesamten Läsion zu erwägen

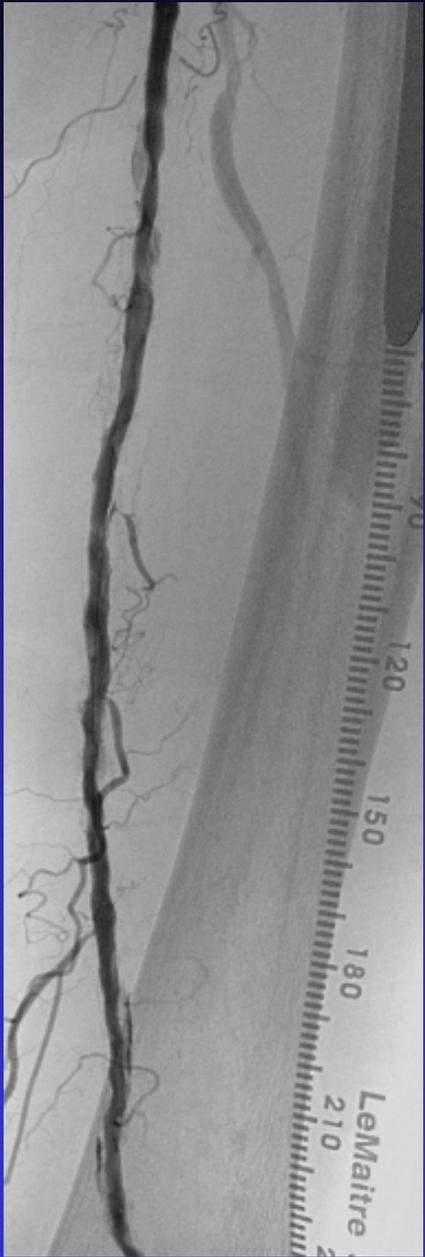
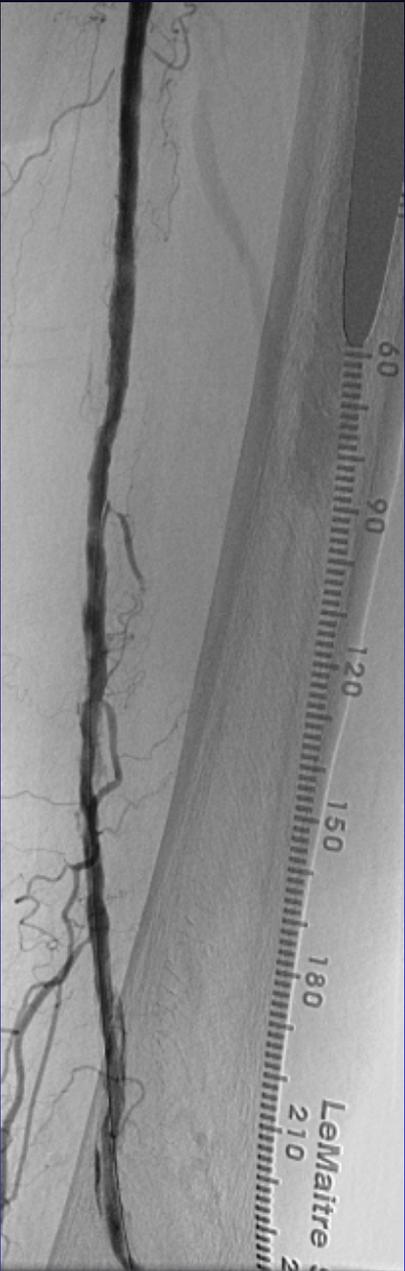
# Case 8

# Anamnese

- 91 Jahre alte Frau
- Limitierte Gestrecke: 50 m (kein Ulcus)
- Risikofaktoren
  - DM
  - Hypercholesterol.

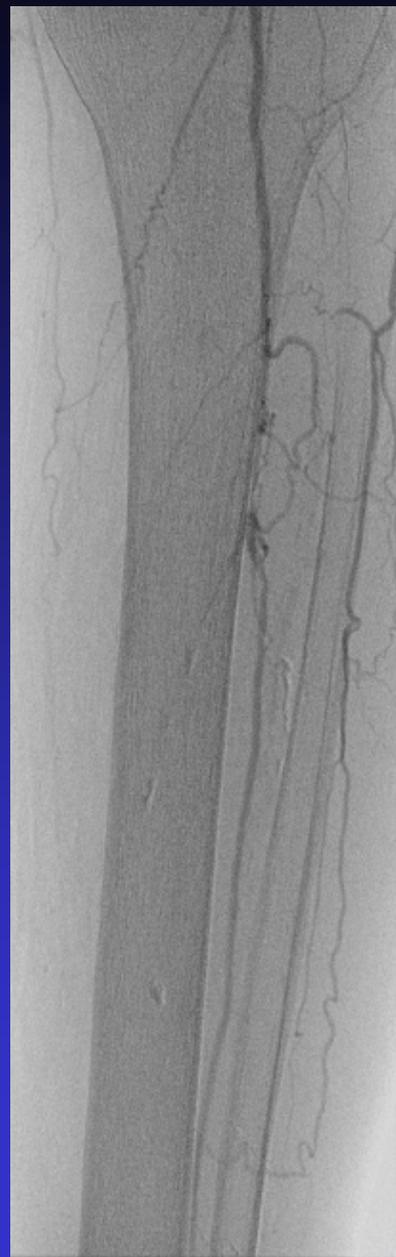
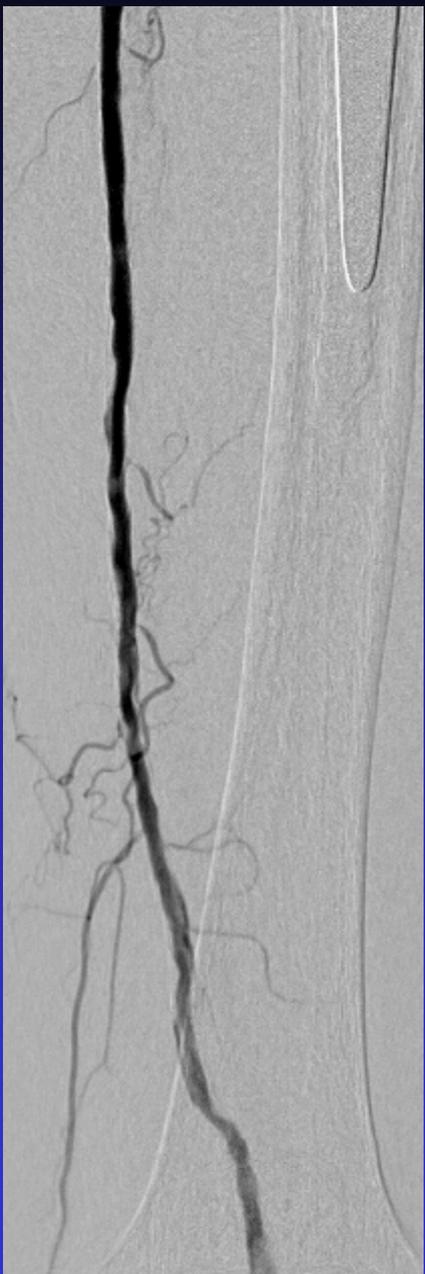


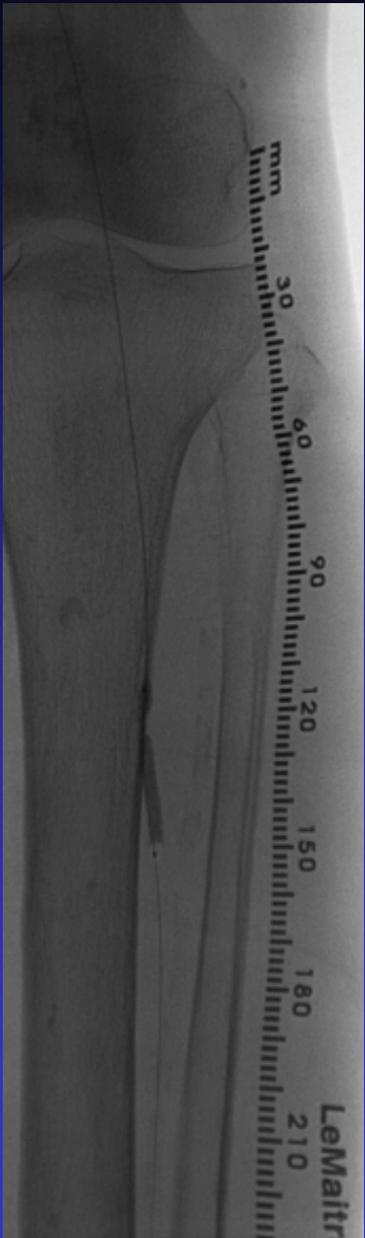
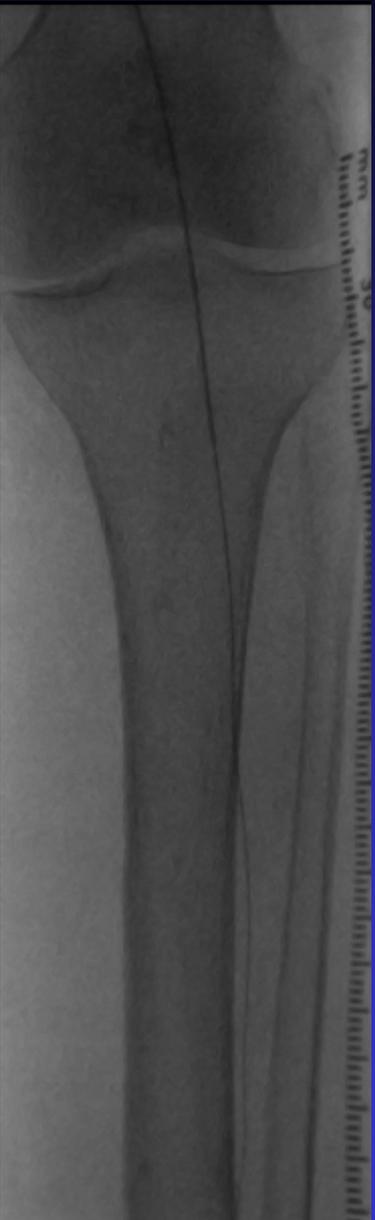


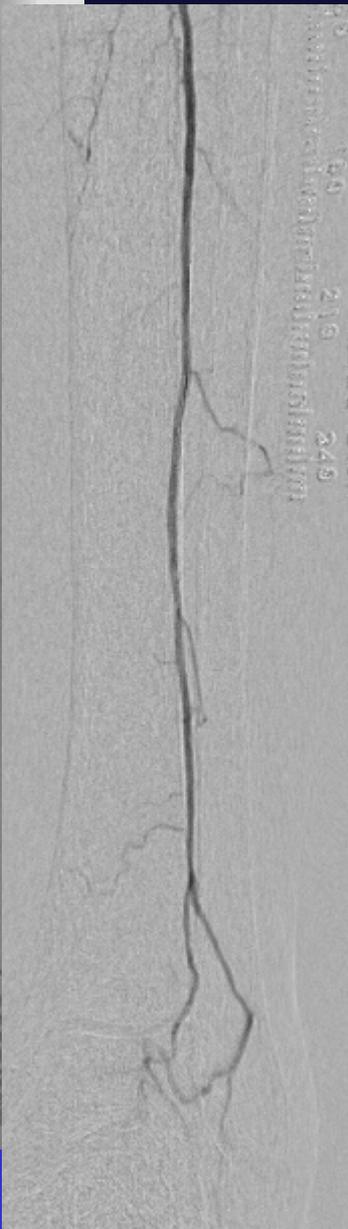
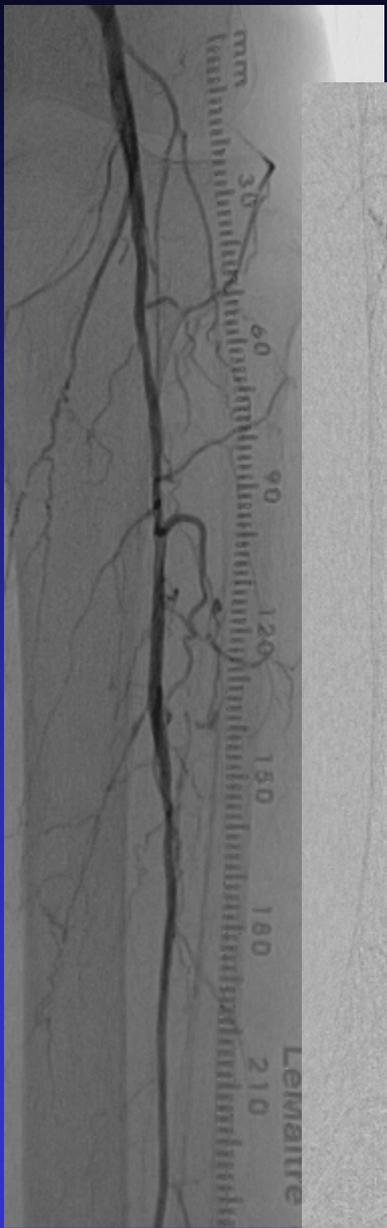
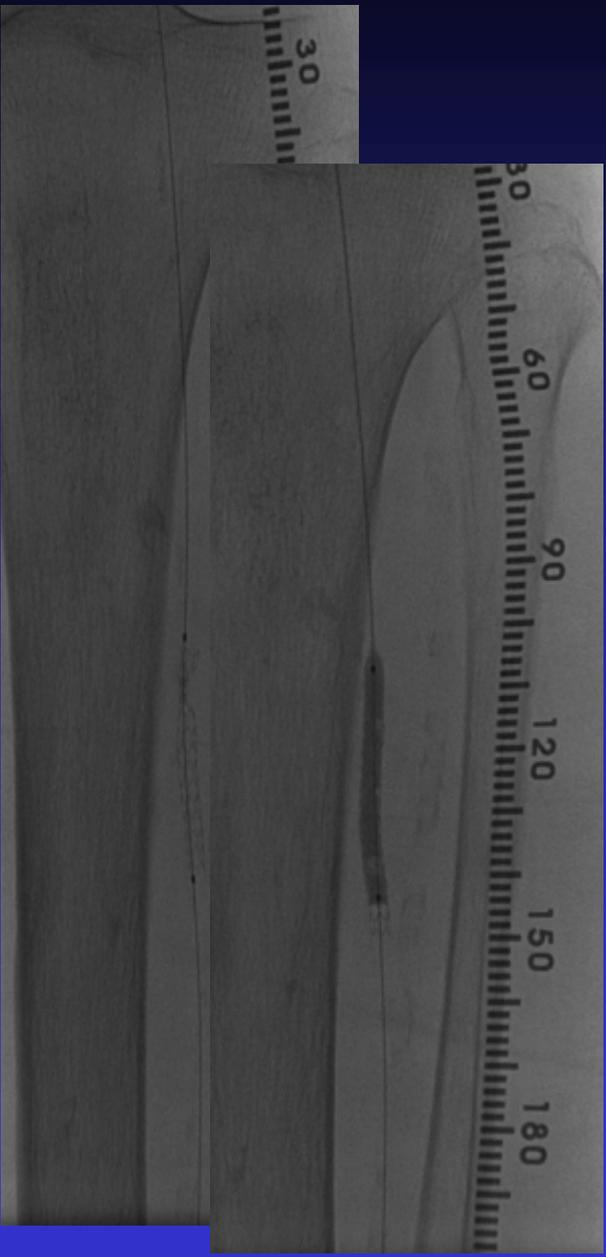


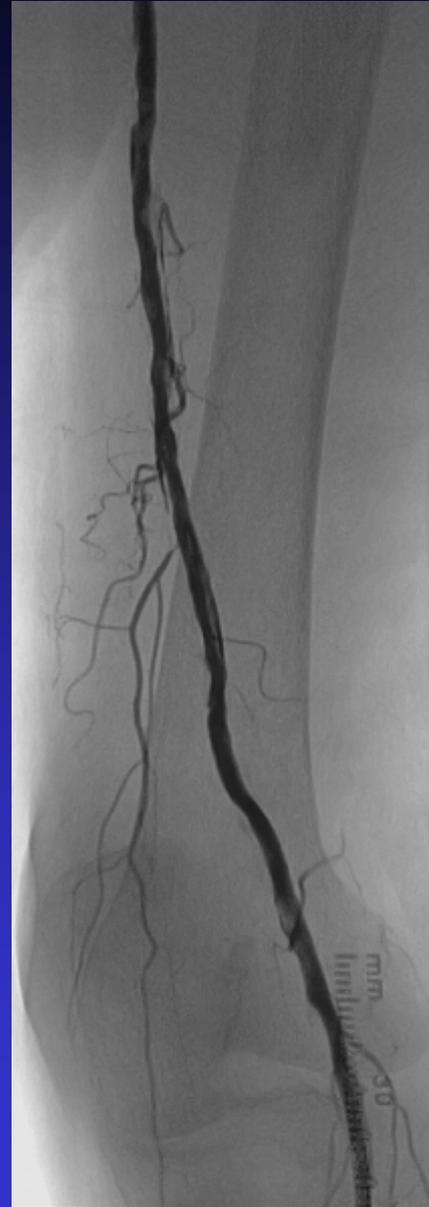
**... nach 3 Monaten**

- Entwicklung einer Ulceration am Fuß



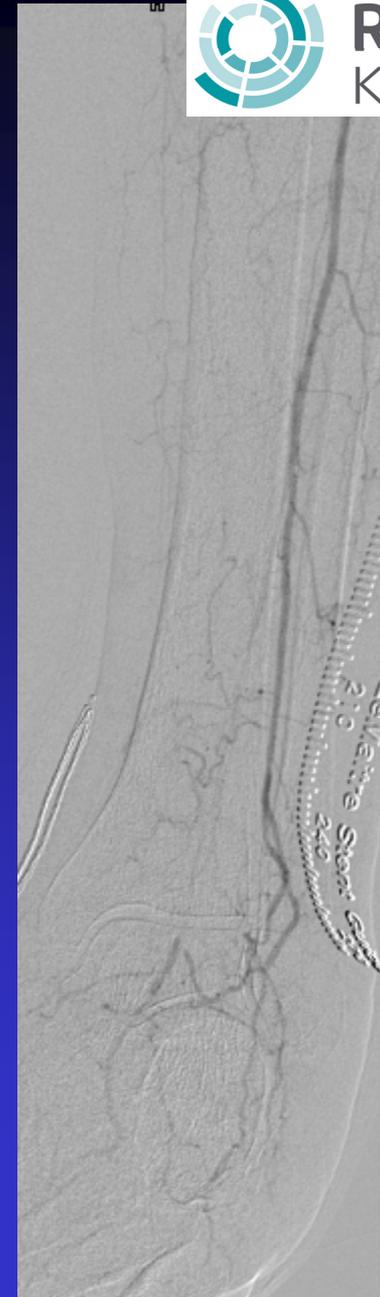
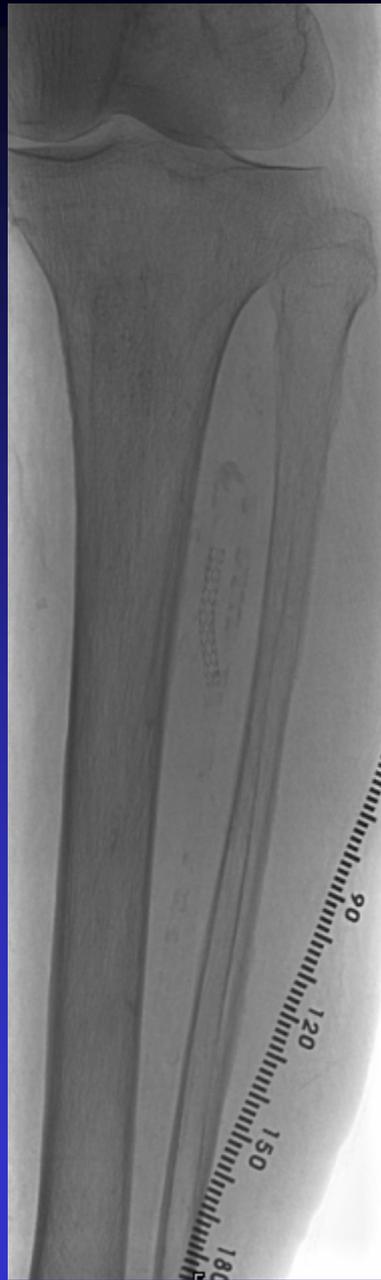
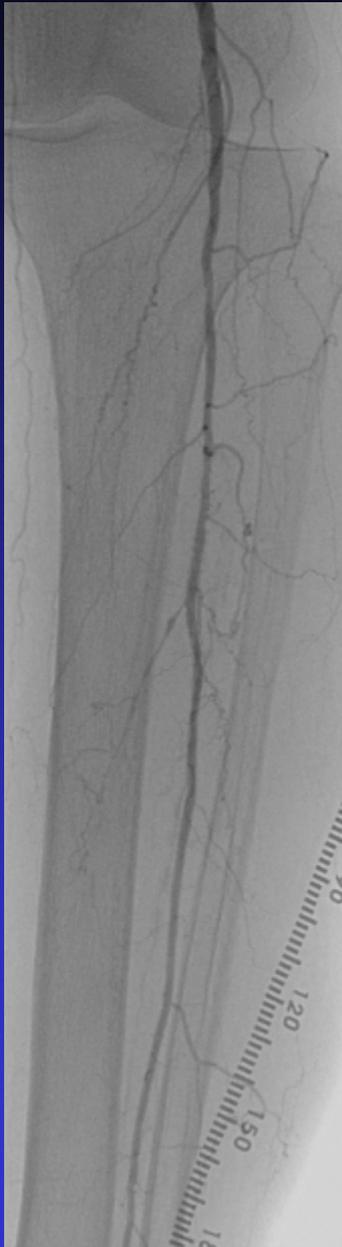






**... nach 6 Monaten**





# Follow up

- nach weiteren 3 + 6 Monaten: Ulcus geheilt
- nach 18 Monaten: weiterhin klinisch unauffällig

# Learning Objectives

- auch bei pAVK IIb: BTK Läsionen ggf. zu therapieren
- Stents bei suboptimalem PTA-Ergebnisse
- Diskussion: spot stenting? Restenose - DES?

# Fazit für die klinische Praxis

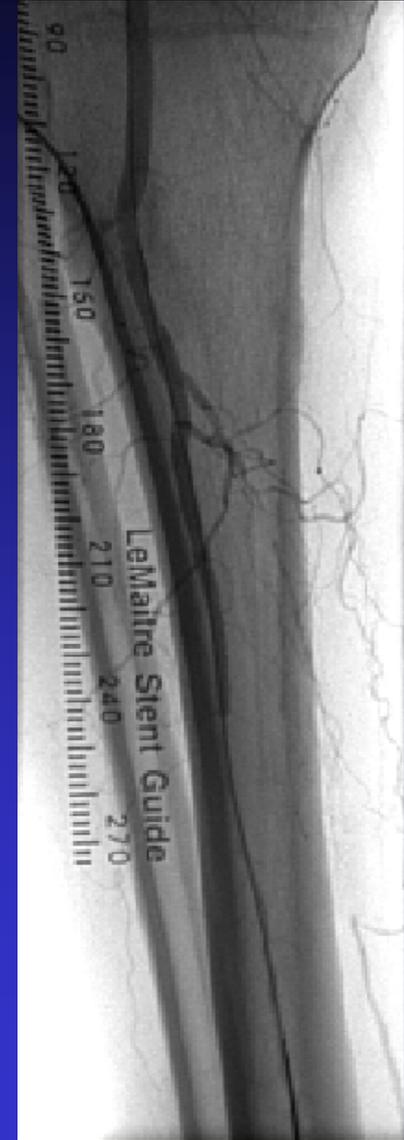
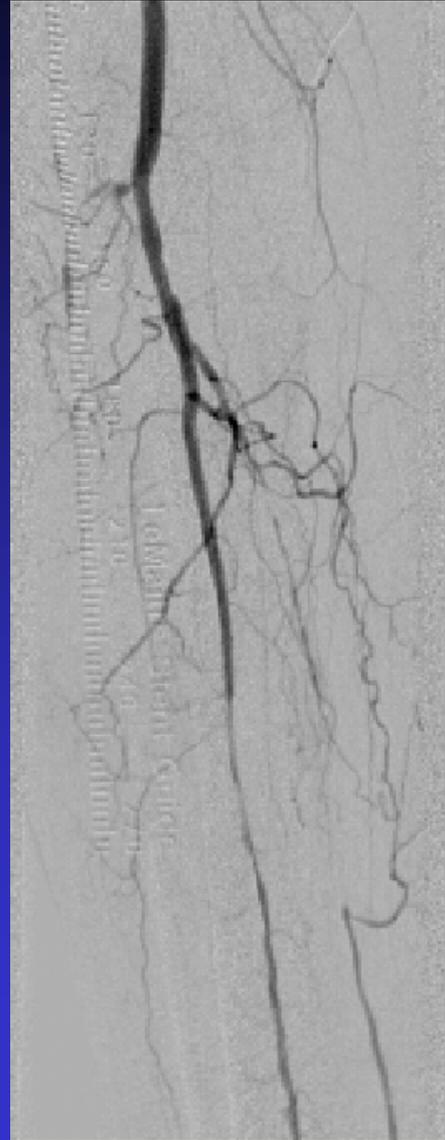
- Indikation für BTK Stent:  
technisch erfolglose PTA
- “bisher” keine Indikation für BTK Stent:  
Prävention der Restenose
- Stahlstent vs. selbstexpandierend?:  
Offenheit? Läsionstyp? Läsionsort?
- Indikation für DES:  
Prävention der Restenose – aber
  - Läsionslänge, Outflow, Thrombosegefahr

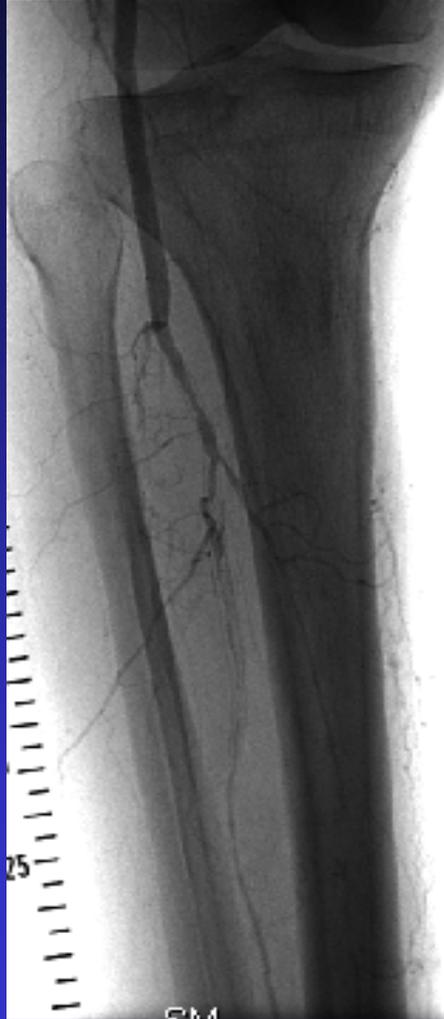
# BTK

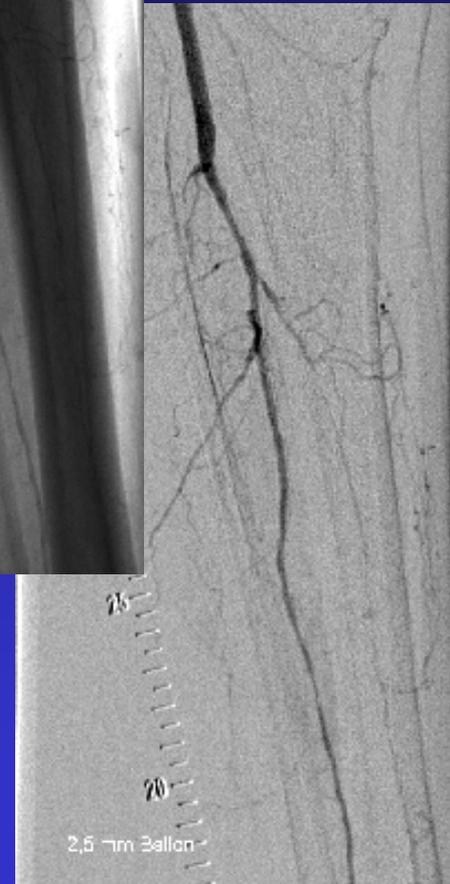
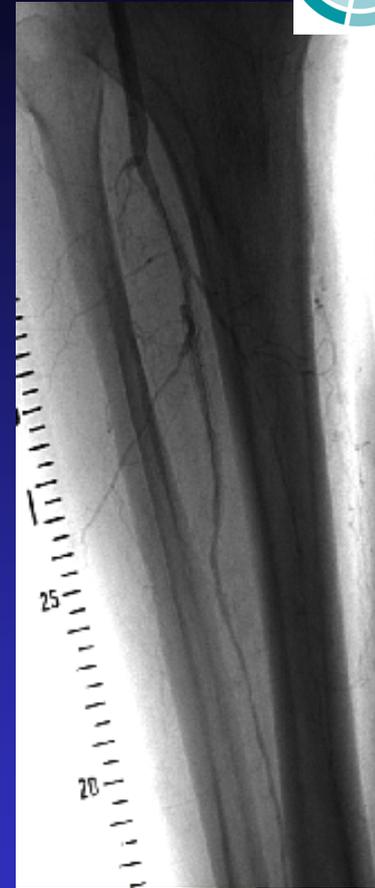
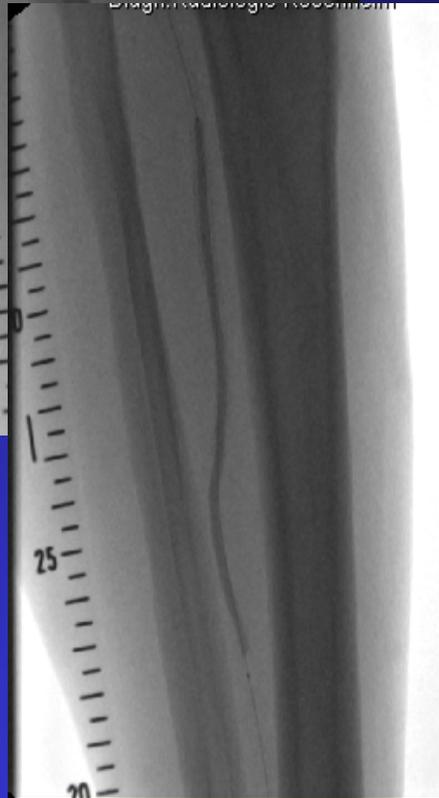
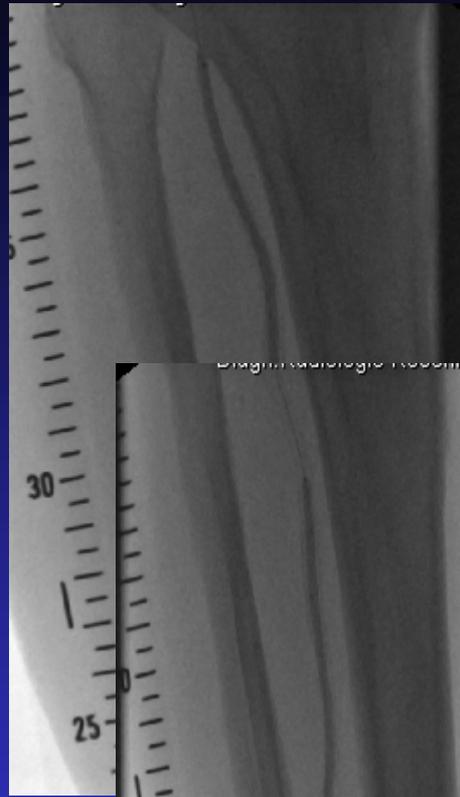
**.....tolles Interventionsareal aber viele Variablen**



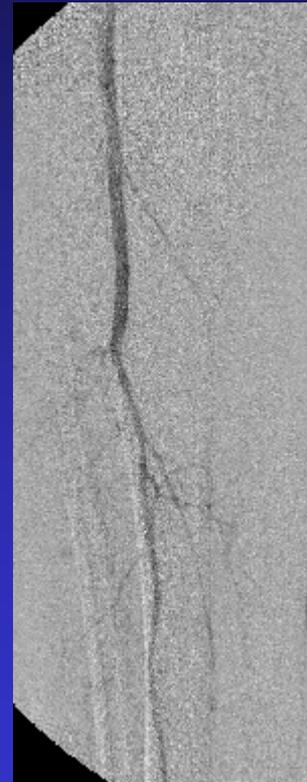
# Noch ein Case







# BTK Intervention



DCB....ein neuer tool!