

Case Reports

PTA balloons
NyloTrack +

NyloTrack +

PERFORMANCE AND VERSATILITY WITHIN REACH

FEATURES

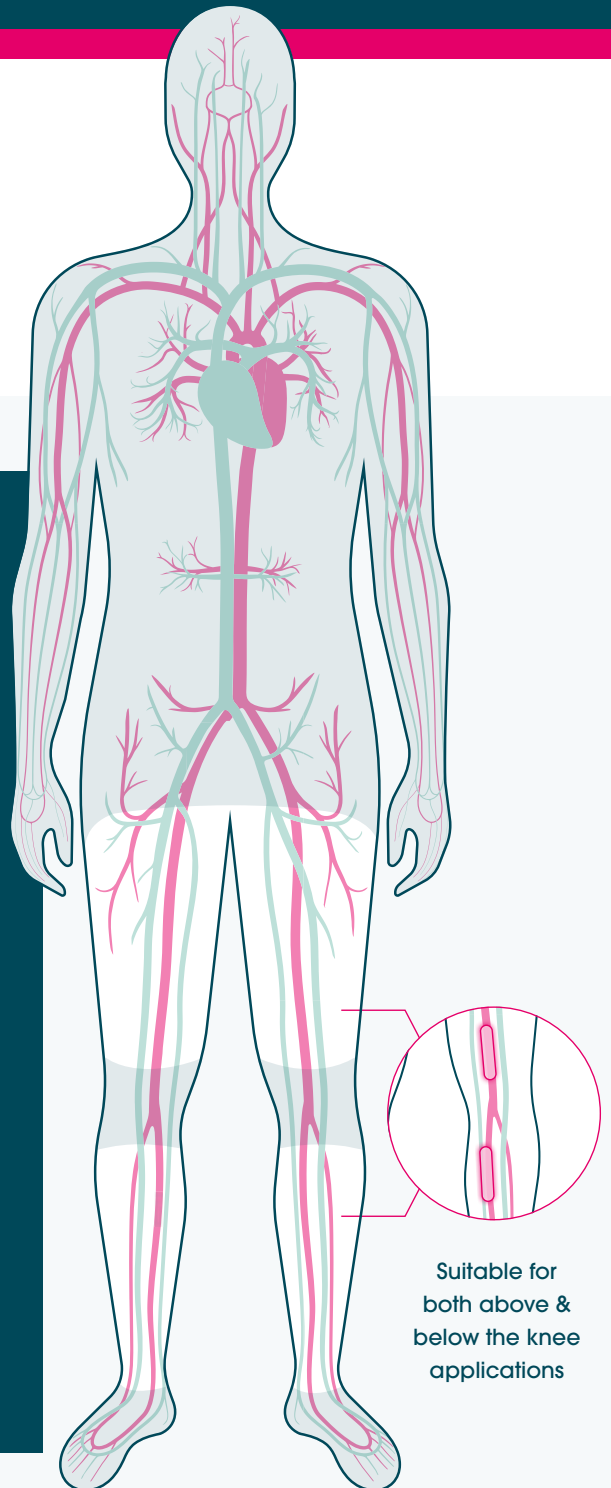
OTW, dual & Coaxial Lumen
Shaft configuration options

Optimized folding process
for low balloon profile

Hydrophilic coating for
enhanced trackability

Excellent pushability to navigate
through tortuous vasculature*

Slender tapered and atraumatic
tip design for higher flexibility



*Internal testing

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Stenosis of the common iliac artery



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CASE SUMMARY

A 75-year-old patient presented for angioplasty of the common iliac artery with PAD Rutherford stage I. A diagnostic MR examination of the pelvic vessels was available. There could be seen a severe stenosis of the common iliac artery (CIA) on the left side (Fig.1). The left CIA had previously been treated with a stent.

THERAPY

The left CFA was punctured in retrograde direction and a 6F sheath was inserted (Terumo). The proximal in-stent-stenosis was confirmed by contrast-enhanced DSA (Fig. 2). A balloon catheter (NyloTrack+ 35 PTA OTW, 8/40mm, optimed) was inserted into the stenosis using a 0.035" Glidewire (Terumo). The balloon was inflated with 12 atm for 2 minutes (Fig 3). Thereafter the balloon was moved distally. The previous dilated balloon could easily be re-inserted and re-inflated. Dilatation was performed again for 2 minutes with 12 atm (Fig. 4). To reduce the re-stenosis rate, insufflation was carried out again with a paclitaxel-coated balloon (IN.PACT Admiral, 7/60 mm, Medtronic) (Fig. 5). After all inserted material had been removed, the access was secured with a 6F closure system (AngioSeal 6F, Terumo).

CONCLUSION

The final angiography after PTA shows a significantly improved flow after good re-expansion of the CIA (Fig. 6/7). The patient received dual antiplatelet therapy for 3 months postintervention. Anticoagulation with ASS 100 mg/d should afterwards be continued permanently.



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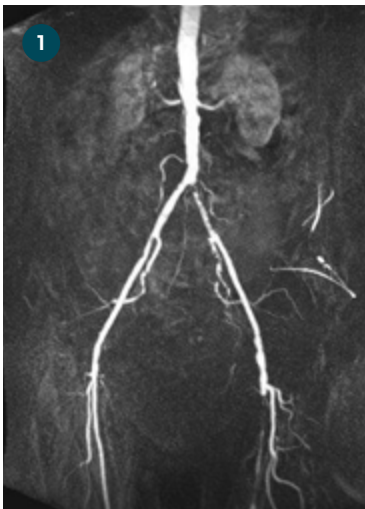


Figure 1: Stenosis of the common iliac artery

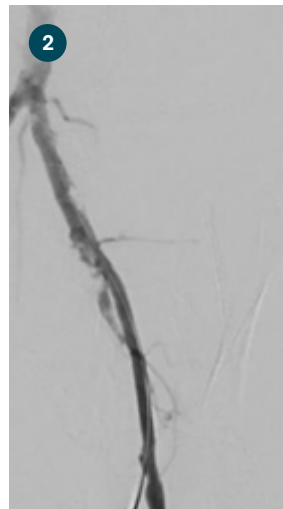


Figure 2: Proximal in-stent-stenosis



Figure 3: Inflated balloon

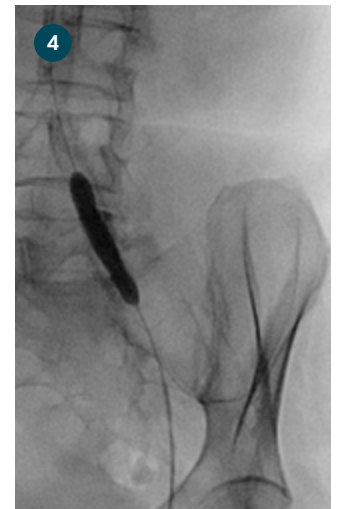


Figure 4: Dilatation in progress



Figure 5: Insufflation with paclitaxel-coated balloon

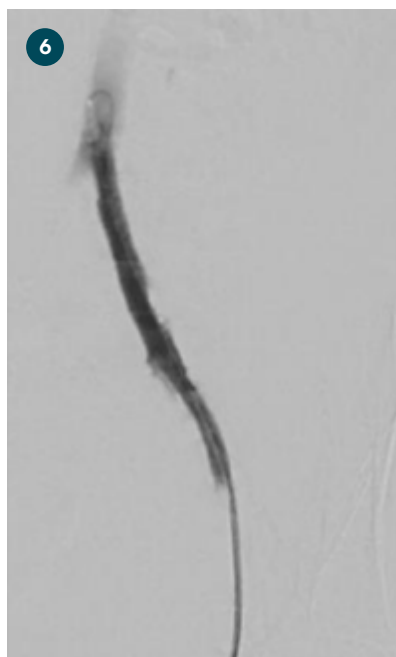
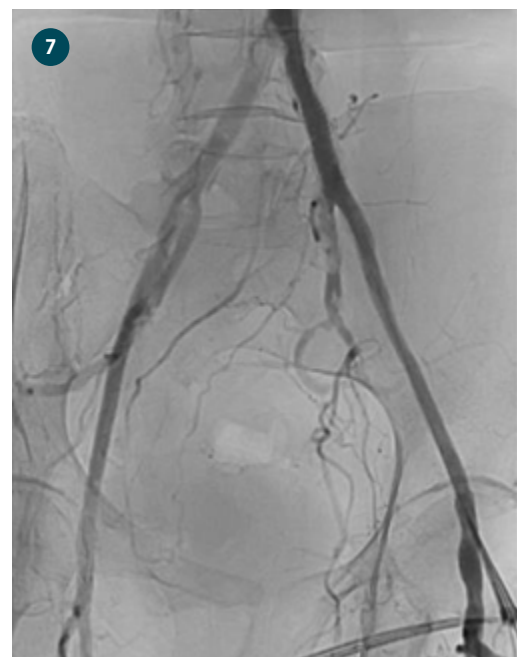


Figure 6 & 7: Improved flow after re-expansion of the CIA



Stenoses of the superficial femoral artery

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CASE SUMMARY

A 63-year-old female patient with known PAD presents with increasing limitations of walking distance. She had already undergone a PTA of the SFA on both sides in 2001. A PTA with stenting of the common and external iliac artery was performed on the left side. A current diagnostic MR angiography of the pelvic / leg arteries shows high-grade circumscribed stenoses of the SFA on the left side (Fig. 1).

THERAPY

The left CFA was punctured in antegrade direction and a 6F sheath was inserted. The contrast-enhanced DSA showed several cascading stenoses in the middle of the superficial femoral artery (Fig. 2). A balloon catheter (NyloTrack + 18 PTA OTW, 5/80 mm, optimed) was inserted into the stenoses using a 0.018" guide wire (Advantage, Terumo). The balloon was insufflated for 2 minutes with 14 atm (Fig 3). Subsequently, a dissection was found in the dilated area (Fig 4), so an additional stent was implanted here (Protege EverFlex,

6/120 mm, Medtronic). The previously used balloon could easily be reinserted to model the stent (Fig 5). Reinsertion and repeated insufflation of the already used balloon was successful without any problems. Finally the used material was removed, and vessel access was fitted with a 6F closure system (AngioSeal 6F, Terumo).

FOLLOW-UP

The final DSA showed good flow conditions with the SFA dilated again and good distal outflow (Fig 6/7). The patient received dual antiplatelet therapy for 4 weeks postintervention. Anticoagulation should then be continued permanently with ASS 100 mg.



Figure 1: Circumscribed stenoses of the SFA

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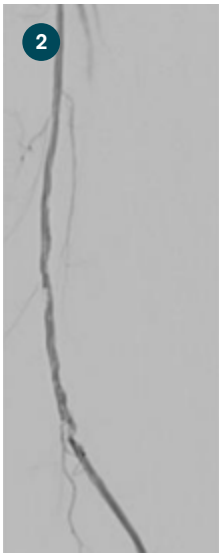


Figure 2: Cascading stenoses in the superficial femoral artery

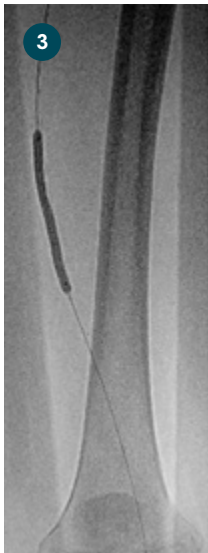


Figure 3: Insufflation in progress

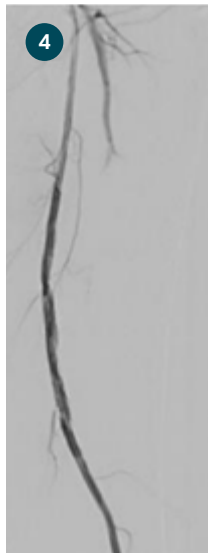


Figure 4: Dissection in dilated area

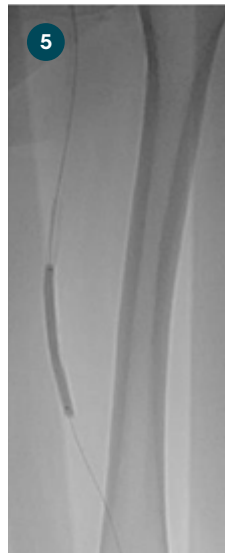


Figure 5: Reinsertion of used balloon



Figure 6: Good flow condition



Figure 7: Good distal outflow



Occlusion of the superficial femoral artery

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CASE SUMMARY

A 71-year-old patient presented with known PAD, dominating on the left side. The DSA brought from abroad showed an occlusion of the left SFA.

THERAPY

A puncture of the left CFA was performed in an antegrade manner and a 6F sheath was inserted. The contrast-enhanced DSA revealed a proximal occlusion of the SFA with distal reperfusion via collaterals off the PFA (Fig. 1 & 2). After successful passage of a 0.018" guidewire (Terumo) with the help of a suitable support catheter (Navicross 18, Terumo), change to a catheter +35 and a guidewire +35. After that, insertion of a balloon (NyloTrack + 35 PTA OTW 6/100mm, optimed).

The balloon was insufflated step-by-step from distal to proximal several times for 2 minutes with 14 atm to recanalize the occlusion (Fig. 3, 4 & 5). This succeeded without any problems even though the balloon had to be moved several times.

After the dilatation, the SFA showed a dissection (Fig. 6 & 7), so that several self-expandable stents had to be implanted (RENZAN peripher rapid exchange 6mm, Terumo) (Fig. 8 & 9). Those were modeled by the balloon that had already been inserted before (NyloTrack + 35 PTA OTW 6/100 mm, optimed) (Fig.10). Although the balloon had already been insufflated several times, it could easily be reinserted through the sheath and also could be

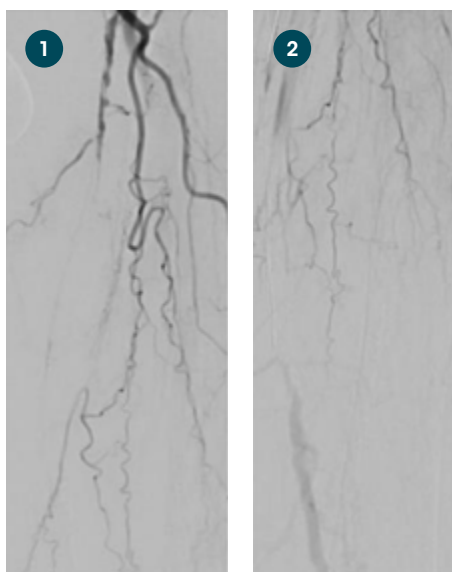


Figure 1 & 2: Proximal occlusion of the SFA with distal reperfusion

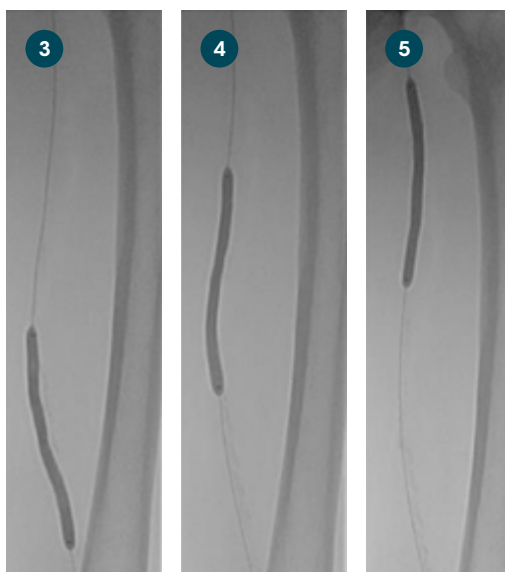


Figure 3,4 & 5: Step-by-step insufflation from distal to proximal

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used to modulate the stents. After the used material had been removed, the access was secured by a 6F closure system (ExoSeal 6F, Cordis).

CONCLUSION

The final DSA shows a completely recanalized SFA with good peripheral outflow (Fig. 11 & 12). The patient received dual antiplatelet therapy for 3 months post-intervention. Afterwards anticoagulation with ASS 100 mg should be continued permanently.

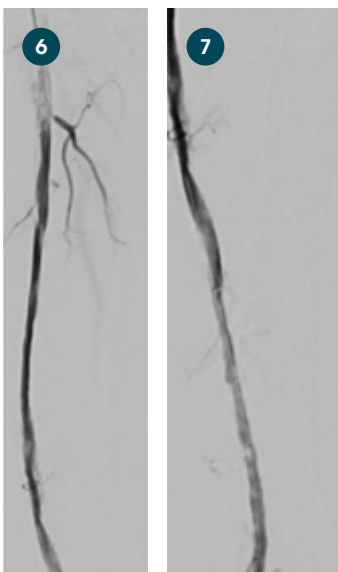


Figure 6 & 7: Visible dissection

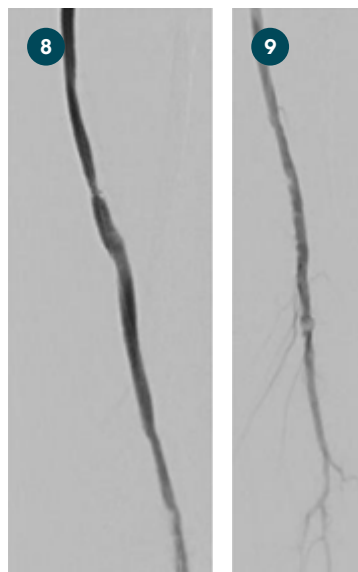


Figure 8 & 9: Implantation of self-expandable stents

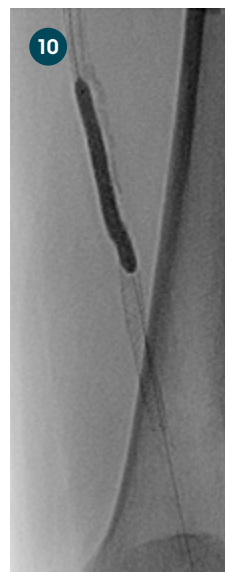


Figure 10: Previously inserted balloon

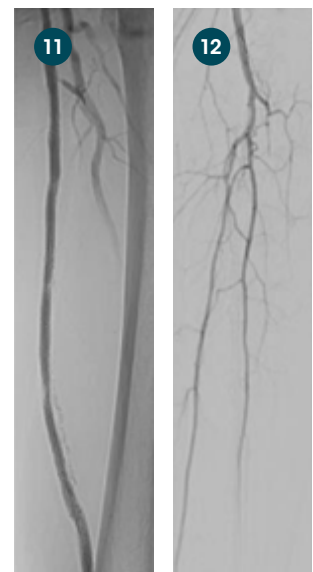


Figure 11 & 12: Completely recanalized SFA with good peripheral outflow

Stenosis of the distal popliteal and fibular artery

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CASE SUMMARY

An 86-year-old patient was referred to us for PTA at PAD Rutherford Stage III. The patient complained about increasing pain at rest. A monophasic signal was derived sonographically on the left lower leg, but the vascular course could not be assessed due to the pronounced leg edema.

THERAPY

The left CFA was punctured in antegrade direction and a 5F sheath (Terumo) was inserted. The angiography showed a circumscribed stenosis of the tibiofibular trunk and a short distal occlusion of the fibular artery. After inserting a 0.014" wire (Advantage, Terumo), the balloon (NyloTrack+ 14 PTA OTW 2/60 mm, optimed) was first dilated in the proximal stenosis. Afterwards further advancement of the balloon distally into the occlusion of the fibular artery was easily achieved. Dilatation in both locations was carried out for 2 minutes by 14 atm.

FOLLOW-UP

The final angiography after PTA shows a successful dilatation of the trunk and a completely recanalized distal fibular artery with good outflow to the vessels of the foot (Fig. 6). Permanent anticoagulation with ASS 100 mg was recommended.

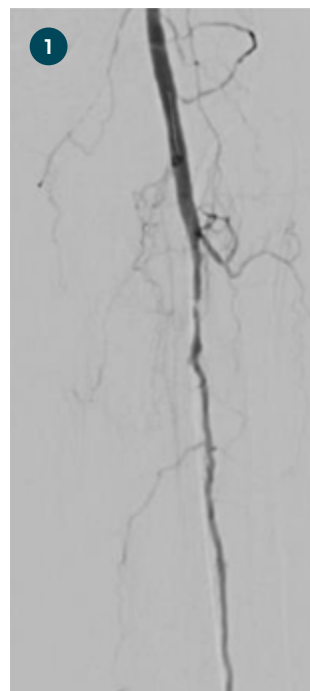


Figure 1: Proximal occlusion of the SFA with distal reperfusion

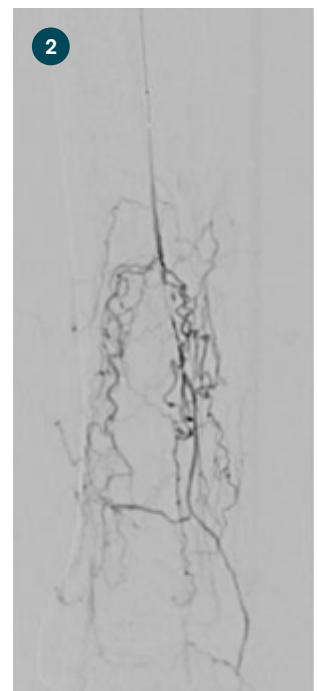


Figure 2: Short distal occlusion of the fibular artery



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Figure 3: Dilatation in the proximal stenosis



Figure 4: Dilatation of the fibular artery

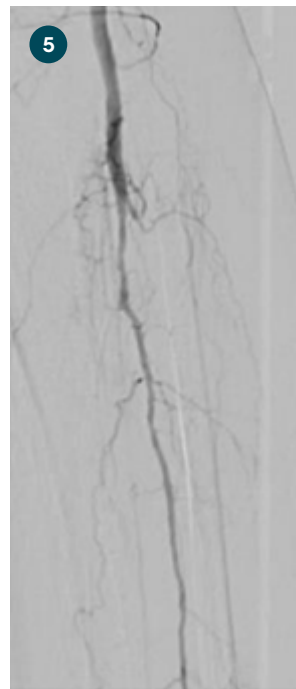


Figure 5: Successful dilatation of the trunk

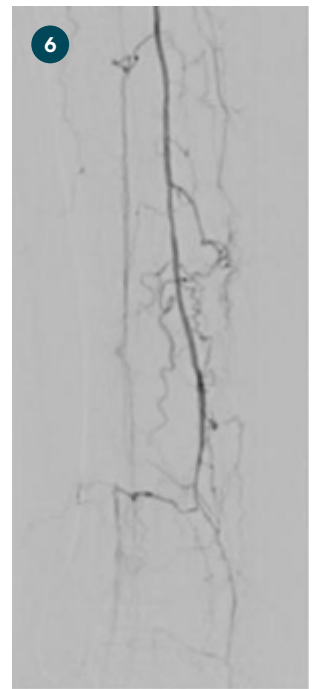


Figure 6: Completely recanalization of the distal fibular artery

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