Slender TRA-PCI are backup-Improving Techniques Dependent

Opinion


In 2015, the trans-radial access (TRA) has been the default route in many countries for percutaneous coronary interventions (PCI) thanks to its well-established reputation as a safe procedure [2,3], the patient’s enhanced comfort and the reduced cost mainly due to shorter hospital stays. Credits are to be granted for this major move away from the trans-femoral approach to the anatomical properties of the radial artery itself [4] and to a group of “rebels and believers” who spread the “good news” since the mid-nineties.

But the victory of the TRA over the trans-femoral approach has had a cost for this splendid vessel: radial artery occlusion (RAO). RAO stays clinically silent in the vast majority of cases, due to the rich and complex hand vascularisation but its occurrence limits further use of this route for the patient. RAO is the direct consequence of a vascular injury: injury at the puncture step, at the time of insertion of a catheter (sheath or sheathless catheter) and finally at the hemostasis-compression step, after the intervention. Minimizing the degree of injury at each step will result in a lower RAO rate. There is no longer a need to make a case for the use of the TRA but TRA-PCI believers must now spread the word of acting gently.

Slender techniques [5] are comprised of any technique that reduces trauma to the radial artery. One Slender approach is the miniaturization of trans-radial coronary access devices, an obvious but not unique way to minimize vascular damage. For most PCI operators, 6F are the default size for guiding catheters (GC); this size provides adequate backup support for routine PCIs and the lumen allows passage of current stents/intra coronary interventional devices. “6F sheath” designs products that accepts 6F catheters but they are in fact larger than 6Fs: their outer diameter (o.d.) is actually around 2.62 mm (for the market’s leader) or more.

The Slender technique proponents saw a welcome move(6) in 2014 when the first 6F Glidesheath Slender (GSS) hit the market: thanks to its thinner wall construction, this introducer allows passage of a working 6F GC but only a “virtual 5F” sheath enters the radial artery. In fact, the 6F GSS is a little bit larger than a normal 5F sheath (o.d. is actually 2.46 mm and the normal o.d. of the 5F is 2.29 mm). A few months ago, the same company released a 5F sheath (o.d. 2.13 mm), equivalent to a virtual 4F sheath but allowing the use of 5F Guiding catheters, bringing us even closer to a true minimally invasive cardiology practice. The next step to further extend the slender attitude for TRA-PCI should be to convince our colleagues to move away from their 6F routine use for PCIs to a 5F by default technique (with 5F GSS). The only obstacle preventing most PCI-operators to switch from 6 to 5F-guided PCI when 5F sheaths have already existed for more than a decade is fear: fear to fail the PCI attempt. Operators are afraid of backup support failure and of adequate materials availability.

But devices indeed already exists: actual wires, stents and balloon catheters are perfectly suited for work into the inner diameter of current 5F GC. More than 85% of TRA-PCI I perform are through 5F sized catheters, leaving 6 or 7F (sheathless) catheters for true bifurcation lesions (large branches), thrombi aspiration (this indication will vanish) and TRA-CTO-PCI. With a second “true” 0.014 (0.36mm) coronary wire along the stent-delivery catheter, the 5F GC (inner diameter (i.d.) 1.47 mm) allows the positioning of a 4.0 mm BMS (Pro-Kinetic Energy, biotronik AG, diameter of 1.10 mm at the stent level) or of a 4.0 mm DES (minimum GC i.d. required: 1.42 mm for both Ultimaster™, Terumo® and Orsiro, Biotronik AG). A 4.5 mm BMS (Pro-Kinetic Energy, Biotronik AG, diameter of 1.21 mm at the level of the stent) can be placed through the same 5F GC (use of a second wire is not possible). I have easily delivered BVS stents less or equal to 3.0 mm through a 5F GC. And fortunately, miniaturization will continue to grow [5] and bring increasingly efficient tools/devices to the practice, thus reducing the need for large lumen catheter/sheath.

Adequate GC support is achievable using two different but not exclusive ways: I practice both. The first one is through work on the GC’s shape: most of the current GC shapes were designed when the femoral route was the rule. Some believers (Kiemeneij, Barbeau, Ikari and others) introduced a few dedicated and better suited shapes for the radial route. I personally drew new shapes especially at the level of the subclavian - innominate artery. The Slender technique proponents saw a welcome move(6) in 2014 when the first 6F Glidesheath Slender (GSS) hit the market: thanks to its thinner wall construction, this introducer allows passage of a working 6F GC but only a “virtual 5F” sheath enters the radial artery. In fact, the 6F GSS is a little bit larger than a normal 5F sheath (o.d. is actually 2.46 mm and the normal o.d. of the 5F is 2.29 mm). A few months ago, the same company released a 5F sheath (o.d. 2.13 mm), equivalent to a virtual 4F sheath but allowing the use of 5F Guiding catheters, bringing us even closer to a true minimally invasive cardiology practice. The next step to further extend the slender attitude for TRA-PCI should be to convince our colleagues to move away from their 6F routine use for PCIs to a 5F by default technique (with 5F GSS). The only obstacle preventing most PCI-operators to switch from 6 to 5F-guided PCI when 5F sheaths have already existed for more than a decade is fear: fear to fail the PCI attempt. Operators are afraid of backup support failure and of adequate materials availability.

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For many of our colleagues however, there is no other choice than to use currently available GCs. If they want to succeed equally
well using 5F GC, they have to adopt a secondary way to obtain support by using backup improving techniques. These techniques are numerous and I will only present my most practical techniques here.

A. Never hesitate to ask for a second wire, as I do on a daily basis: this is the first, fastest and most cost effective way to improve the ease of intervention through a 5F GC. Double wiring may help to

a. Stabilize the guiding catheter: the first wire anchors the GC to the coronary (or graft) ostium and eases the manipulation of the guiding and/or of the second wire to cross the target lesion (Figure 1);

b. Secure the way to a complex lesion, particularly when branch(es) is/are involved in the lesion;

c. Smooth the way to a distal lesion when the anatomy is tortuous; bends can be somewhat straightened, depending on the residual vessel compliance (Figure 2);

d. Track a balloon-catheter or a stent platform toward the target lesion;

e. Deliver multiple stents within the same coronary artery (see below).

B. Use of 5F GC allows you to apply what I call “the mother-and-child-technique-without-the-mother”. There is no extra cost for pushing forward the CG within the first few cm of the coronary artery (or graft) WHILE the balloon is inflated AT THE SITE of the target lesion: the tip of the 5F GC will end up in the same position as the tip of a Guideliner®-or any other guiding extension (Figure 3). Inflating the balloon at the target site is obviously necessary at some point in the intervention and if the coronary anatomy is suitable for a Guideliner® system (5F tube working in a 6F guiding), it will also accept the 5F GC tip. Sharp GC curves should be avoided for this maneuver, namely Amplatz curves.

C. Since the March 2014 report of a series of 10 consecutive cases with the technique of “distal buddy-in-jail technique” [10], it has been applied successfully to another 30 difficult cases. In summary, when dealing with a diffusely multi-stenotic, calcified disease of one coronary artery (or a graft), begin with double wiring and balloon debulking of the most severely stenotic sites and try to deliver a first stent at the most distal lesion, leaving the buddy wire in place. The stent deployment will trap and “jail” the buddy wire (Figure 4). This technique provides a superb backup when using either of the wires (the free or the trapped one) to forward eventually longer and/or larger stent(s) for proximal stenting. For this technique, the danger resides in trapping a wire twice (or to trap both wires...). This technique costs one additional coronary wire but is time, radiation and contrast media saving.
gentle today is achievable, inexpensive and as usual, always rewarding, particularly for the radial artery.

Figure 4: "Distal buddy-in-jail" technique: after double wiring and RCA debulking, a first stent is delivered at the most distal stenotic site and trap the buddy wire.

Acknowledgement

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References