Successful treatment of total occluded innominate artery in a patient with subclavian steal syndrome

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Introduction

The innominate and subclavian arteries are the most common locations for stenotic lesions in the upper extremities (1). Innominate artery occlusive disease is often associated with cerebrovascular symptoms such as subclavian steal syndrome, arm claudication, distal embolization, and stroke. In some patients, subclavian steal syndrome can present with symptoms of arterial insufficiency afflicting the brain, typically manifesting as transient brain ischemia (2). Percutaneous interventions have evolved as an effective and safe treatment modality for occlusive lesions of the subclavian and innominate arteries (3). Current guidelines recommend the endovascular-first strategy in patients with atherosclerotic lesions of the upper extremities (1). Herein we report a case of successful percutaneous stent implantation to innominate artery in a symptomatic patient.

Case Report

A 50-year-old man was admitted with complaints of repeated syncope episodes, dizziness when tilting his head back, and numbness in the right upper arm while working. His blood pressure in the left arm was 130/70 mm Hg and in the right arm was 85/50 mm Hg. Physical examination, laboratory tests, and electrocardiography showed that the patient had an innominate artery occlusion. The diagnosis was confirmed by imaging studies, which demonstrated total occlusion of the innominate artery. The patient was treated with a percutaneous stent implantation, and the procedure was successful. The patient’s symptoms resolved after the procedure, and he was discharged with a follow-up plan.

Figure 1. (a) Aortography showing total occlusion of the innominate artery. (b) Dual injection showed total occlusion of the innominate artery. (c) Placement of cerebral embolism protective filter and passing through the lesion using Conquest Pro 9.0. (d) Dilatation using a bigger balloons after the wire was trapped in the catheter that was placed via the right radial artery access. (e) Excellent final result. (f) A 7.0x30 mm balloon expandable stent implantation.
Primary stenting of the subclavian and innominate arteries occlusive lesions with percutaneous techniques should be considered as the first choice of treatment by experienced surgeons and centers because of the high clinical success and low complication rates.

**References**


**Video 1.** Aortography show total occlusion of the innominate artery.

**Video 2.** Dual injection showed total occlusion of the innominate artery.

**Video 3.** Placement of cerebral embolism protective filter and passing through the lesion using Conquest Pro 9.0 and balloon with the trapped wire in the distal catheter.

**Video 4.** Excellent final result.

**Conclusion**

Primary stenting of the subclavian and innominate arteries occlusive lesions with percutaneous techniques should be considered as the first choice of treatment by experienced surgeons and centers because of the high clinical success and low complication rates.

**Discussion**

Percutaneous intervention with or without the placement of a stent and surgical approaches are treatment modalities for subclavian steal syndrome (3). The results of the largest series suggested stenting as the treatment of choice in selected patients (4). In addition, Chatterjee et al. (5) showed that stenting is significantly superior to angioplasty alone. We chose endovascular stenting approach for this patient. Although endovascular stenting of innominate artery stenosis is a well-established mode of treatment, total occlusion of the subclavian or innominate artery poses a special challenge and is technically demanding (6). Vascular access, inability to visualize the distal vessel, and achieving cerebral protection are the main obstacles for endovascular stenting of an occluded innominate artery. Dual injection technique is routinely performed to evaluate the length of the lesion and decide whether an antegrade or a retrograde approach is required (7). In this case, we initially choose antegrade approach because there was a significant narrowing in the proximal part. Although endovascular stenting is first-line treatment for subclavian stenosis, it can cause intraluminal hyperplasia, and the restenosis rates are higher than for extra-thoracic surgical revascularization (8). Surgical revascularization can be chosen when endovascular techniques fail.

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