24. **Endovascular Recanalization of Total Occlusions of the Mesenteric Arteries**
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**OBJECTIVE:** Evaluate our experience with the endovascular treatment of total occlusions (TO) of the mesenteric and celiac arteries.

**PATIENTS & METHODS:** We treated 13 lesions in 12 patients with symptomatic TO of the mesenteric arteries (6 males, age 71±10 yrs). The presentation was acute in two patients, acute on chronic in 5 and chronic in 4. The initial approach was transfemoral in 9 patients, and transbrachial in 4. The approach was converted to brachial after failure of the tranfemoral approach in 4 patients. Treated vessel was SMA in 11 and Celiac artery in 2. Mean occlusion length was 3.2±.8 cm. Heavy calcification of the main artery trunk were present in 10 lesions. Associated calcified aortic plaque was present in 8 occlusions. A stump (1 mm projection beyond the aortic lumen at the expected level of the occlusion was identified in 10 occlusions on CT and/or angiography.

**RESULTS:** Technical success was achieved in 12 procedures (92%). The majority of occlusions could be crossed intraluminally. The single-most important prerequisite for recanalization of ostial TO was proper localization of the true stump, stable catheter tip position for subsequent negotiation of the stenosis which is function of access approach and catheter curve, and lastly the traversal route (intraluminal vs subintimal). Subintimal recanalization is less advised in severely diseased vessels. Complications included brachial artery thrombosis/hematoma necessitating exploration and repair (3). Clinical improvement was noted in all patients. Delayed instant restenosis developed in three patients, including one who had subintimal recanalization of a long-occlusion who developed restenosis of the lumen distal to the stent due to a chronic dissection. Recurrences were treated with cutting balloon angioplasty or restenting.

**CONCLUSION:** Endovascular recanalization of mesenteric arterial occlusion is feasible and highly successful provided careful planing is used. CT and good quality fixed lateral fluoroscopy were crucial for the localization of the stump and to plan the level of probing on angiography during the recanalization procedure.
stumpless (flush) occlusion of SMA and Celiac

LONG SEGMENT OCCLUSION PROXIMAL

POST STENTING