



# INVOLVEMENT OF SUBCLAVIAN ARTERY INTO A SEVERE COARCTATION, IS IT A CONTRAINDICATION FOR STENTING?

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We describe a case of severe coarctation with subclavian artery involvement of a 22 years old symptomatic female referred to our center for endovascular resolution. She was under losartan, amlodipine, diuretics and beta blockers with mild response to medical treatment.

For admittance her BP was 180/100 mmHg and a soft pan systolic murmur was heard on left sternal border and between the spine and left scapula. Absence of pulses on inferior limbs was markedly noted.

Prior to angiography a CT contrast scan with 3d reconstruction was performed and details of anatomy and collaterals were discussed with the cath lab crew (figure1 -2). After review of all data an endovascular procedure was planned.

The case was done under general anaesthesia without pacing. Adequate stent deployment under balanced general anaesthesia, with remifentanyl and sevoflurane was given. The main purpose was to induce a relative decrease of 20-25% of baseline BP values with hemodynamic stability, until the release of the stent. Controlled hypotension was carried out, increasing the dose infusion of remifentanyl and propofol bolus of 50 to 75 mg .

Non significant residual gradient was detected and flow to left subclavian artery was normal (figure 3-4).

Involment of left subclavian artery into a severe coarctation is infrequent but it is an issue of concern.

These techniques helped to leave the non covered part of stent's struts (1,2) at the edge of coarctation, and where the clue for safe coarctation relief and keep adequate flow to LSA (3).

Control CT scan one month after the procedure confirmed postop findings (figure 5-6).

LSA involvement not should be considered an absolute contraindication for coarctation stenting. Team work is essential for adequate stent deployment on these cases.



FIGURE 1



FIGURE 2

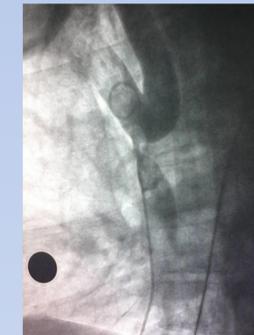


FIGURE 3

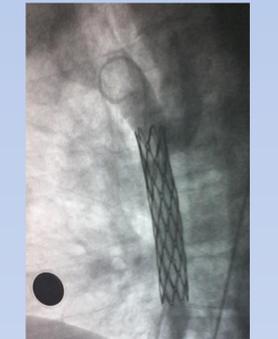


FIGURE 4

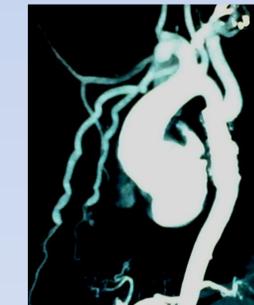


FIGURE 5

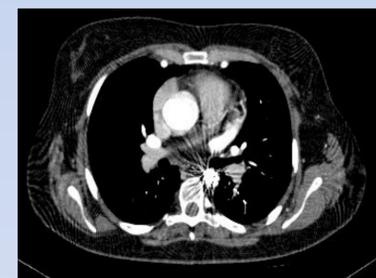


FIGURE 6

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