treated with urgent coronary artery by-pass grafting (CABG) immediately after CAS; 108 (19%) patients underwent staged CABG one month after CAS. Distal cerebral protection devices were used in 85% of the procedures. Soft plaques were present in 110 patients (18%). 49 (9%) patients were submitted to CAS for bilateral carotid artery stenosis.

**Results:** we obtained a successful immediate angiography result in 99% of the patients. Major complications occurred in 11 patients (1.9%) and included: death (1 fatal stroke), major stroke (3), intracerebral hemorrhagic stroke (1), minor stroke (3), acute instant thrombosis (1 patient treated with thromboendoarterectomy and stent removal). Puncture site hematoma occurred in 4 patients treated with vascular surgical repair, one patient died for hemorrhagic shock.

**Follow-up:** we have a complete follow up in 95% of the patients. Instant restenosis occurred in 6 patients (1%) and was successfully treated with a new CAS. 50 patients died (22 for cardiovascular causes), but no one died for causes directly related to CAS.

**Conclusions:** in our experience CAS is a safety procedure with low complications also in high risk patients; the long term efficacy of CAS is very good with low rate of restenosis.

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**Peripheral Vascular Intervention**

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**CRT-207**

**Role of Nitinol Stent Fractures in the Development of In-Stent Restenosis in the Superficial Femoral Artery**

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**Background:** In-stent restenosis (ISR) in the superficial femoral artery (SFA) remains to be an Achilles heel of endovascular treatment of obstructive PAD. Stent fracture (SF) was identified as one of possible causes of ISR, but data on the role of SF in development of ISR remains controversial.

**Methods:** We studied 97 consecutive patients (105 limbs) with angiographically confirmed obstructive nitinol self-expandable stent ISR in the SFA. Mean age of the group was 73.31 ± 8.28 years, 45% females, 31% smokers, 65% Diabetes. We excluded patients with Viabahn stents. Stents were evaluated by fluoroscopy/CINE using at least 2 orthogonal views for SF presence. We analyzed SF rates, severity and angiographic relationship to restenosis, number of stents, stented length, stent diameter and type, run off score, smoking, age, sex, and presence of co-morbidities were analyzed as well.

**Results:** Mean time from stent implantation to presentation with ISR was 15.3 ± 15.3 months. Out of 105 limbs with ISR, SF was present in 31 (30%) limbs and among those only 3 (10%) limbs had SF angiographically associated with ISR. SF occurred more frequently in males (p = 0.036). Mean stented length was numerically but not statistically longer in patients with SF than in those without, 218.1 ± 101 versus 194.8 ± 103.2 (p = 0.297), respectively. There were no differences in other procedural and demographic characteristics between groups with and without SF.

**Conclusions:** Stent fractures in SFA play a modest role in the development of ISR. In our study, the association was seen in only 10% limbs (3 out of 31 limbs) with SF, which corresponds to 2.9% of total 105 limbs with ISR. Majority of the patients with ISR did not have SF. Stent fracture occurred more frequently in males.

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**CRT-208**

**Comparison of Peripheral Arterial Chronic Total Occlusion Crossing Strategies in the XLPAD Registry**

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**Background:** Successful treatment of superficial femoral artery (SFA) and below-the-knee (BTK) chronic total occlusions (CTO) involves selection of an optimal crossing strategy (wire-catheter vs. dedicated CTO crossing device).

**Methods:** We analyzed data from the multi-center XLPAD registry between July 2005 and September 2013 to compare primary CTO crossing strategies.

**Results:** A total of 343 SFA and BTK CTO interventions on 246 patients with symptomatic peripheral arterial disease were performed; 63.0% lesions were attempted with a primary ‘wire-catheter’ and 37.0% with a primary crossing device. In the primary ‘wire-catheter’ group 64.4% lesions were successfully crossed, 34.3% required a provisional crossing device and 1.4% were failures. Provisional use of a crossing device following a failed primary ‘wire-catheter’ attempt was successful in 95.9% cases. In the primary crossing device arm, 95.3% of lesions were successfully crossed. Figure 1 depicts comparative success rates with the primary ‘wire-catheter’ and crossing device strategies. Lesion lengths in the primary ‘wire catheter’ and crossing device arms were 138.9 ± 84.9 and 135.7 ± 79.6 mm (p = 0.75) with stent lengths of 166.9±150.6 and 163.2±153.1 mm (p = 0.84), respectively.

**Conclusion:** In contemporary practice, most operators select a primary ‘wire-catheter’ strategy to cross infra-inguinal peripheral arterial CTO, which is associated with lower success compared to a primary crossing device strategy.