Clinical Bulletin
Salvage of a Femoropopliteal Bypass Graft Using the Fogarty® Graft Thrombectomy Catheter

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Patient History
Patient is a 56-year-old male with a long history of peripheral vascular disease and hypercoagulable state who underwent a fem-pop bypass with a vein graft in 1999. Then in 2002 due to recurrent disease, he required a redo fem-pop using a Hemashield vascular graft.

Clinical Events and Case Notes
The patient with a history of hypertension, diabetes and hypercoagulable state presented with severe left leg pain. On arrival to the hospital he had no Doppler signal in his foot. CT angiography was performed and showed occlusion of his previous fem-pop bypass graft. Due to his severe ischemia it was felt the patient needed an immediate thrombectomy of the graft. The patient was already on the anticoagulant Coumadin. Figure 1 shows pre-procedure occlusion affecting flow. An open cut down was performed on the bypass graft. At first a regular embolectomy catheter was used without success after multiple passes. Next an over-the-wire embolectomy catheter was passed several times also without success in addressing the adherent thrombus. Image after image showed no improvement in flow.

It appeared that the clot was predominately chronic with acute thrombosis of the reduced lumen. It was apparent that a device specifically designed for adherent clot would be necessary. A 5F Fogarty graft thrombectomy catheter (GTC) catheter was inserted into the 6 mm graft and expanded to its full diameter of 8 mm (figure 2). After six passes of the GTC and one final pass with an embolectomy catheter the graft appeared clear as no more clot was retrieved. The thrombus had been very adherent to the graft walls and upon removal appeared gelatinous and rubbery. The patient had good popliteal and pedal pulses. Per images taken, post-procedure blood flow was markedly improved (figure 3). The patient was continued on his anticoagulants and was discharged three days later.

By using a Fogarty GTC the procedure time was significantly decreased; without the Fogarty GTC a revision of the bypass would have been necessary. The GTC is both efficient and effective in removing adherent clot which is chronic in nature.
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