

Rutherford 6

Clinical Case 2

Roberto Ferraresi

Peripheral Interventional Unit

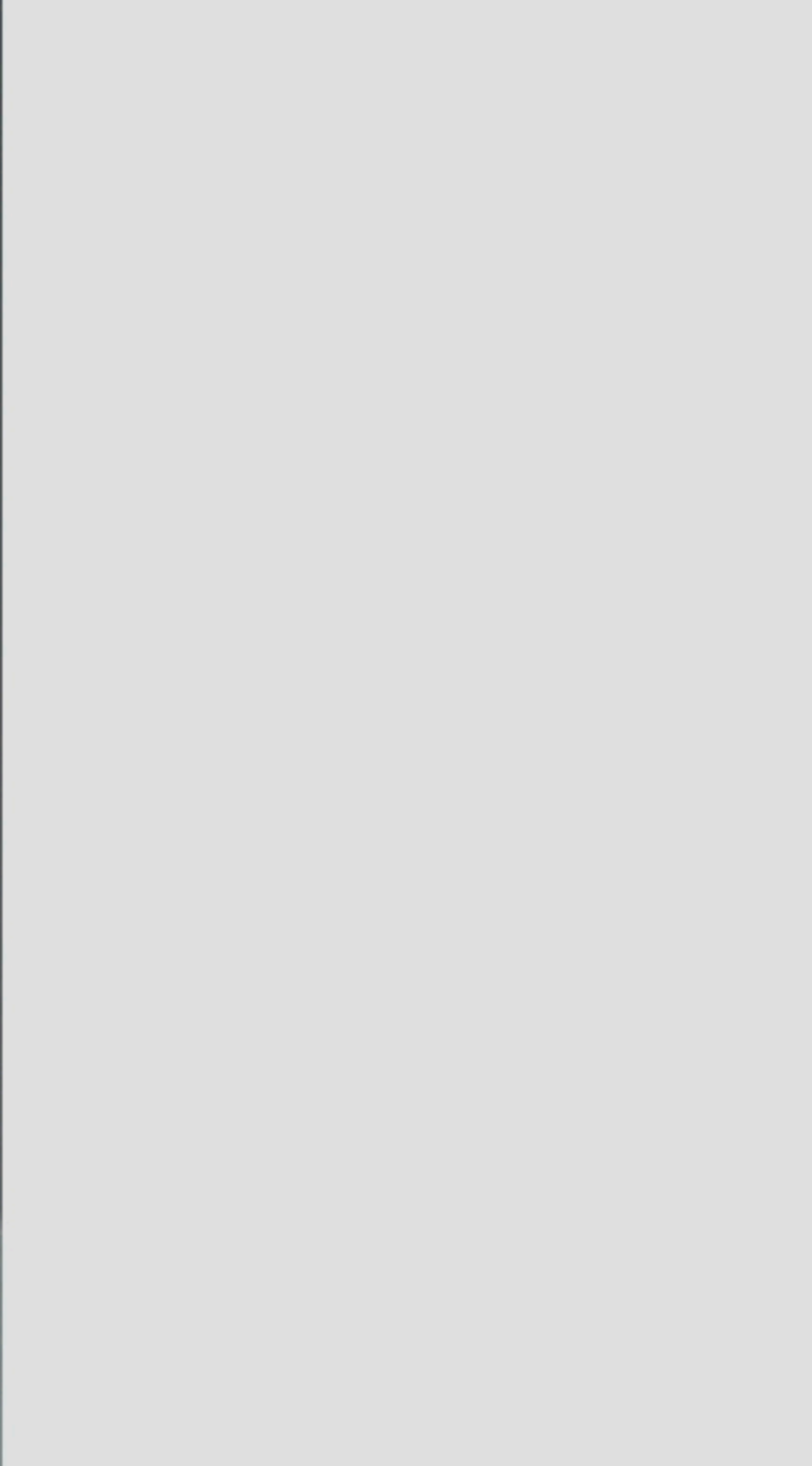
www.robtoferraresi.it

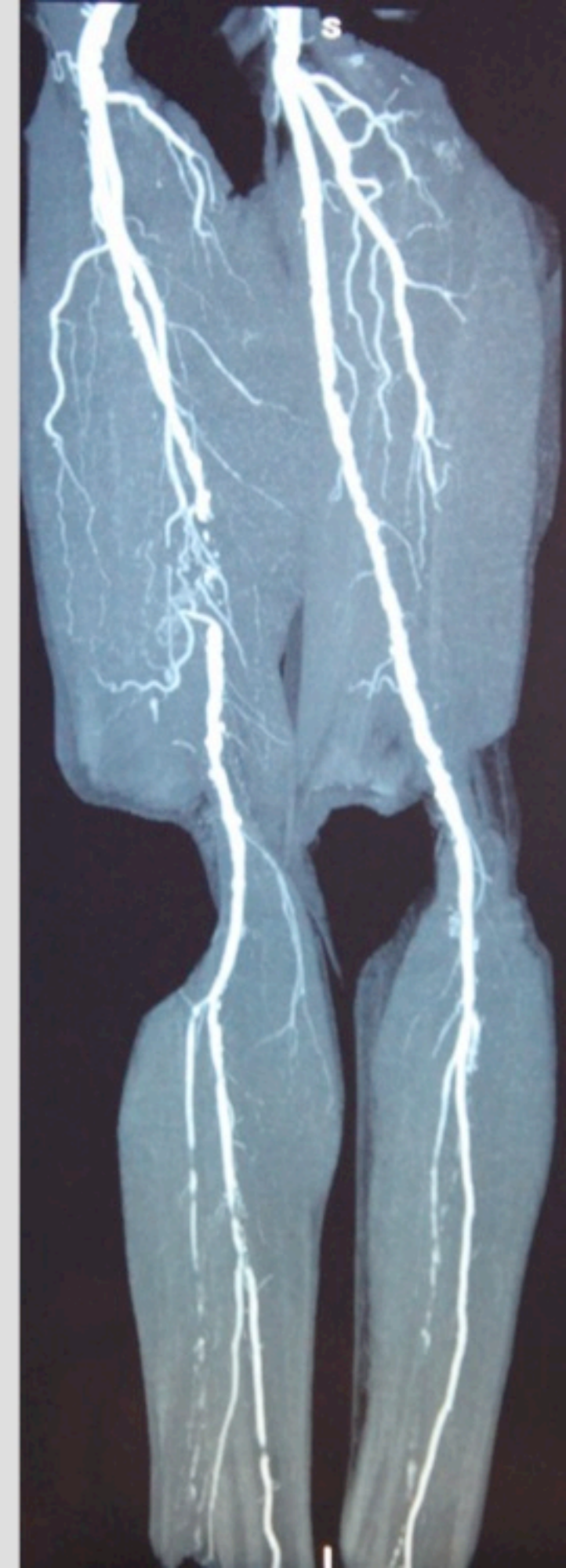
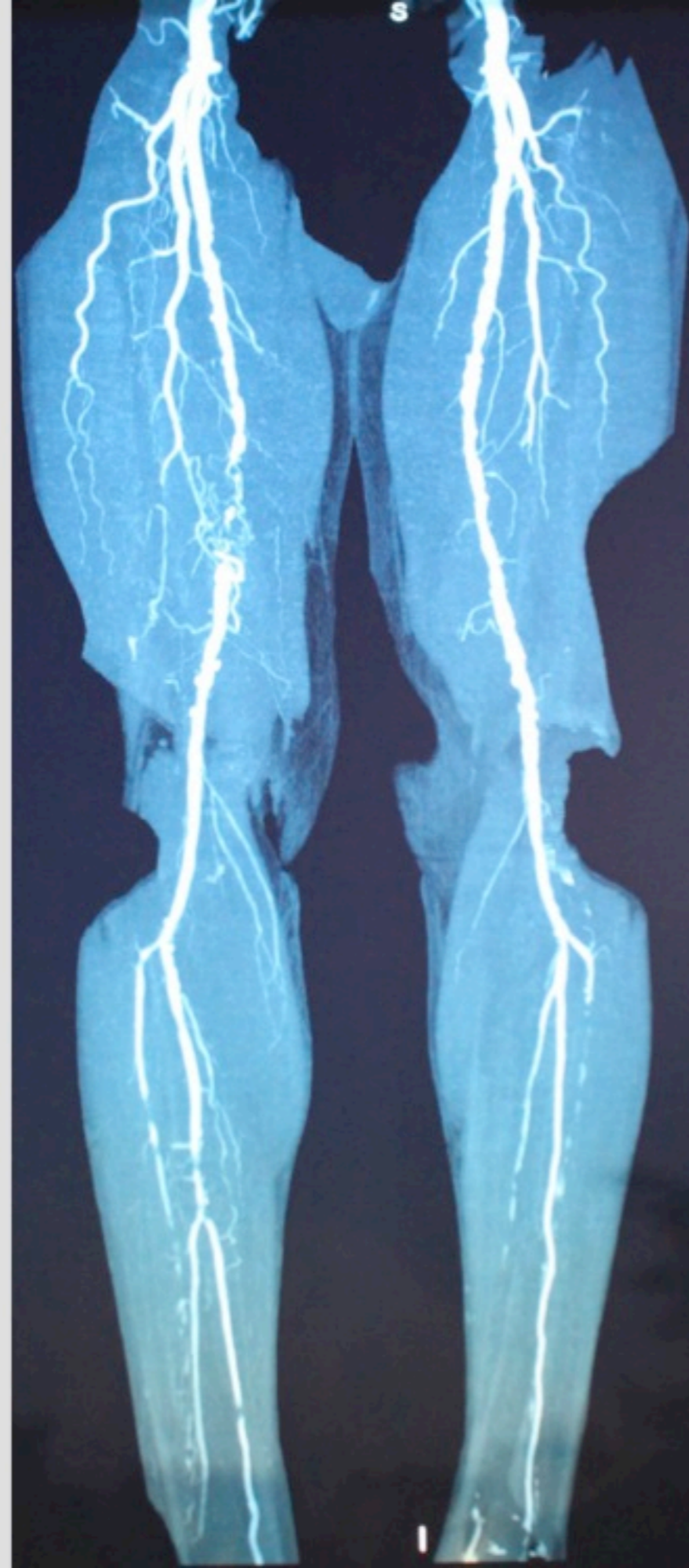
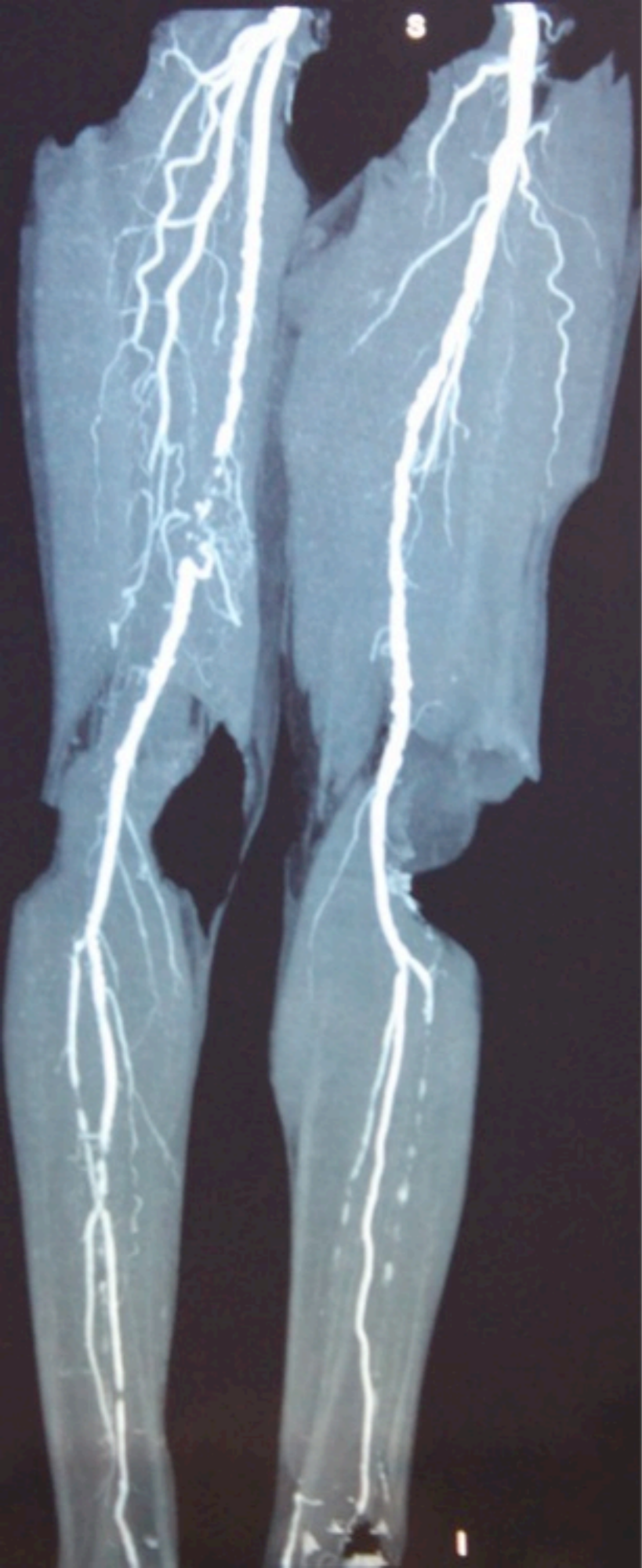


A Rutherford 6 patient

- 74-year-old male
- Type 2 DM (20 yrs), insulin therapy
- High blood pressure
- Creatinine 1.4 mg/dL

2012	
Aug	Superficial burn of the right forefoot
Sept	Evolution of the initial lesion in forefoot dorsal deep ulcer
Oct	Angio-CT study





2012

Aug	Superficial burn of the right forefoot
Sept	Evolution of the initial lesion in forefoot dorsal deep ulcer
Oct	Attempt to perform SFA PTA → failure
Nov	AMI with pulmonary edema → CORO: LM + 3-vessels disease → CABG
Dec	Referral to our diabetic foot clinic: <ul style="list-style-type: none">- Dry forefoot gangrene- No local and systemic signs of infection



Diagnosis

Dry gangrene of the 1° -2° toes, dorsal ulcer with tendon exposure, necrotic lesion of the heel → RTF 6/TUC IIIC

<i>Rutherford</i>		
<i>Grade</i>	<i>Category</i>	<i>Clinical</i>
0	0	Asymptomatic
I	1	Mild claudication
I	2	Moderate claudication
I	3	Severe claudication
II	4	Ischemic rest pain
III	5	Minor tissue loss
III	6	Major tissue loss

University of Texas Wound Classification System		Grade			
		0 Pre or post ulcerative lesion completely epithelialized	I Superficial wound,	II Wound penetrating to tendon or capsule	III Wound penetrating to bone or joint
Stage	A No infection or ischemia	0A	IA	IIA	IIIA
	B Infection present	0B	IB	IIB	IIIB
	C Ischemia present	0C	IC	IIC	IIIC
	D Infection and ischemia present	0D	ID	IID	IIID



No signs of infection → revascularization first

Treatment protocol in TUC C wounds (ischemia without infection)

1°

Urgent medical therapy

- Metabolic balance
- Anemia correction
- Heart evaluation
- Pre-medications:
 - Double anti-PLTs therapy
 - Renal protection

2°

Revascularization

PTA/Bypass are performed before the surgical treatment of the foot lesion

3°

Final treatment

- Medical
- Surgical
- Orthopedic
- Rehabilitation

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noname 05

Dec 04 2012
08:59:06

(Filt. 6)

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FRAME = 1 / 99

WW: 256 WL: 128



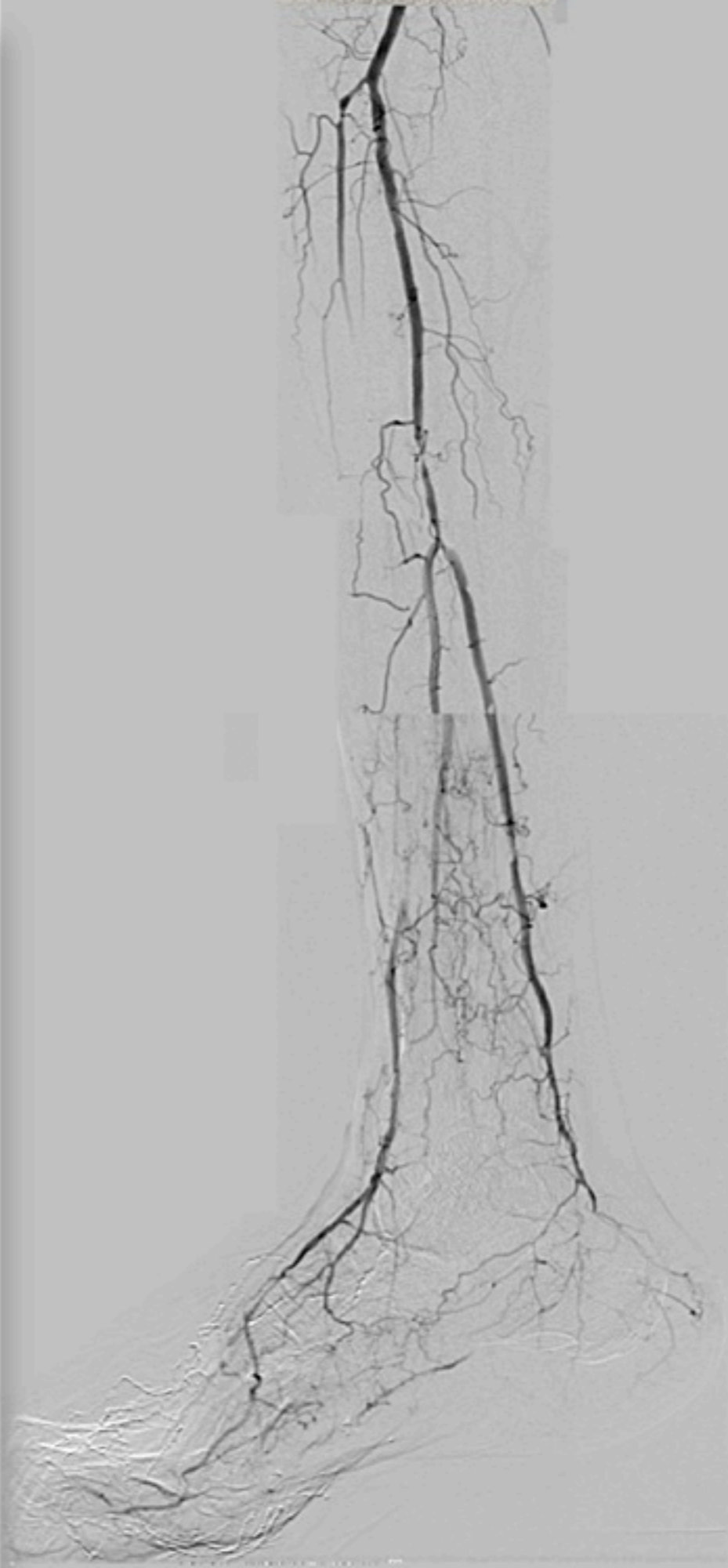
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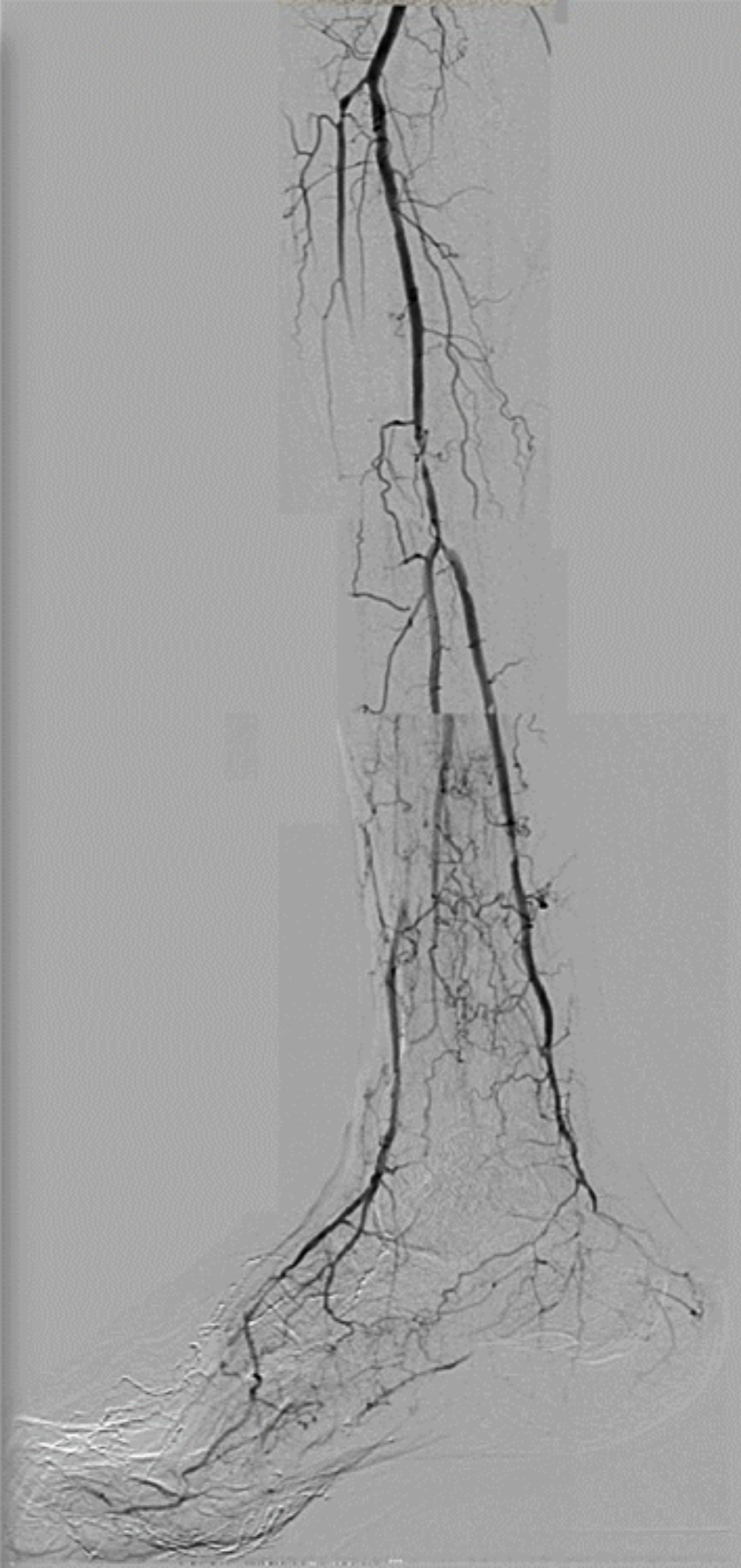
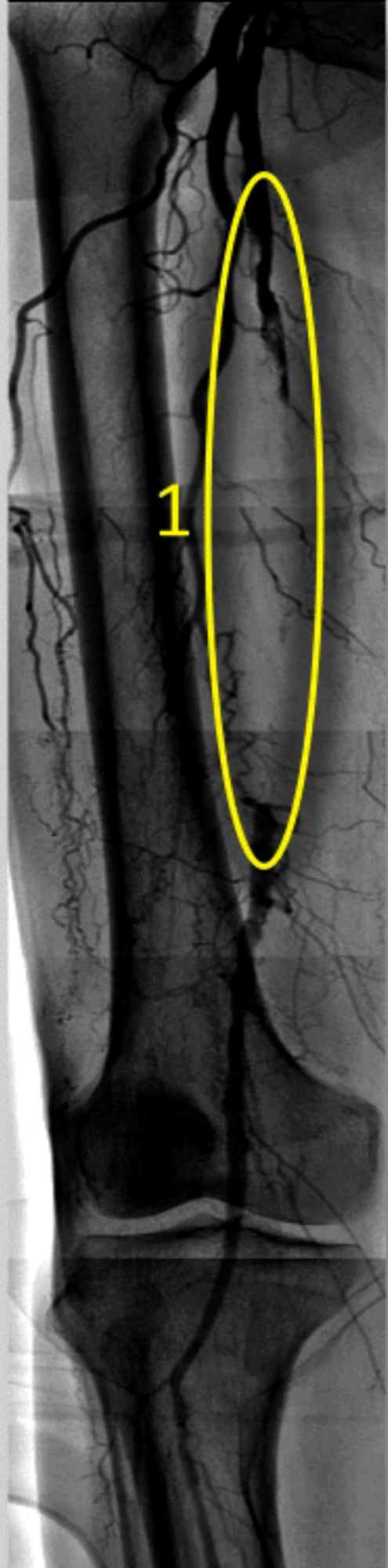
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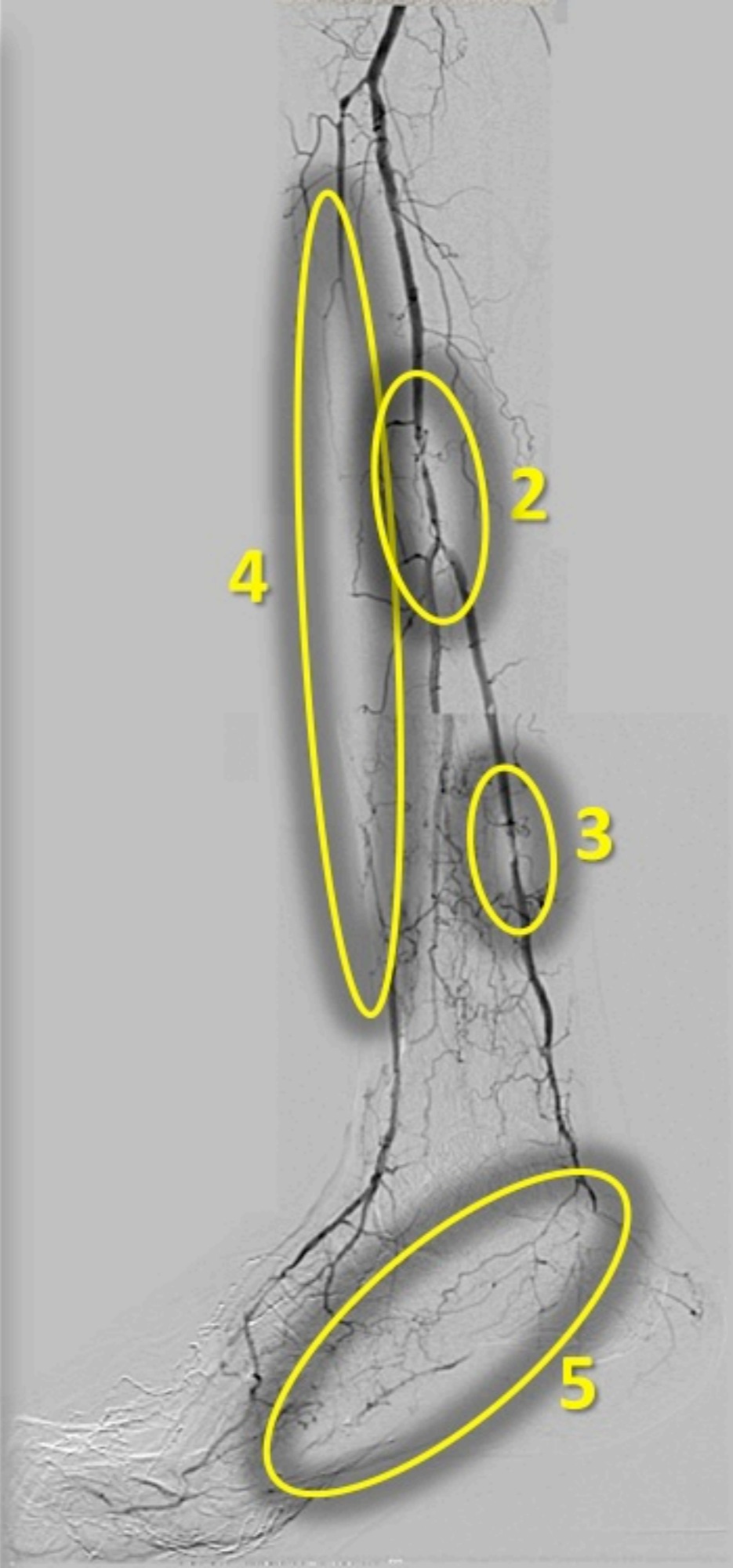
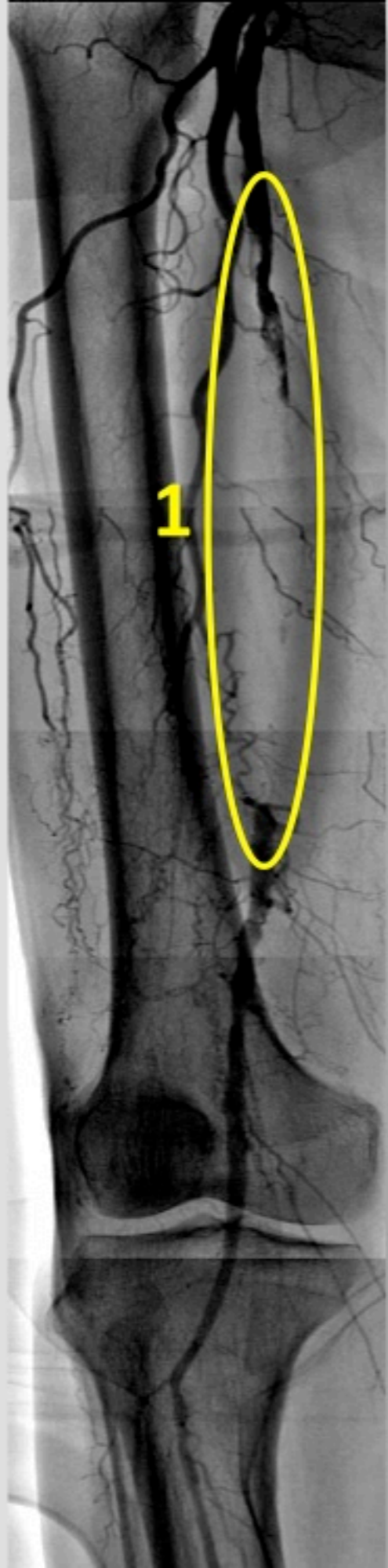
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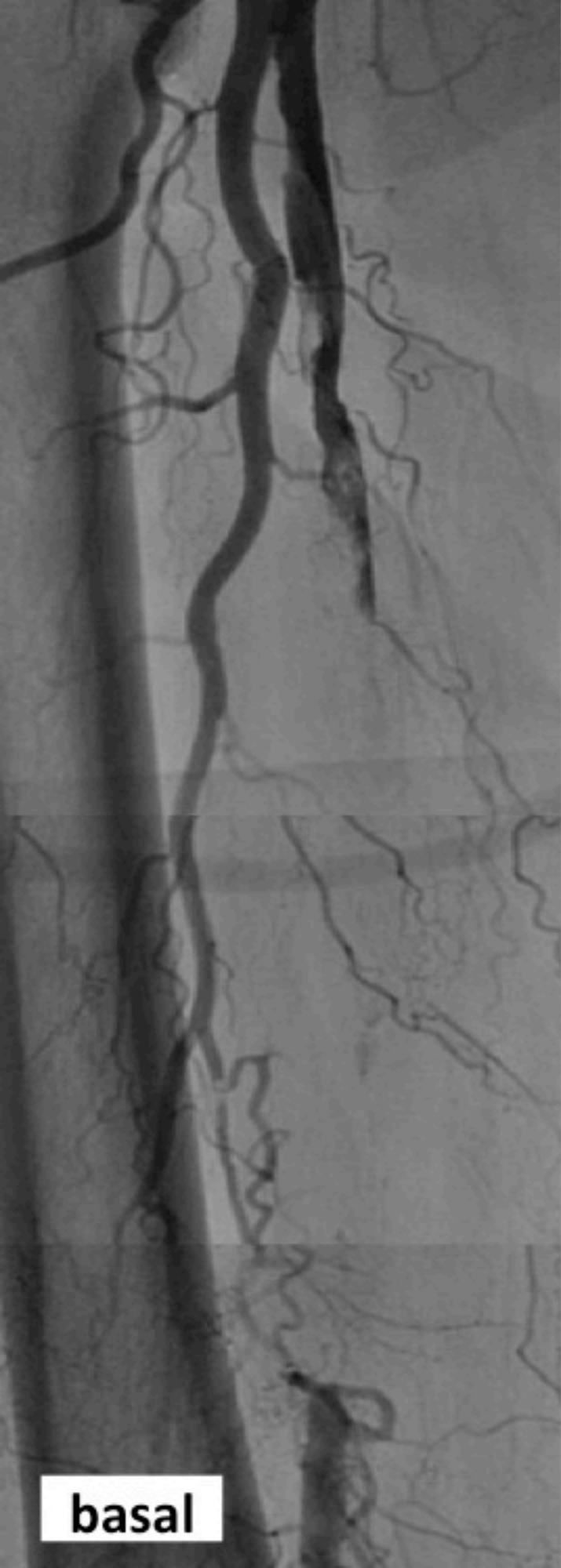
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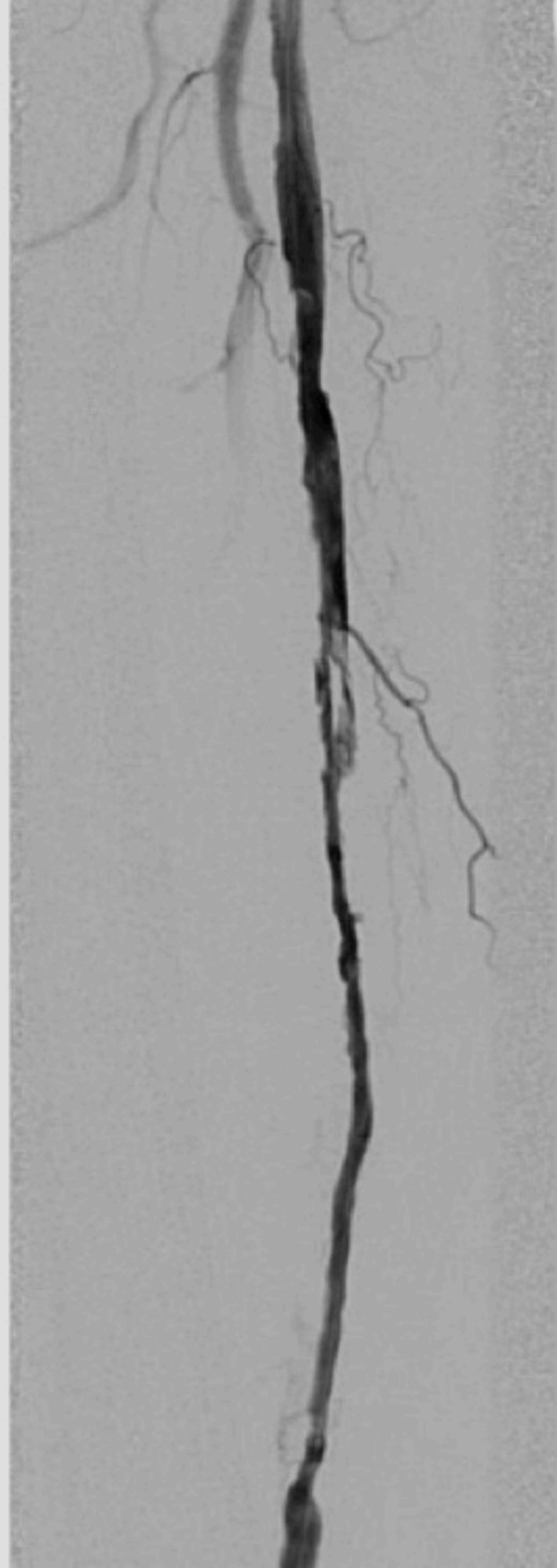








basal



**Nitinol self-expandable
stent 6.0 x 200mm**



basal

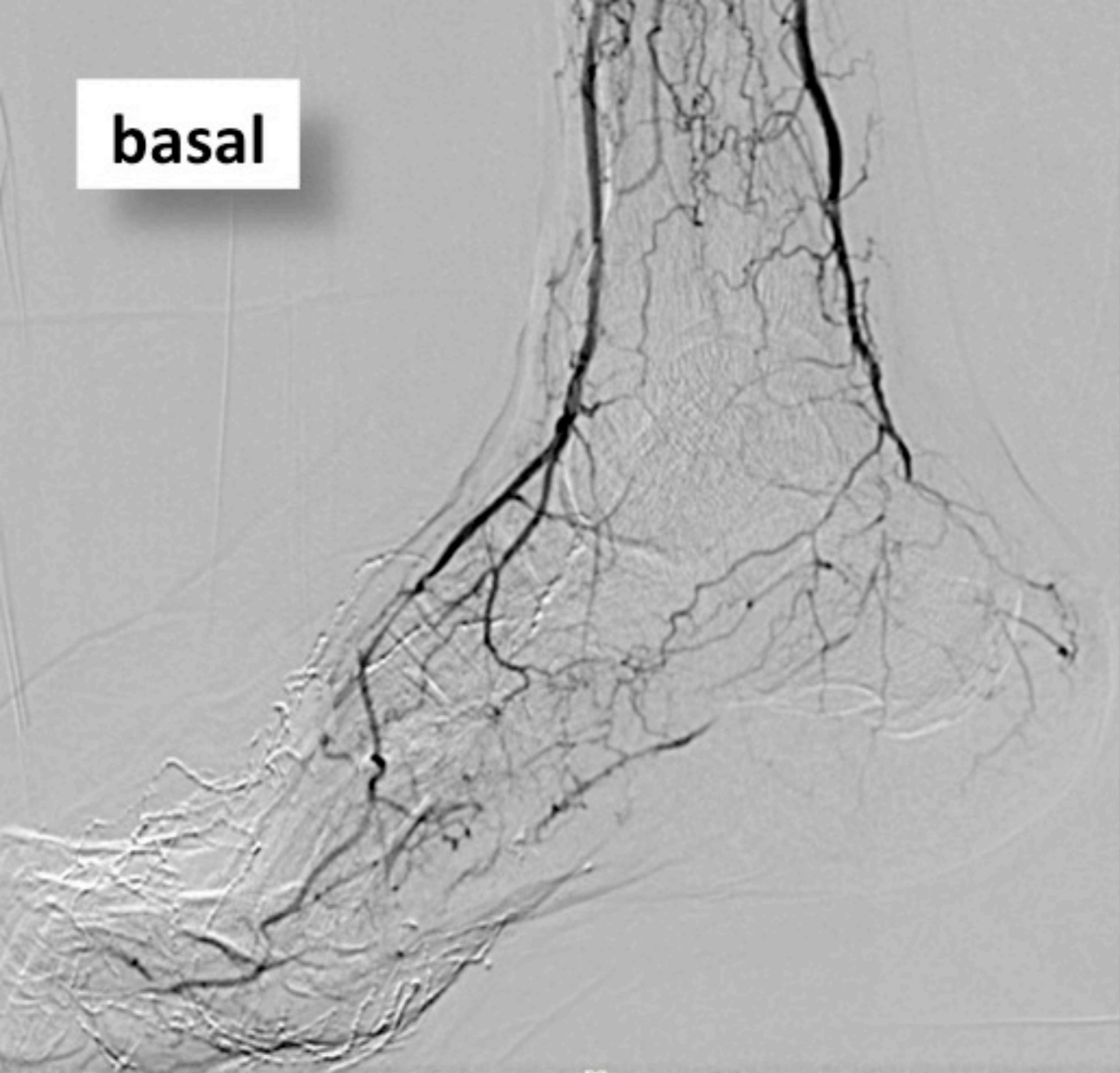
after DEB

TPT + PT: 3.0x40 mm

ATA : 3.0x120 mm x 2



basal



after DEB

4098 WL: 2048

LPA: 2.5.0x120 mm x 2

De

FE

noname 05

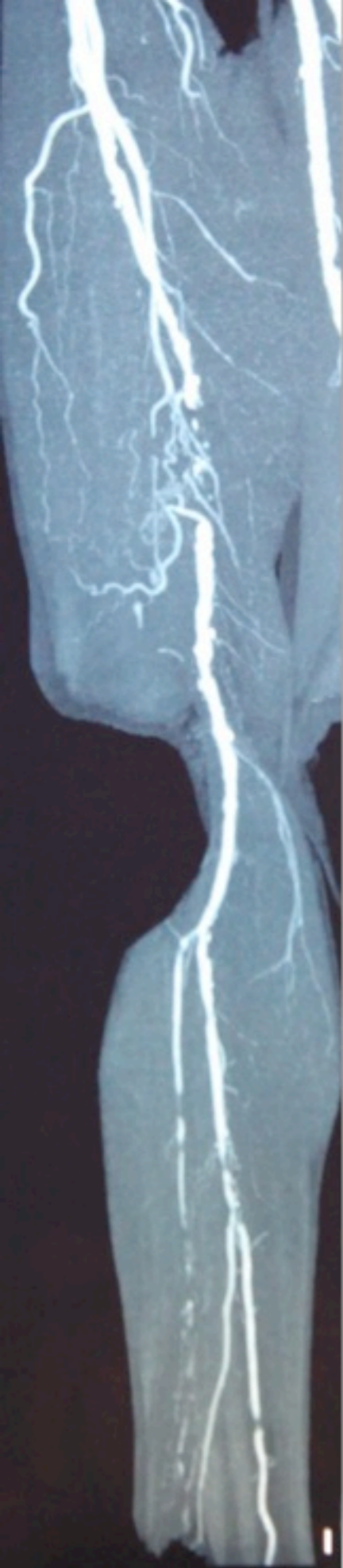
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(Filt. 6)

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WW: 256WL: 128



3WL: 2048

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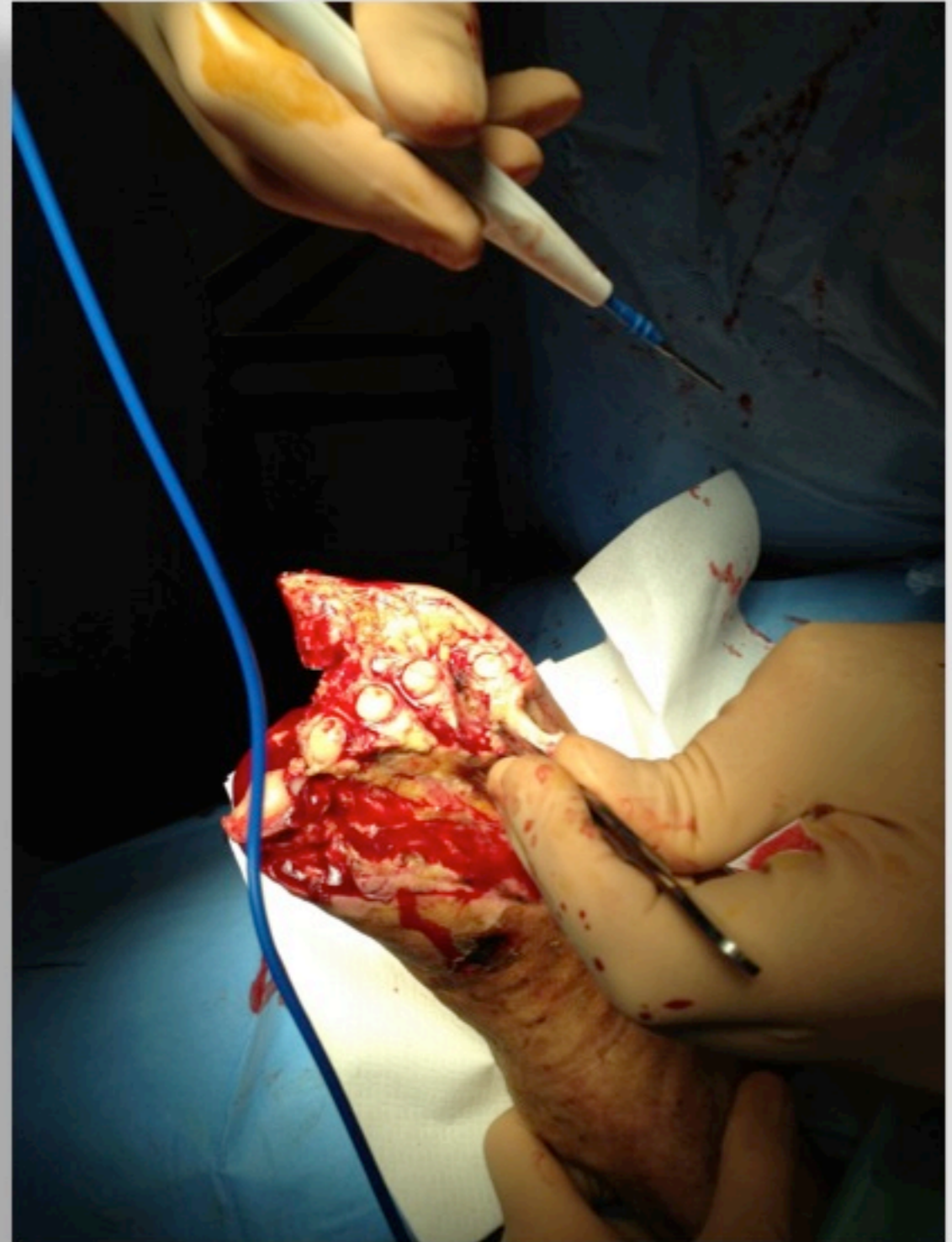
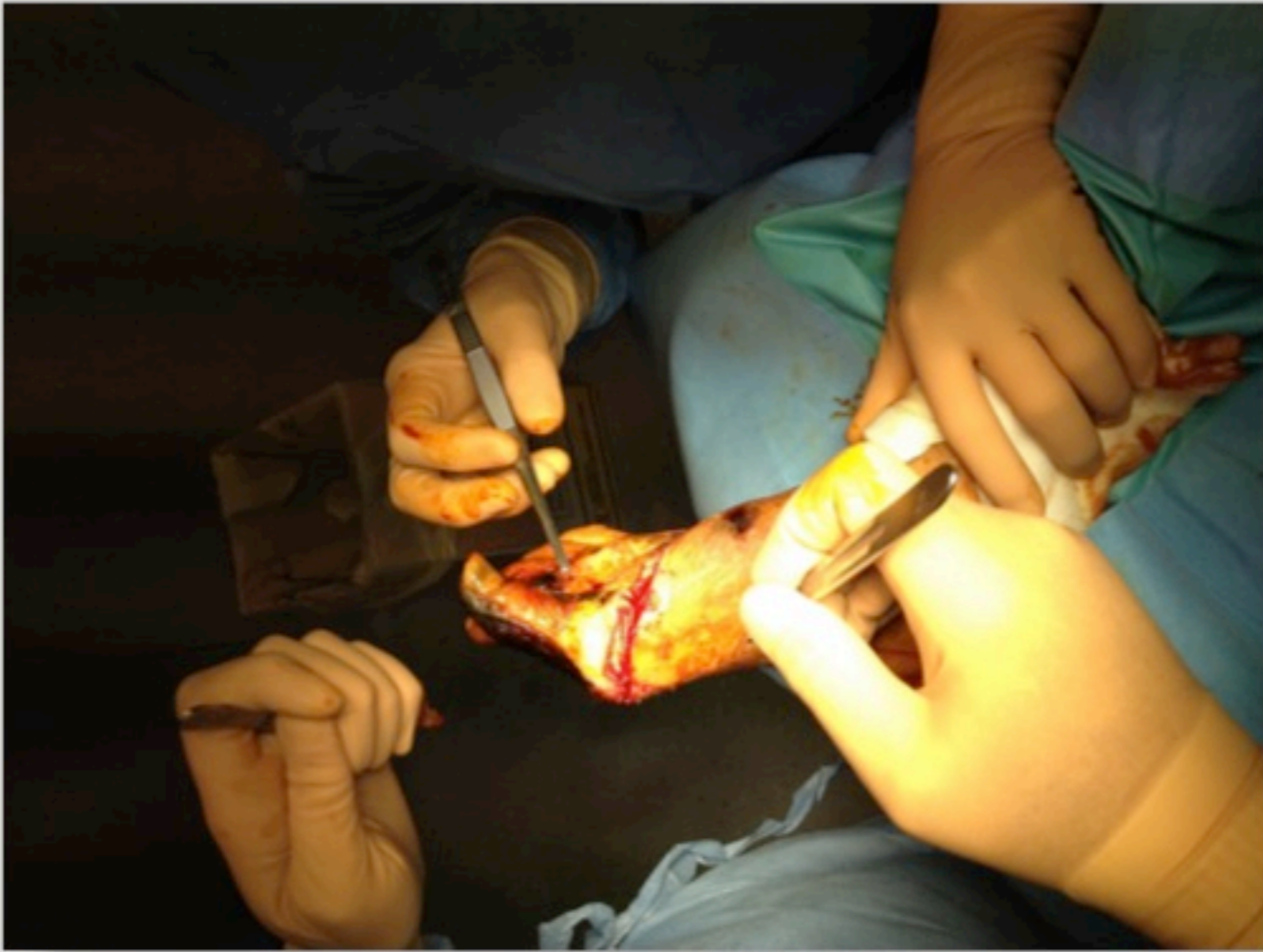
Surgical options considering the “good blood supply to the foot”



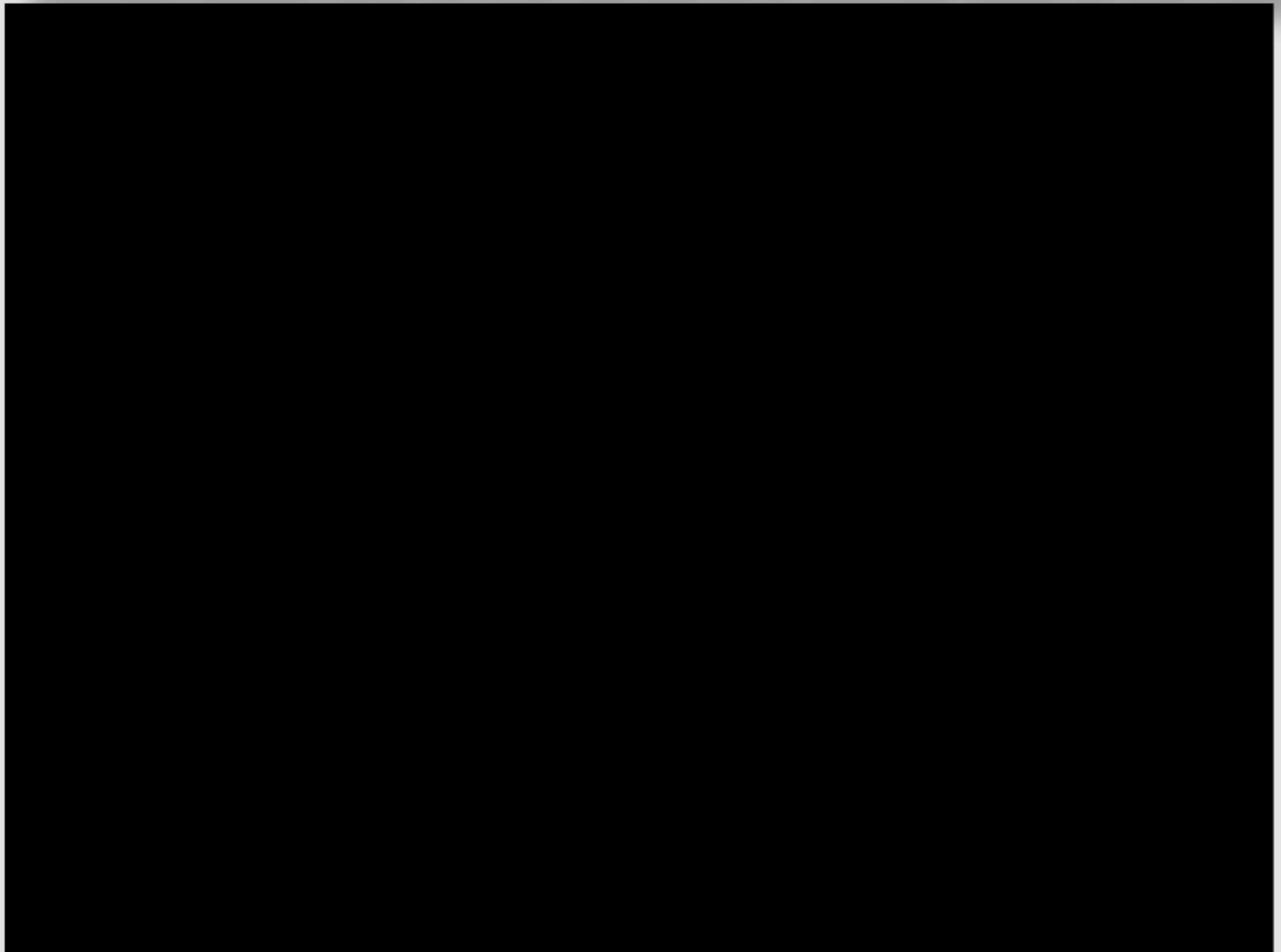
- **Goal: to obtain a long and functional stump**
- **Perform a “proximal” transmetatarsal amputation**
- **Cover residual dorsal ulcer with Hyaf-Based Bioinductive Dermal Substitute**



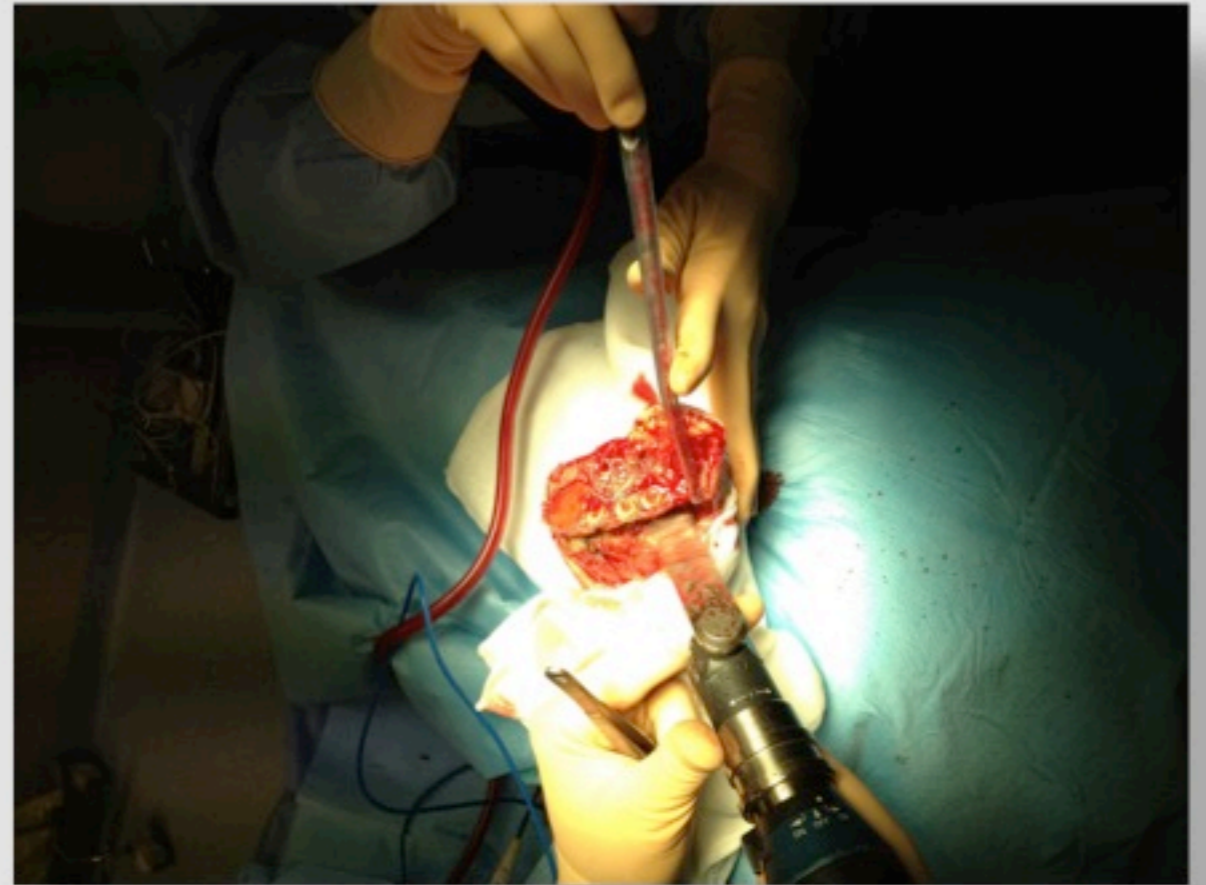
Toe amputation



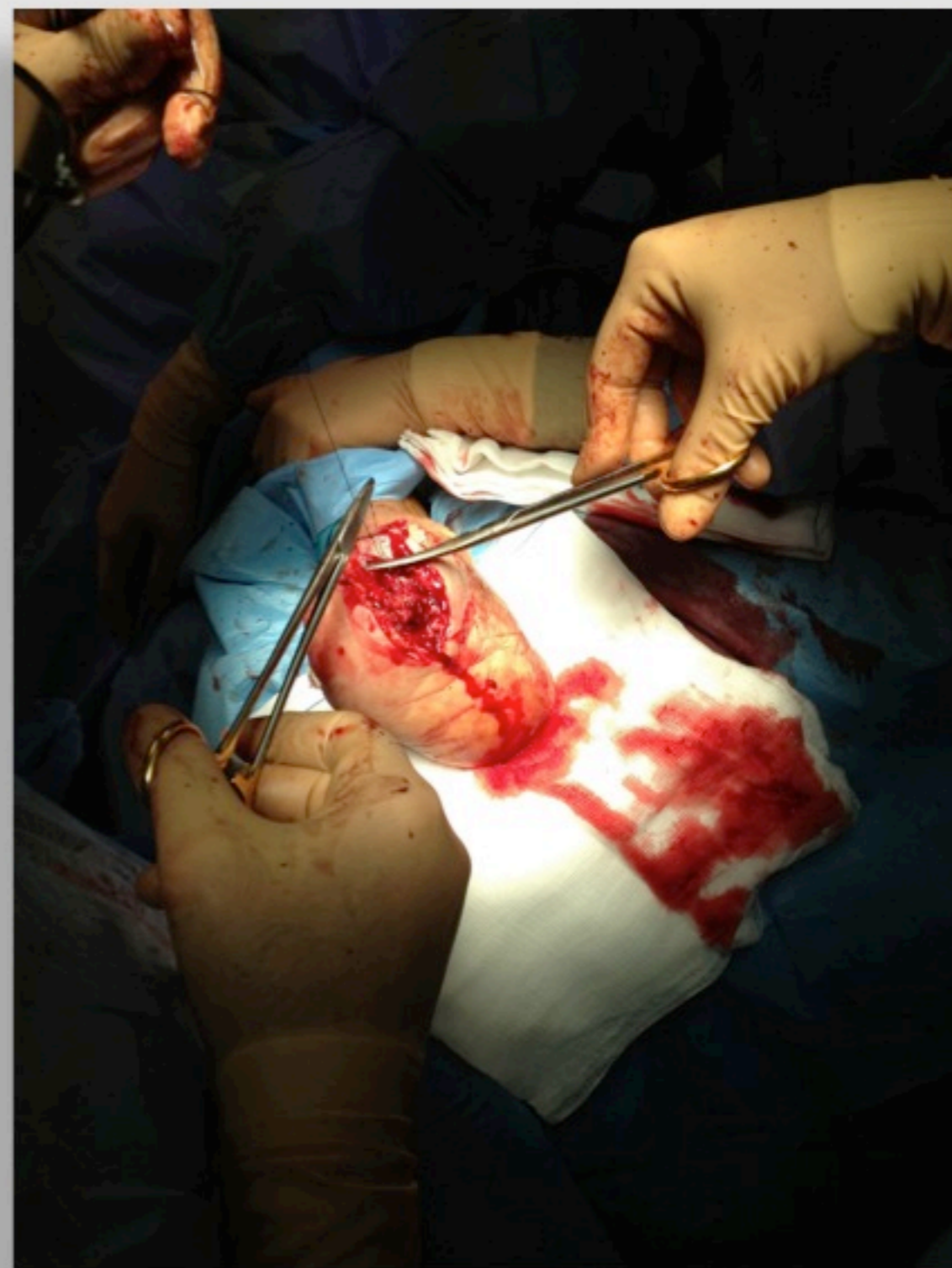
Direct blood flow on the dorsal and plantar side of the foot



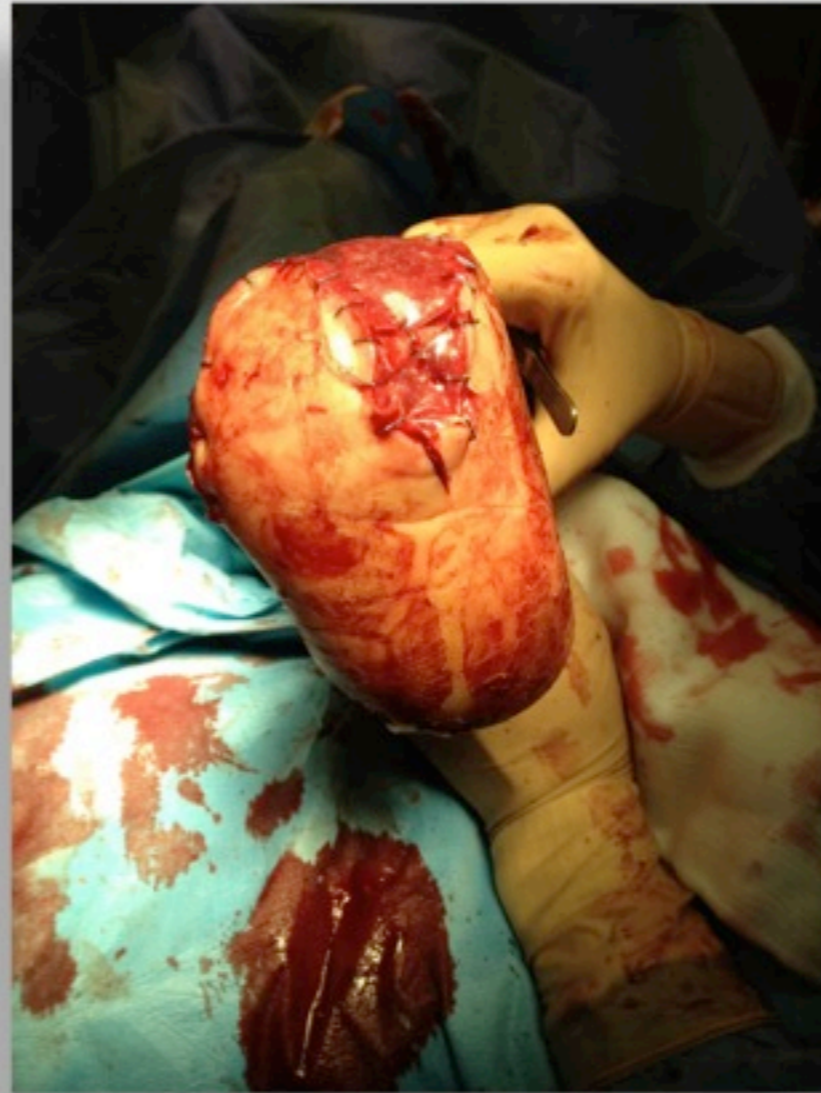
Open TM amputation



Rotation of plantar flaps to cover the exposed bone



Coverage of the residual ulcer with Bioinductive Dermal Substitute



final result...



after two weeks...back to walk



6 months later

