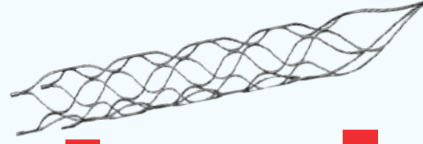


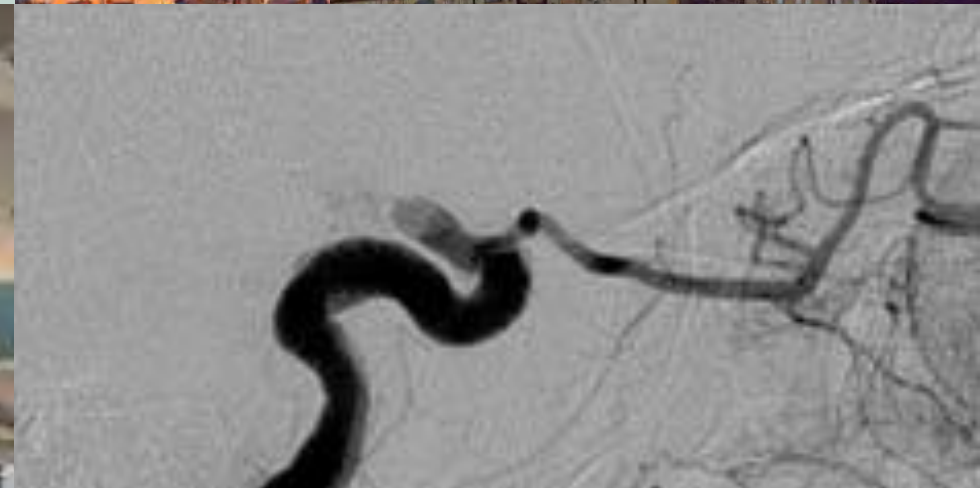
# Ecole de la Thrombotomie



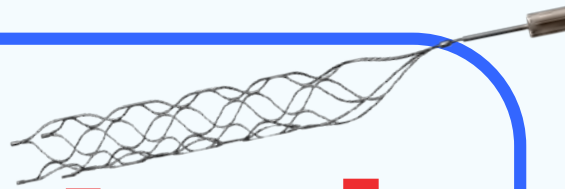
2020



and  
MONTPIED  
du 9  
2018



# Ecole de la **Thrombectomie**



Clermont Ferrand

**GUERI**

GroUpe d'Échange en  
Radiologie Interventionnelle



Paul-Emile LABEYRIE MD, PhD





# Ecole de la **Thrombectomie**

Clermont-Ferrand

Hôpital Gabriel MONTPIED

**Du 7 au 9  
février 2018**

**INTERVENIR**

proximale ?





# BILAN ARTERIO

Premier moment de l'expertise NRI

=> savoir sur quoi on va tomber

Valide la thrombectomie +++

Conditionne le choix du matériel

=> stent , aspi , bi-axial, tri-axial...

Identifier la nature de l'obstacle

Examiner le réseau de suppléance

Bilan TDM, IRM ?

=> incomplet, non exploitable, non dispo, lyse sous tPA

=> Pas toujours les TSA sur le bilan initial



# BILAN EN ROUTINE – LA BASE

⇒ **Rapide et efficace**

- **Toujours**

- la carotide commune cervicale homolatérale face et profil

⇒ Analyse de la navigabilité

⇒ Recherche d'une cause éventuelle ( pas toujours TSA...)

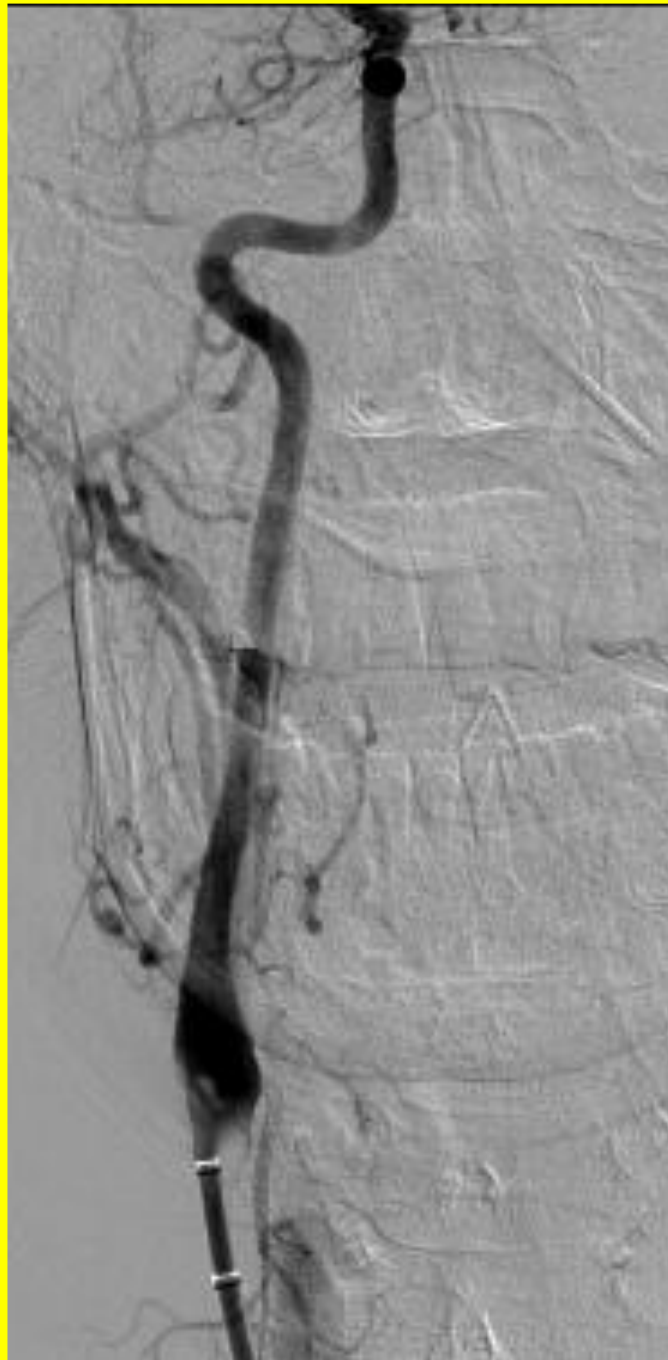
- **Toujours**

- la carotide commune homolatérale de face et profil au crane

⇒ Confirmer l'occlusion intracrânienne



CAROTIDE  
CERVICALE  
HOMOLATÉRALE



[H]



Triaxial ?  
Aspi ?  
MicroKT 160 ?







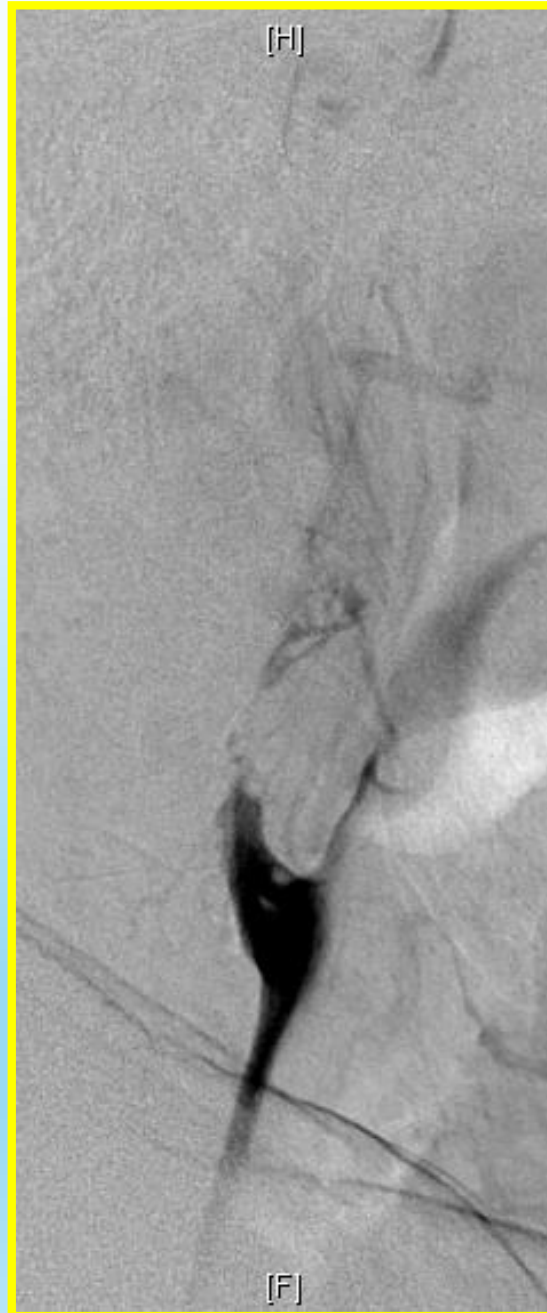


[A]

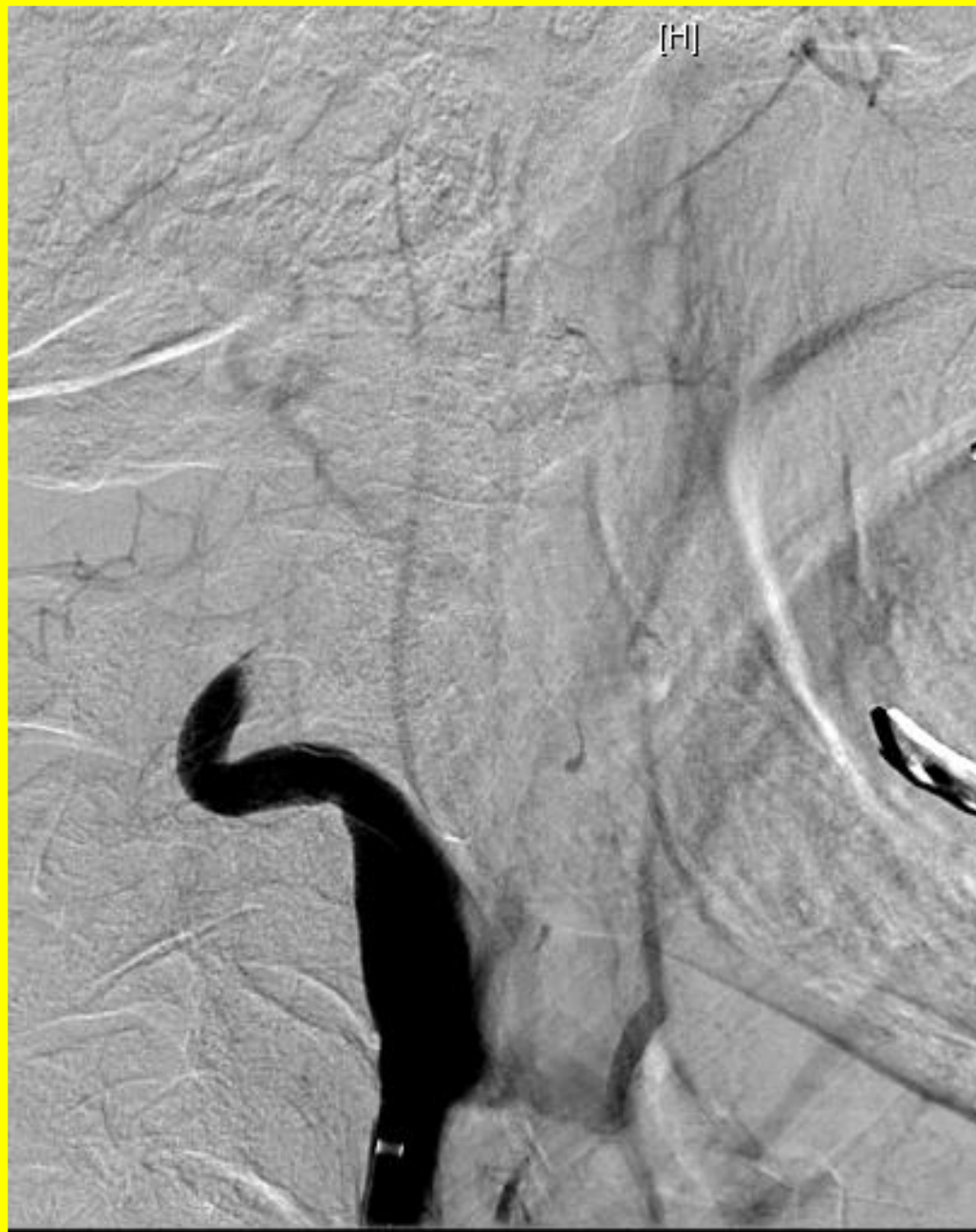
[F]

Arret en « queue de radis »

=> sténose



# Pas d'arrêt net





Progression en déclivité au temps tardif

=> «T»



Arrêt en flammèche

=> dissection



CAROTIDE  
INTRACRANIENNE

Confirmer l'occlusion intracrânienne +++



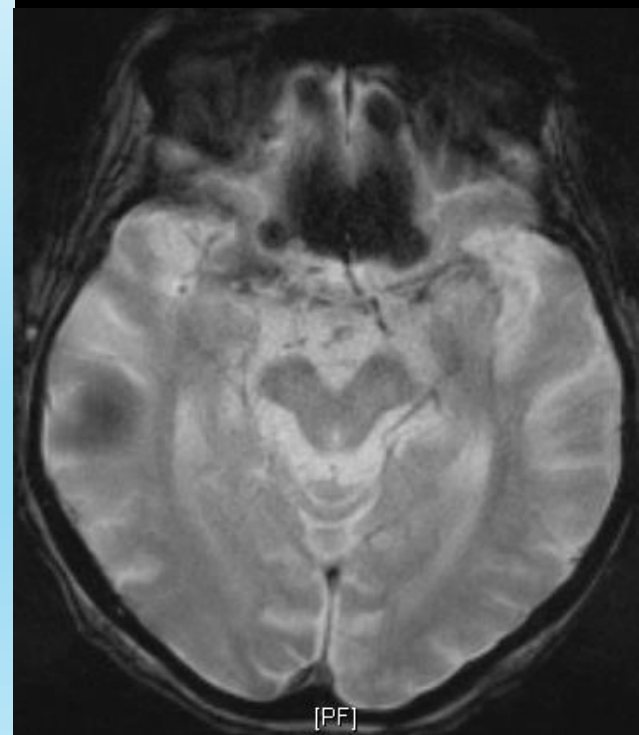
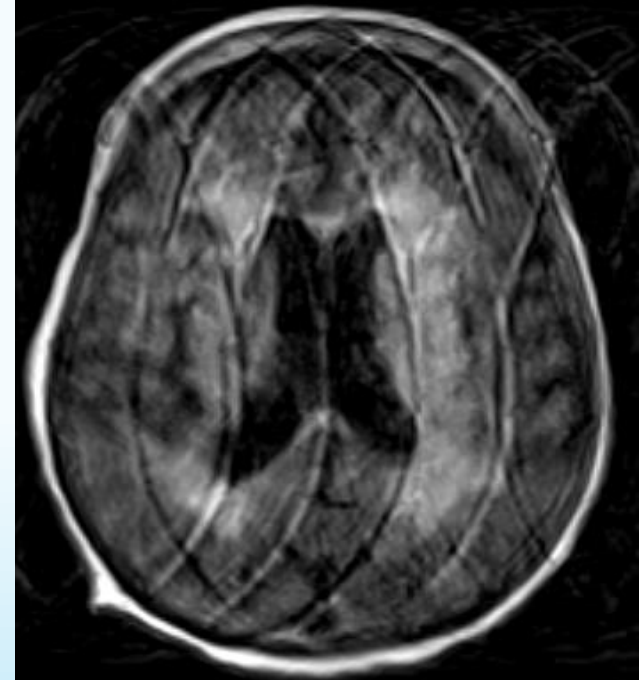
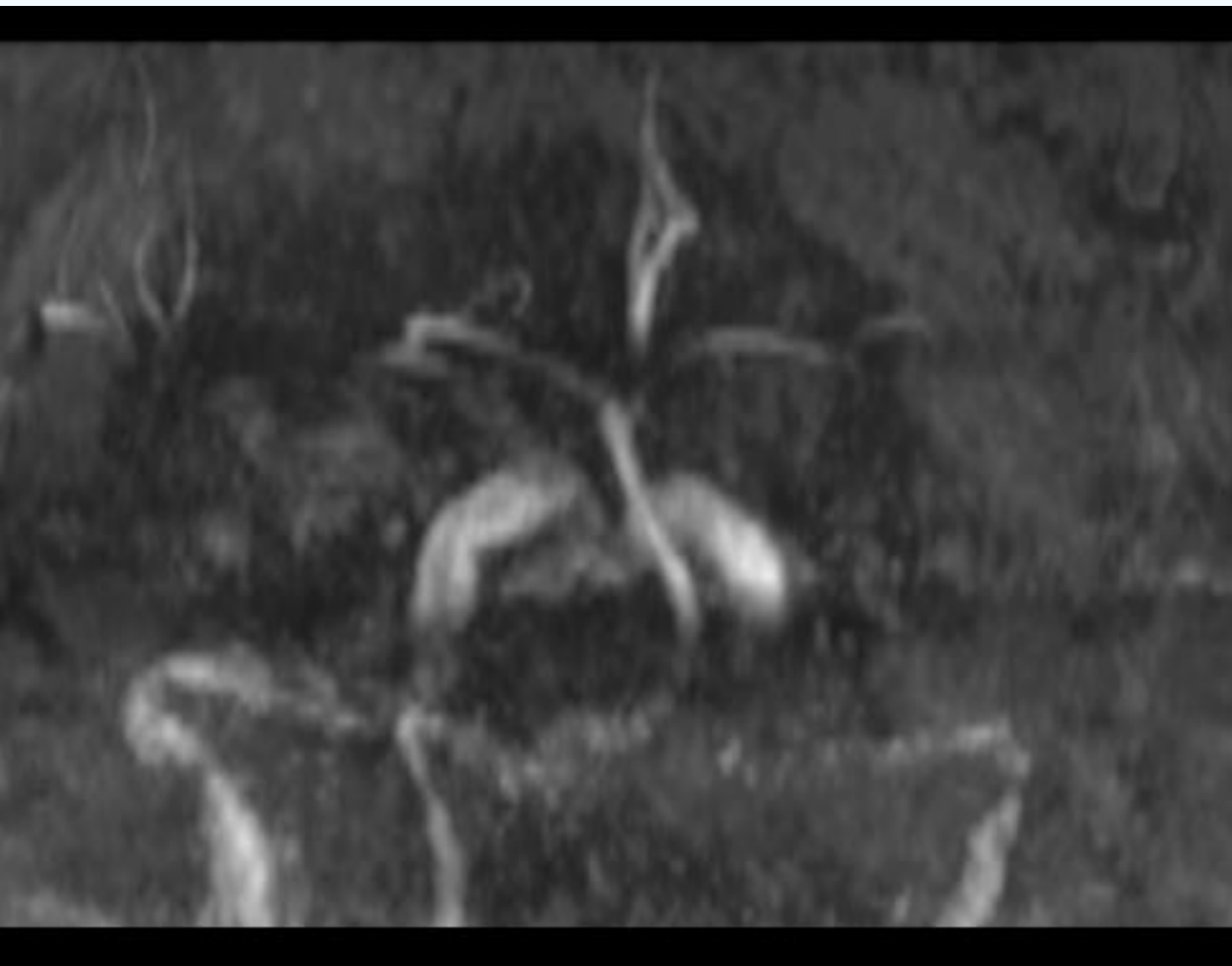


CAROTIDE  
INTRACRANIENNE

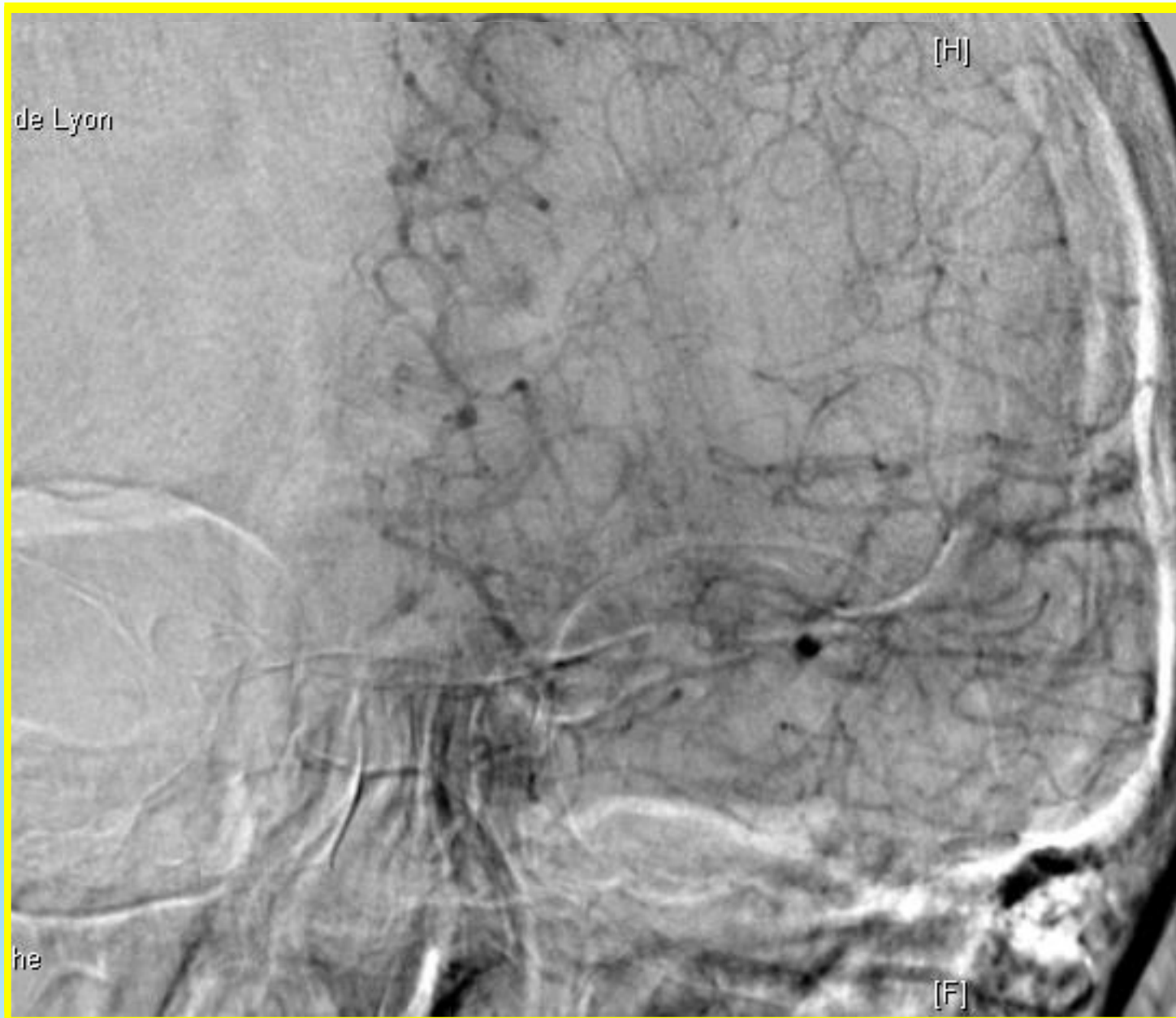
Confirmer l'occlusion intracrânienne +++



NIHSS 16 : ou es l'occlusion ???

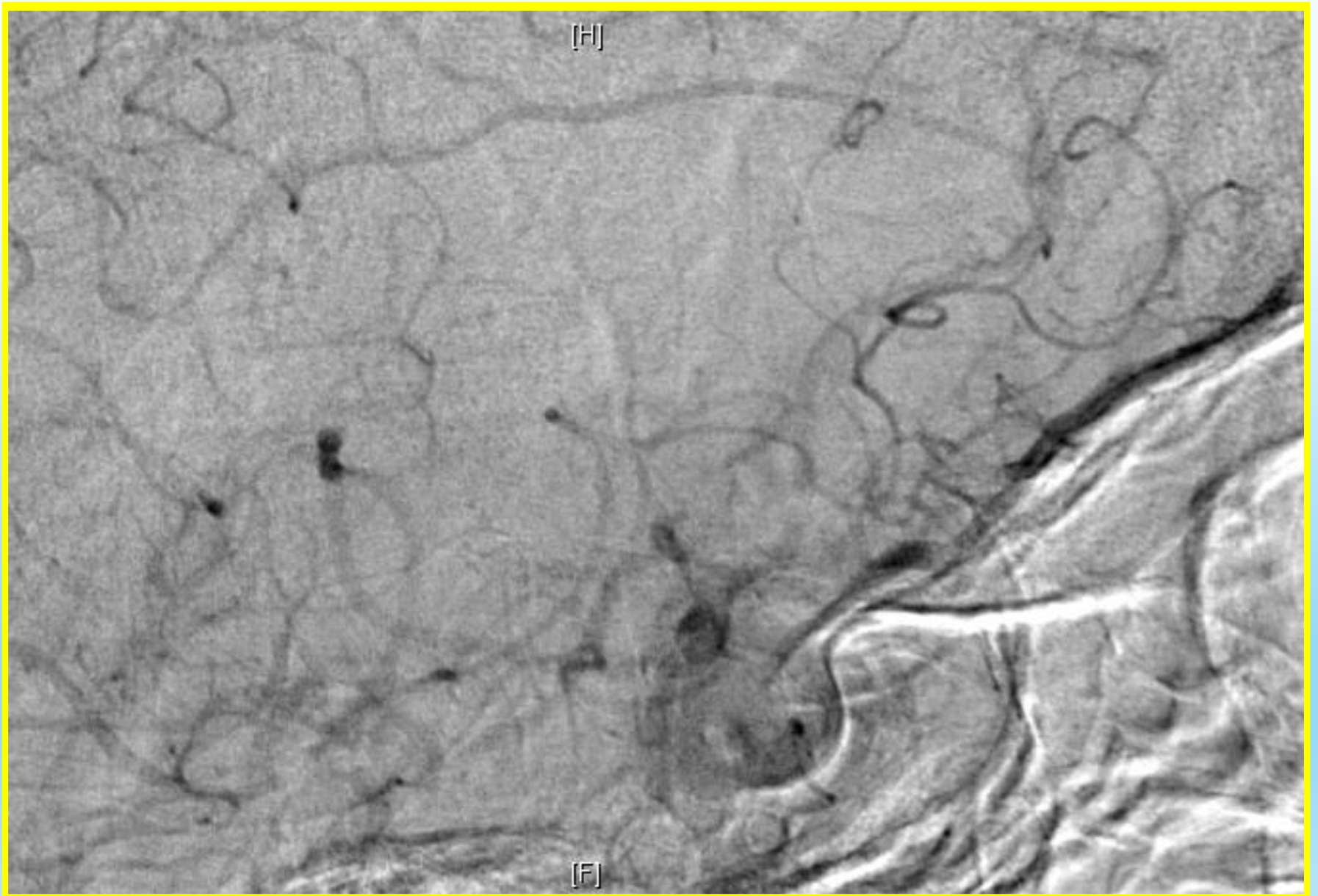


NIHSS 16 : ou es l'occlusion ???





NIHSS 16 : ou es l'occlusion ???



CAROTIDE  
INTRACRANIENNE

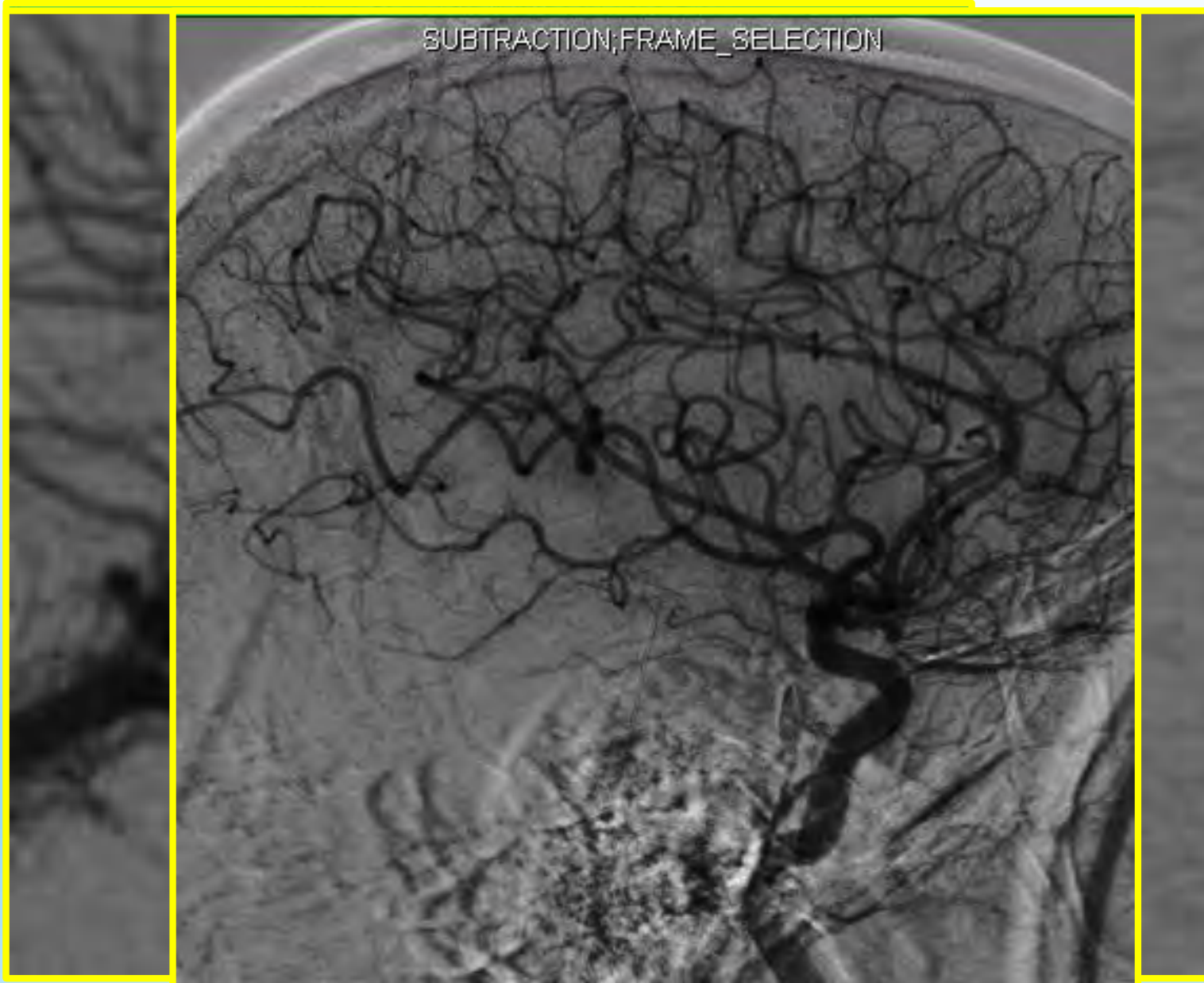
Intérêt des obliques

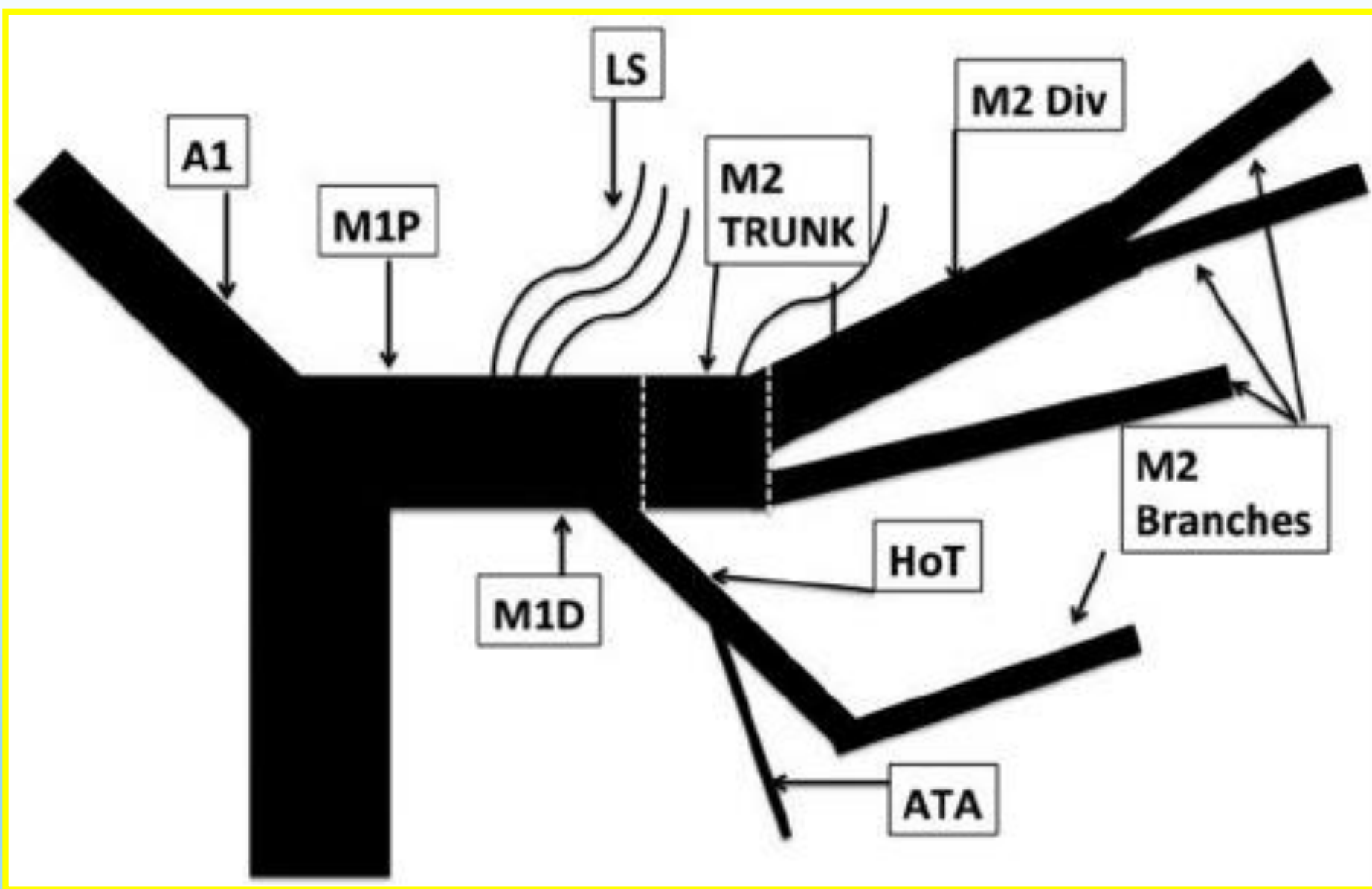
SUBTRACTION;FRAME\_SELECTION



CAROTIDE  
INTRACRANIENNE

Intérêt des obliques +++







# BILAN EN ROUTINE – LES PLUS

## ⇒ **Précision et adaptabilité**

- **+ ou -** face et profil au crane de la carotide controlatérale

- **+ ou -** face et profil au crane de la vertébrale dominante

=> Si occlusion carotide , localisation du caillot

=> Taille du caillot

=> Variantes anatomique

=> Score de collatéralité

- **Toujours**

- Bilan complet si tronc basilaire

- **Rarement**

- Crossographie



[H]



[F]

[G]



[F]

# Localisation du caillot



Hospices Civils de Lyon  
Sé:4  
Im:2 (F13/18)

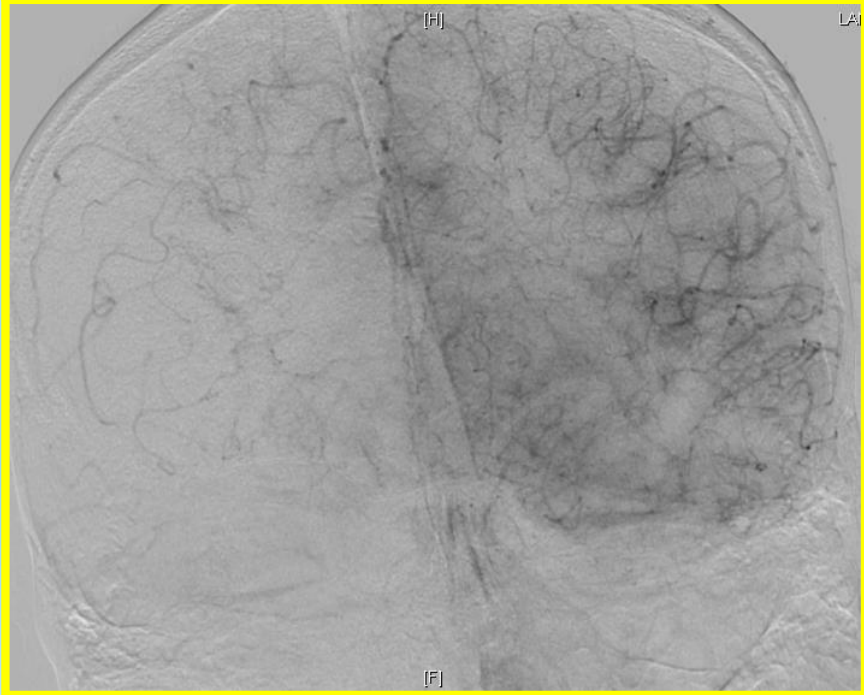


Tandem MI



Localisation du caillot

Tandem « T »





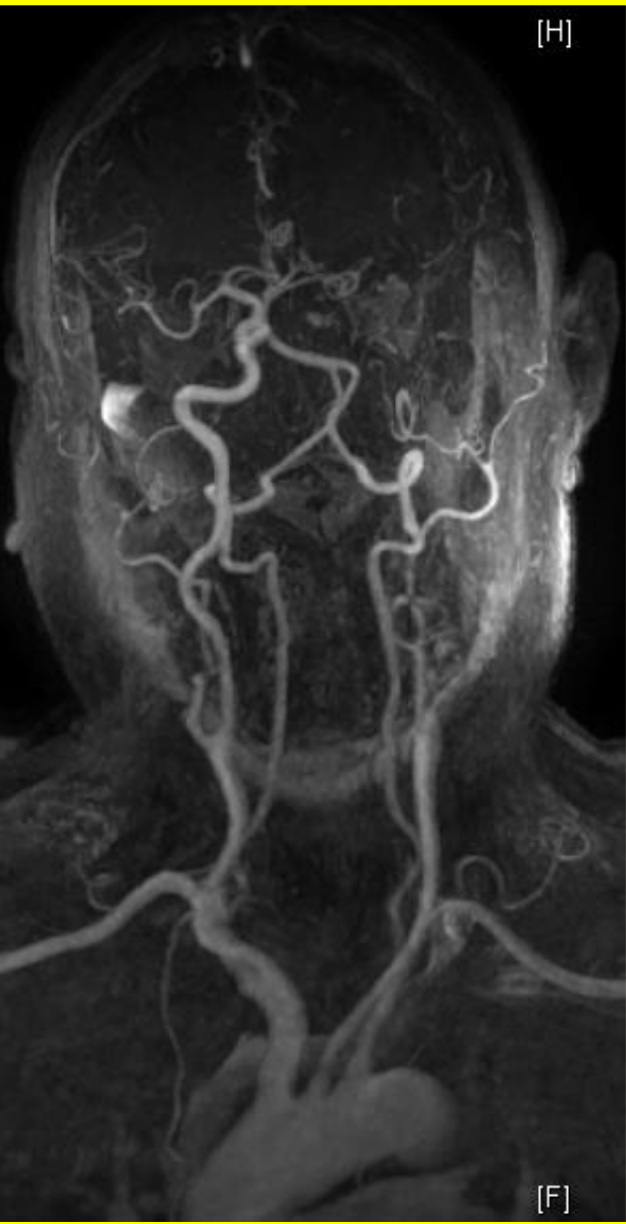
Localisation du caillot

Tandem MI



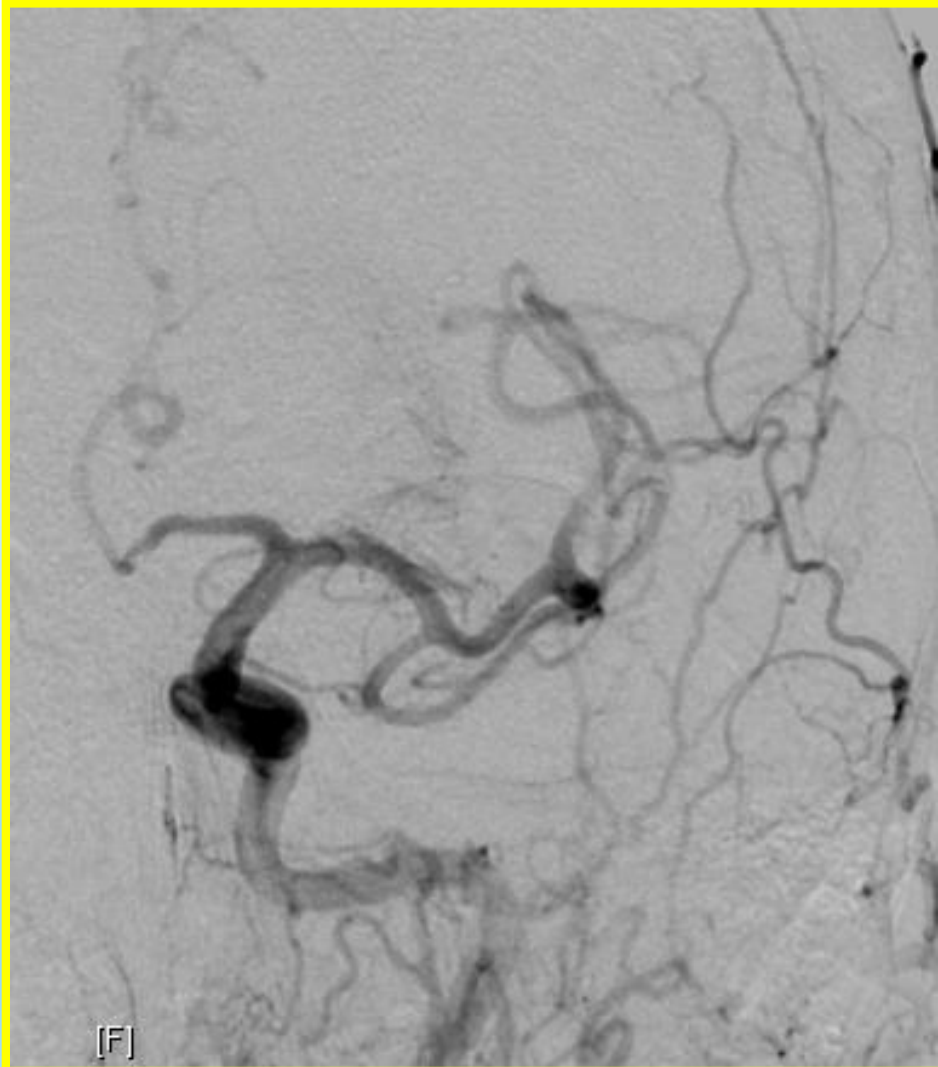


Confirmer l'occlusion proximale



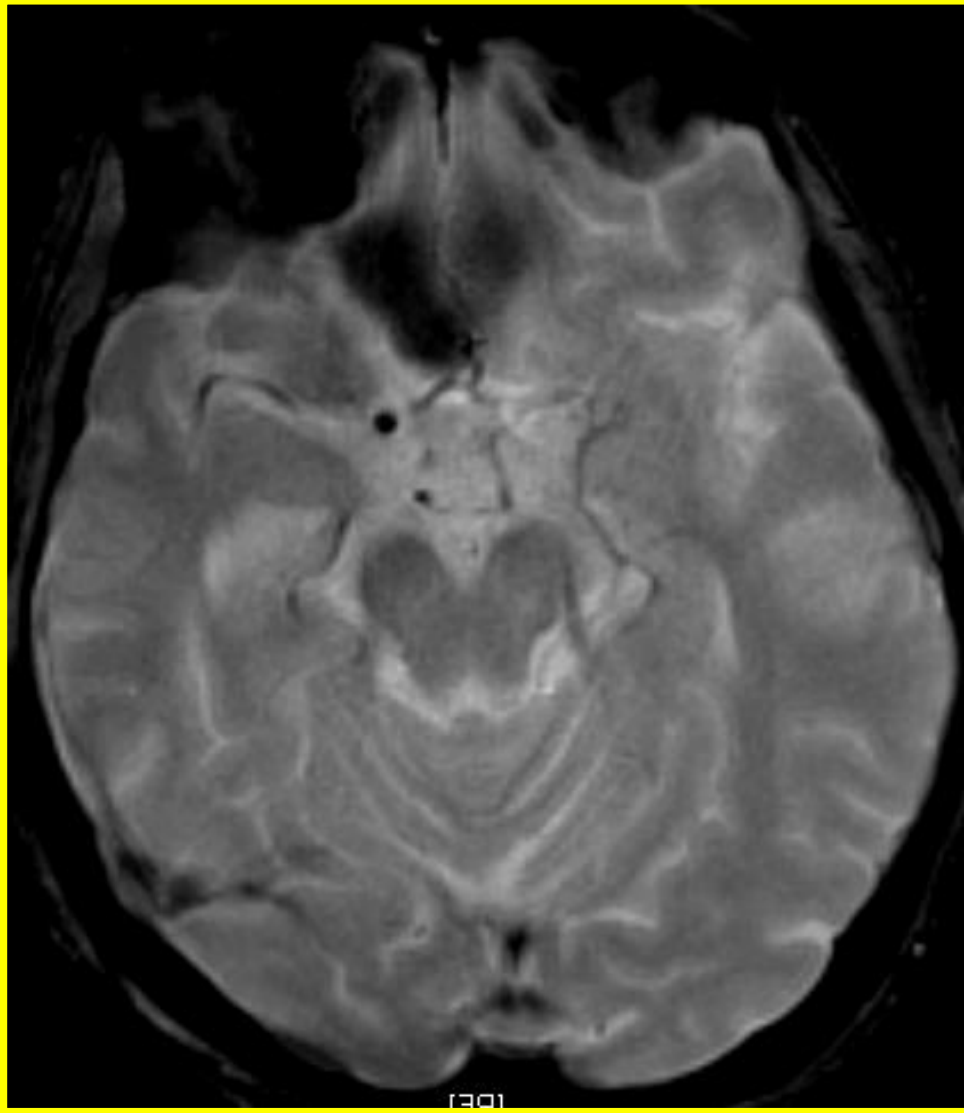
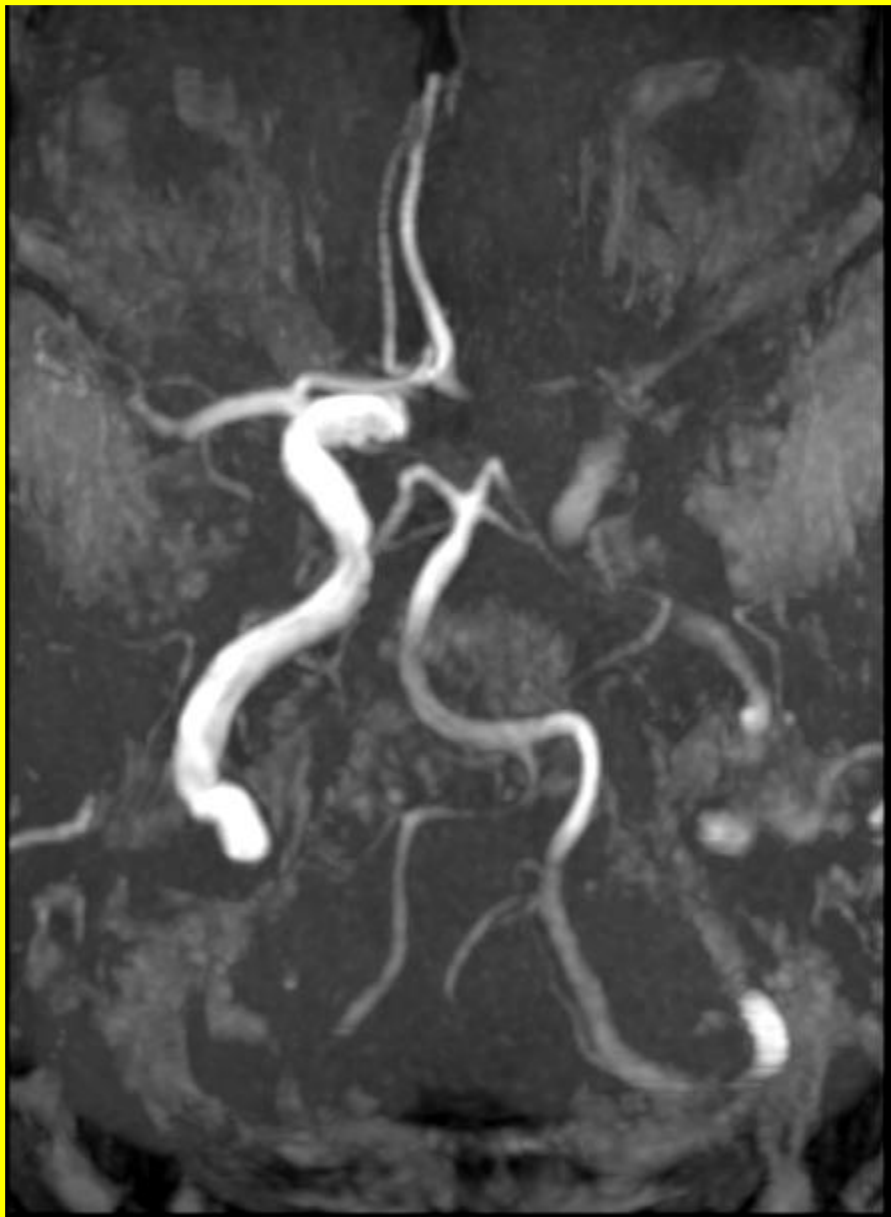


Confirmer l'occlusion proximale

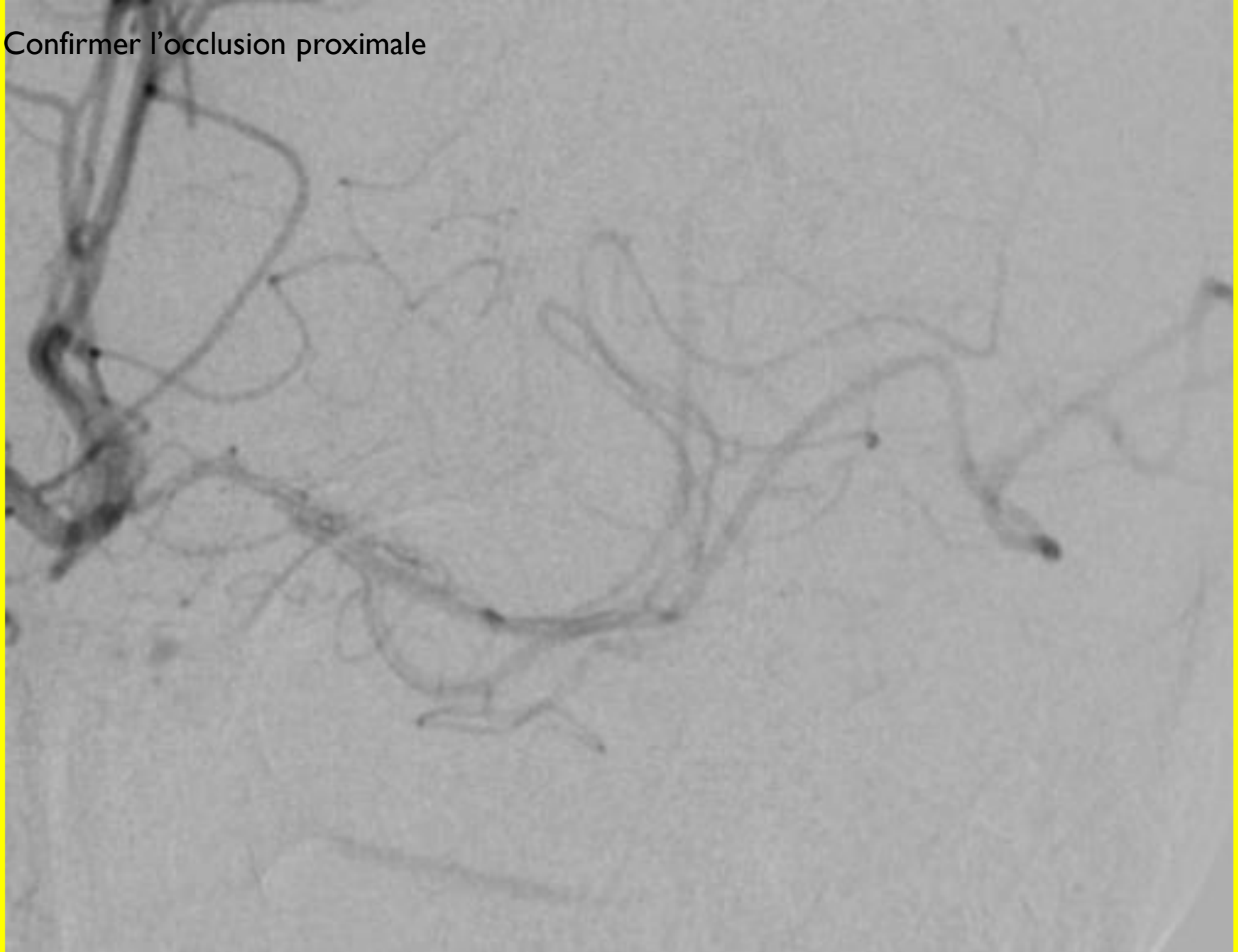




Confirmer l'occlusion proximale



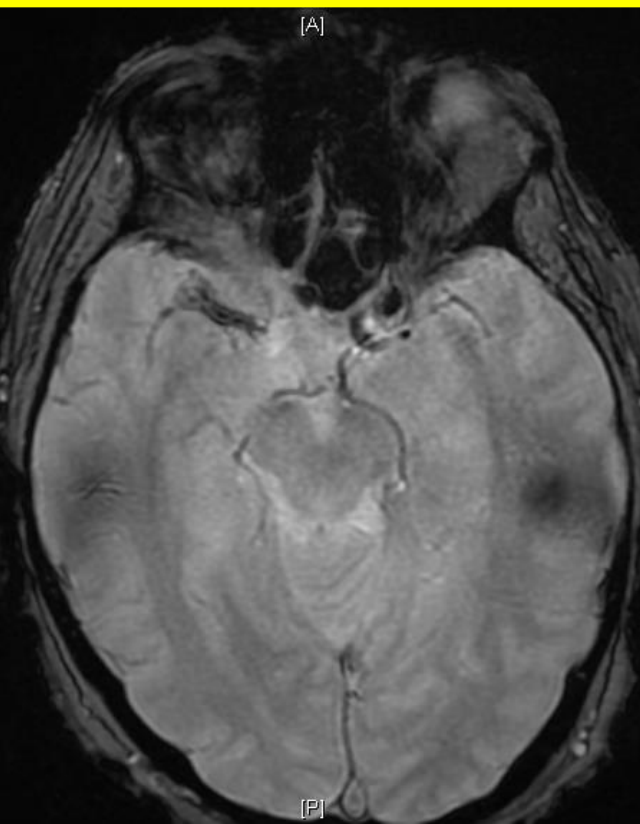
Confirmer l'occlusion proximale

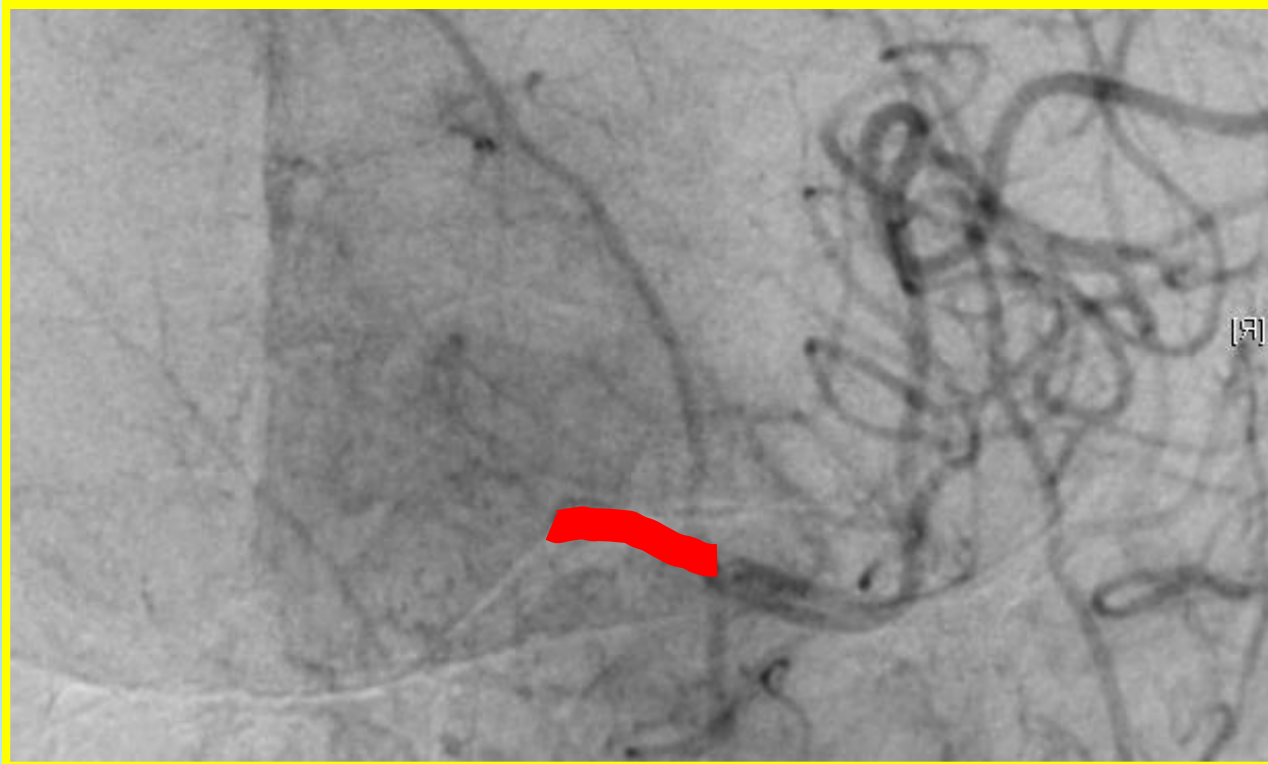
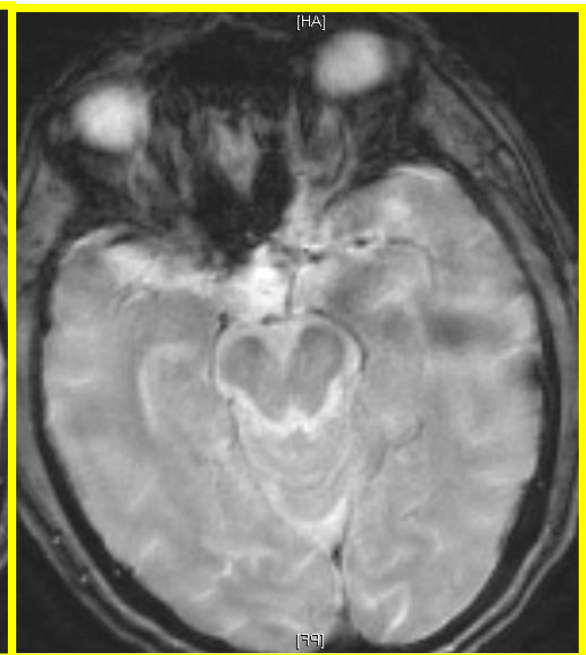
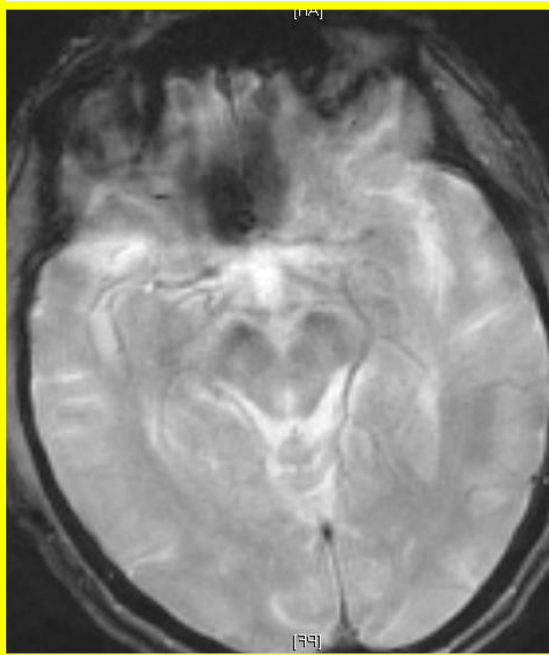
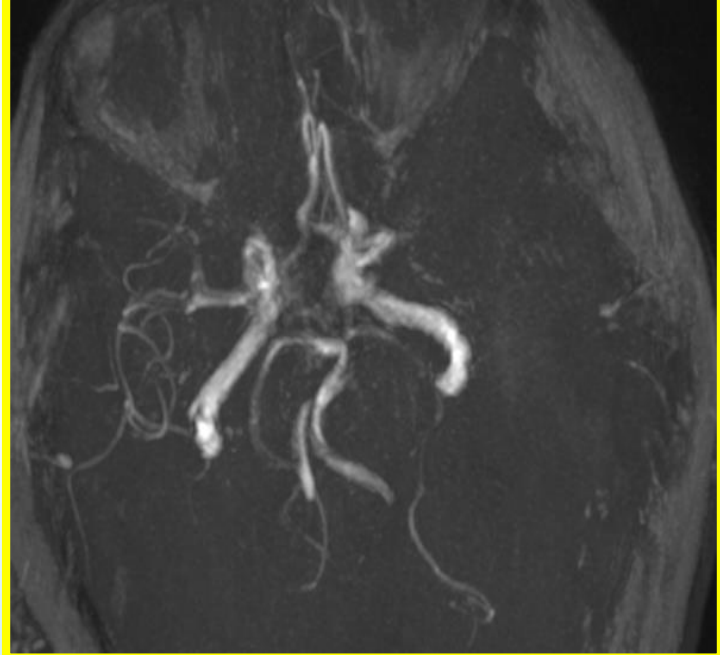


## Taille du caillot

⇒ Navigation ?

⇒ Choix du matériel

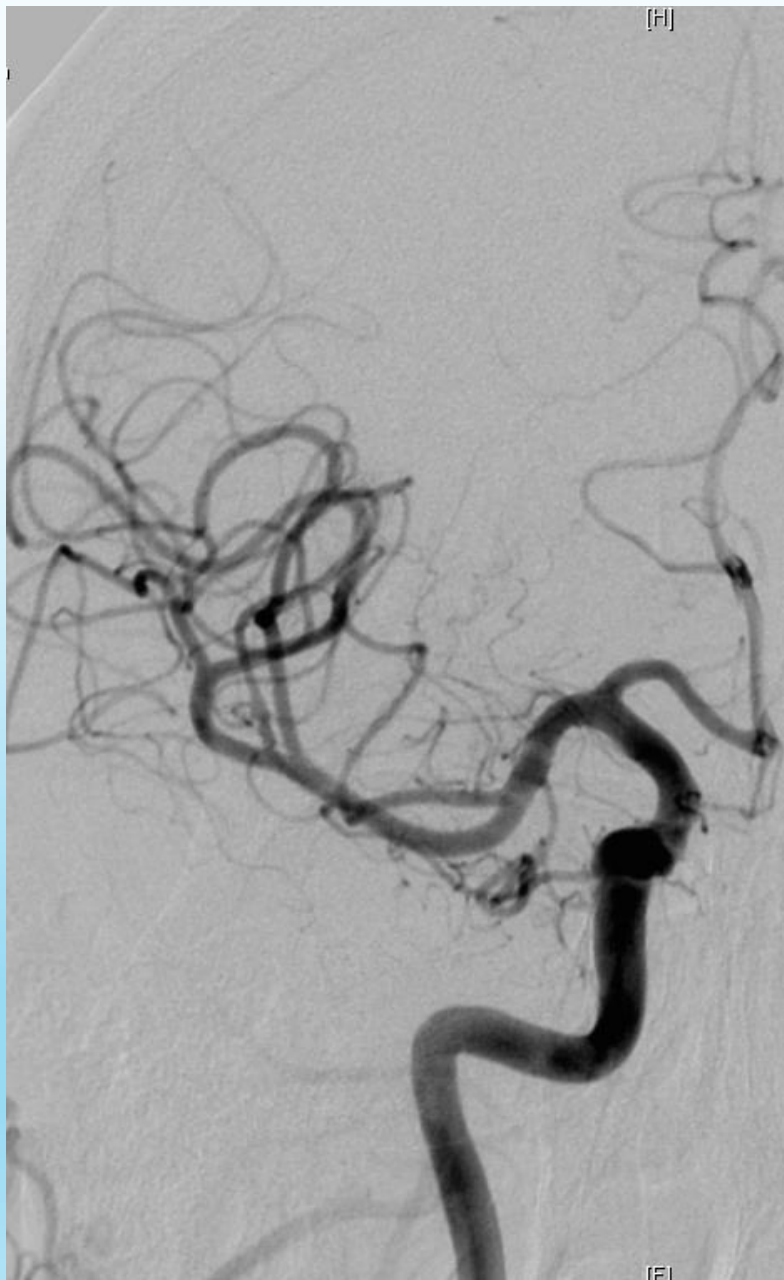




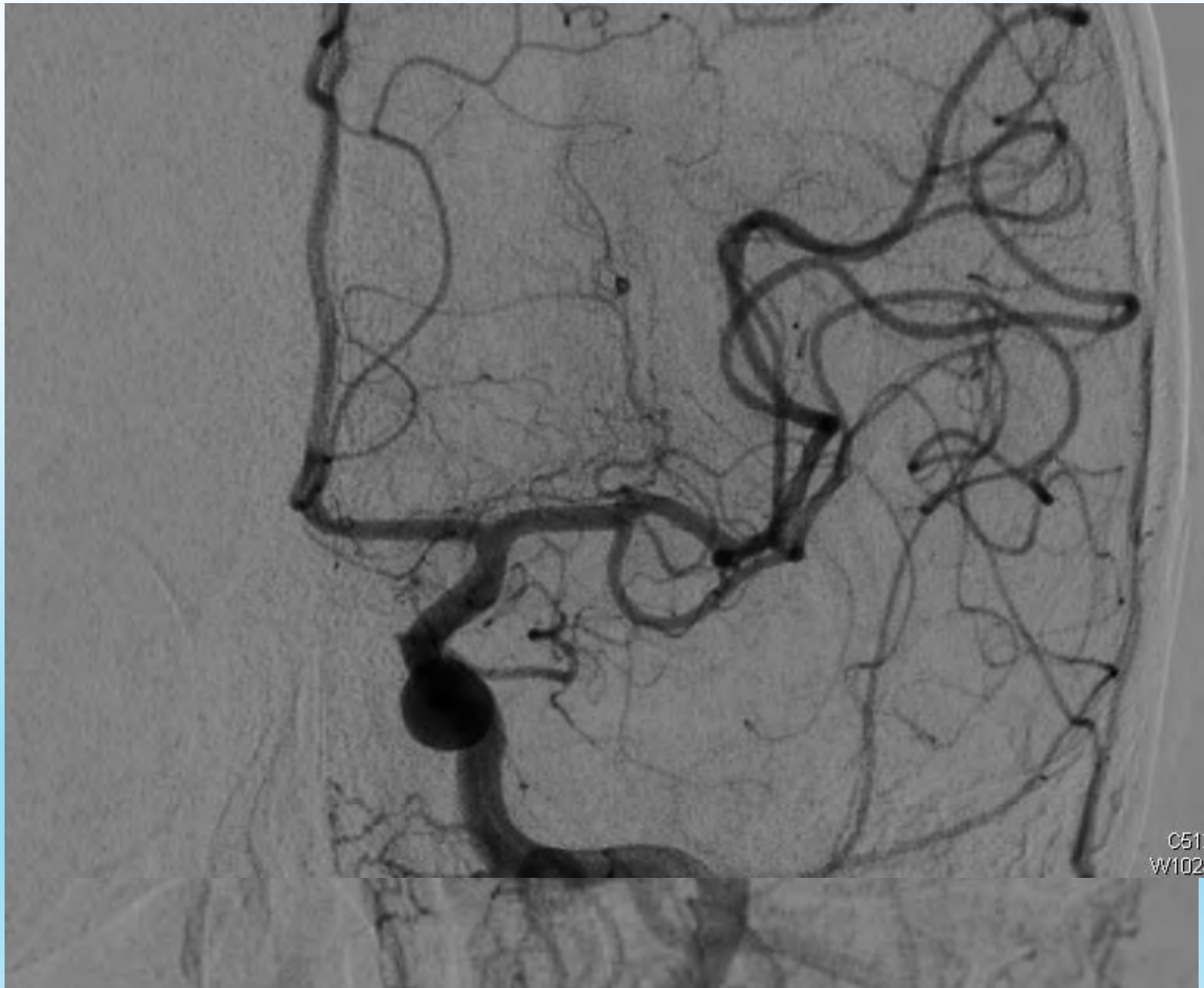
Etendue du caillot



# Variantes anatomiques ?



## Variante anatomique



05 0 0044



**ORIGINAL  
RESEARCH**

## **Systematic Review of Methods for Assessing Leptomeningeal Collateral Flow**

F. McVerry  
D.S. Liebeskind  
K.W. Muir

**BACKGROUND AND PURPOSE:** The importance of LMF in the outcome after acute ischemic stroke is increasingly recognized, but imaging presents a wide range of options for identification of collaterals and there is no single system for grading collateral flow. The aim of this study was to systematically review the literature on the available methods for measuring LMF adequacy.

**RESULTS:** We found 81 publications describing 63 methods for grading collateral flow on the basis of conventional angiography ( $n = 41$ ), CT ( $n = 7$ ), MR imaging ( $n = 9$ ), and transcranial Doppler ( $n = 6$ ). Inter- and/or intraobserver agreement was assessed in only 8 publications.

conventional angiography ( $n = 41$ ), CT ( $n = 7$ ), MR imaging ( $n = 9$ ), and transcranial Doppler ( $n = 6$ ). Inter- and/or intraobserver agreement was assessed in only 8 publications.

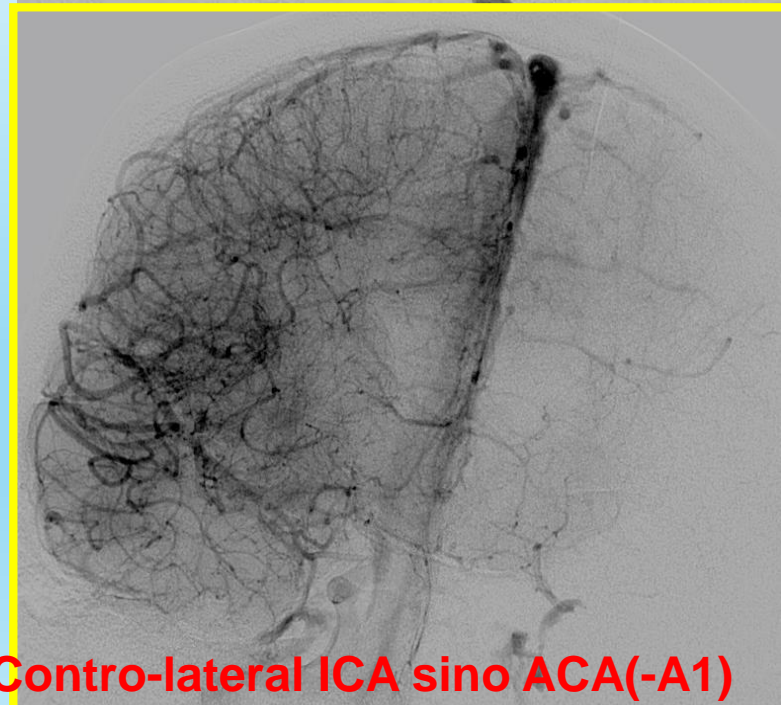
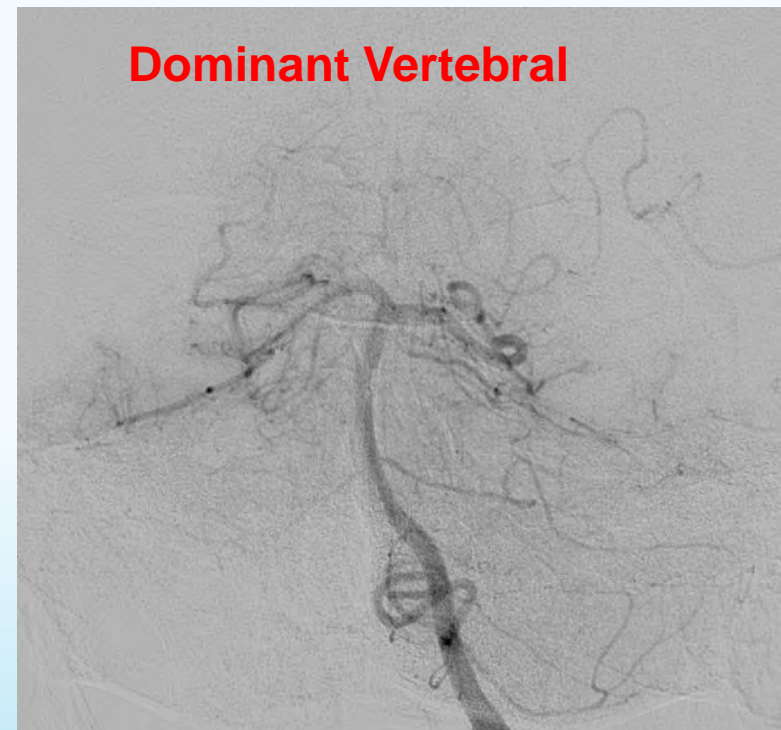
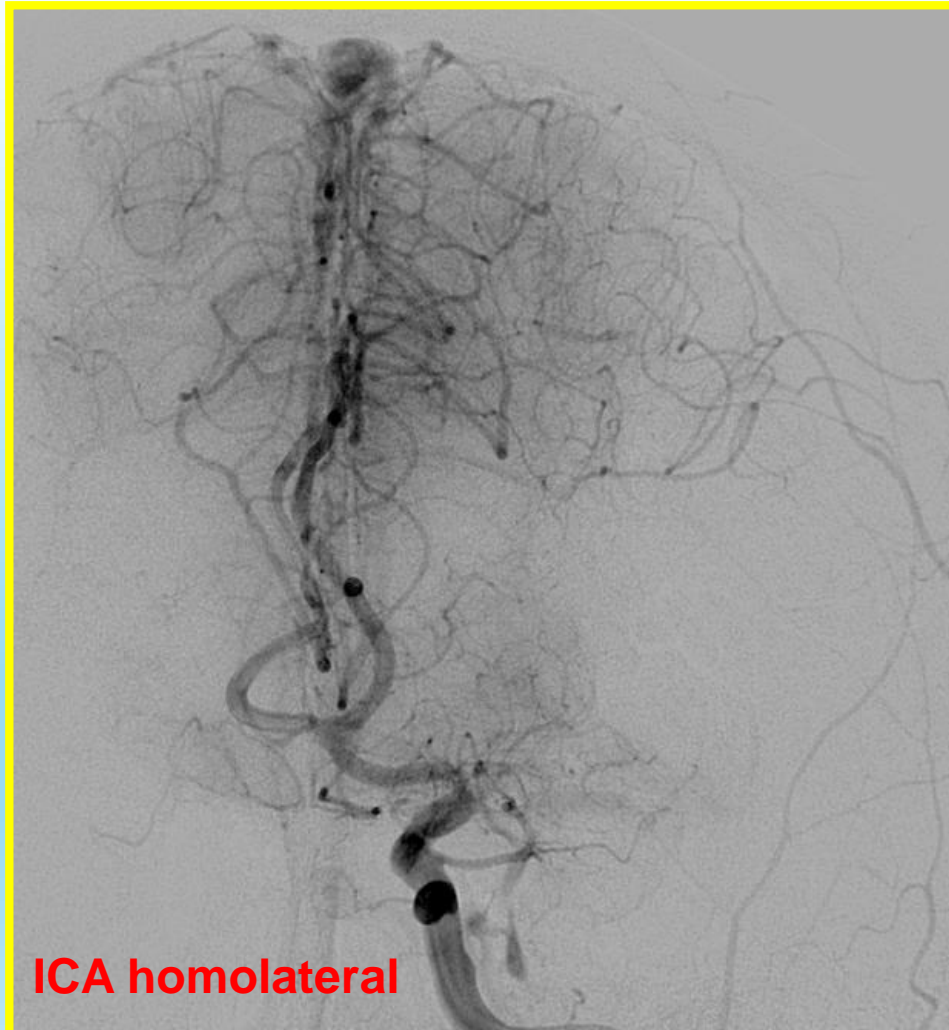
**CONCLUSIONS:** There is inconsistency in how LMF is graded, with a variety of grading scales and imaging modalities being used. Consistency in evaluating collateral flow at baseline is required for the impact of collateral flow to be fully appreciated.



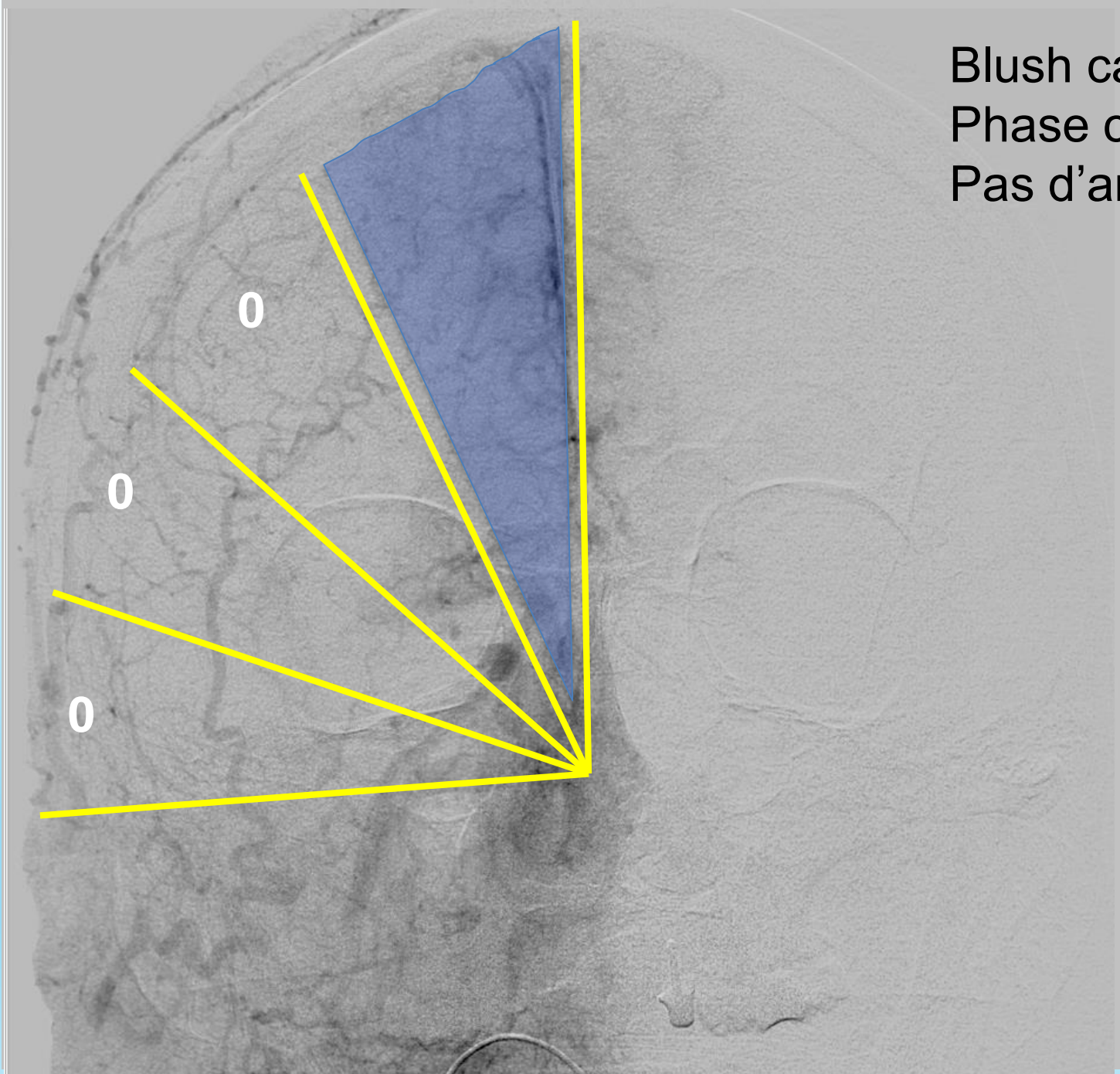
ORIGINAL RESEARCH

## The Capillary Index Score before thrombectomy: an angiographic correlate of favorable outcome

Paul-Emile Labeyrie,<sup>1</sup> Hocine Redjem,<sup>1</sup> Raphaël Blanc,<sup>1</sup> Marc-Antoine Labeyrie,<sup>2</sup>  
Bruno Bartolini,<sup>1</sup> Gabriele Ciccio,<sup>1</sup> Thomas Robert,<sup>1</sup> Boaz Gilboa,<sup>1</sup> Robert Fahed,<sup>1</sup>  
Marie Abrivard,<sup>1</sup> Michel Piotin<sup>1</sup>

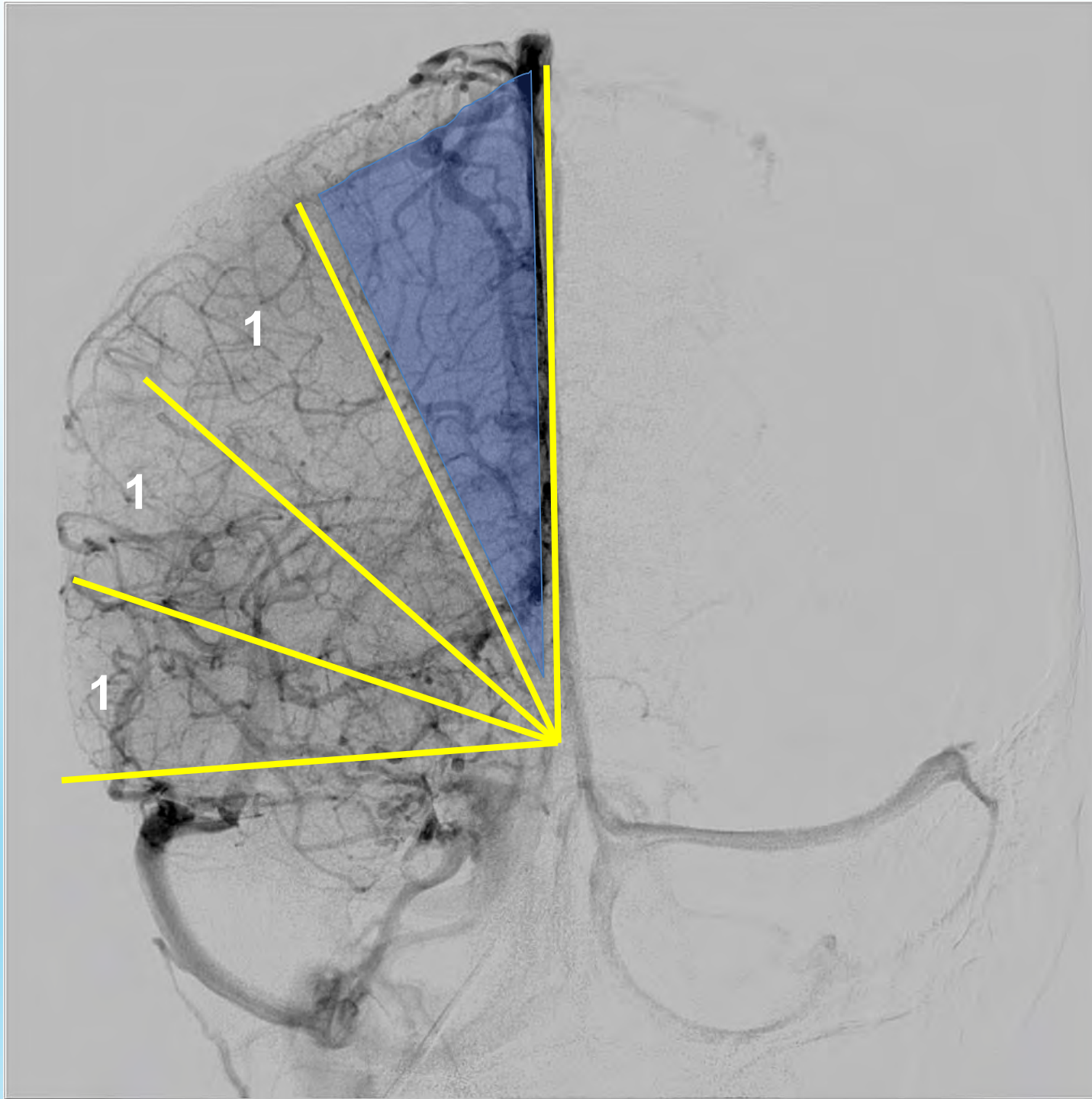


Blush capillaire +++  
Phase capillaire  
Pas d'artère

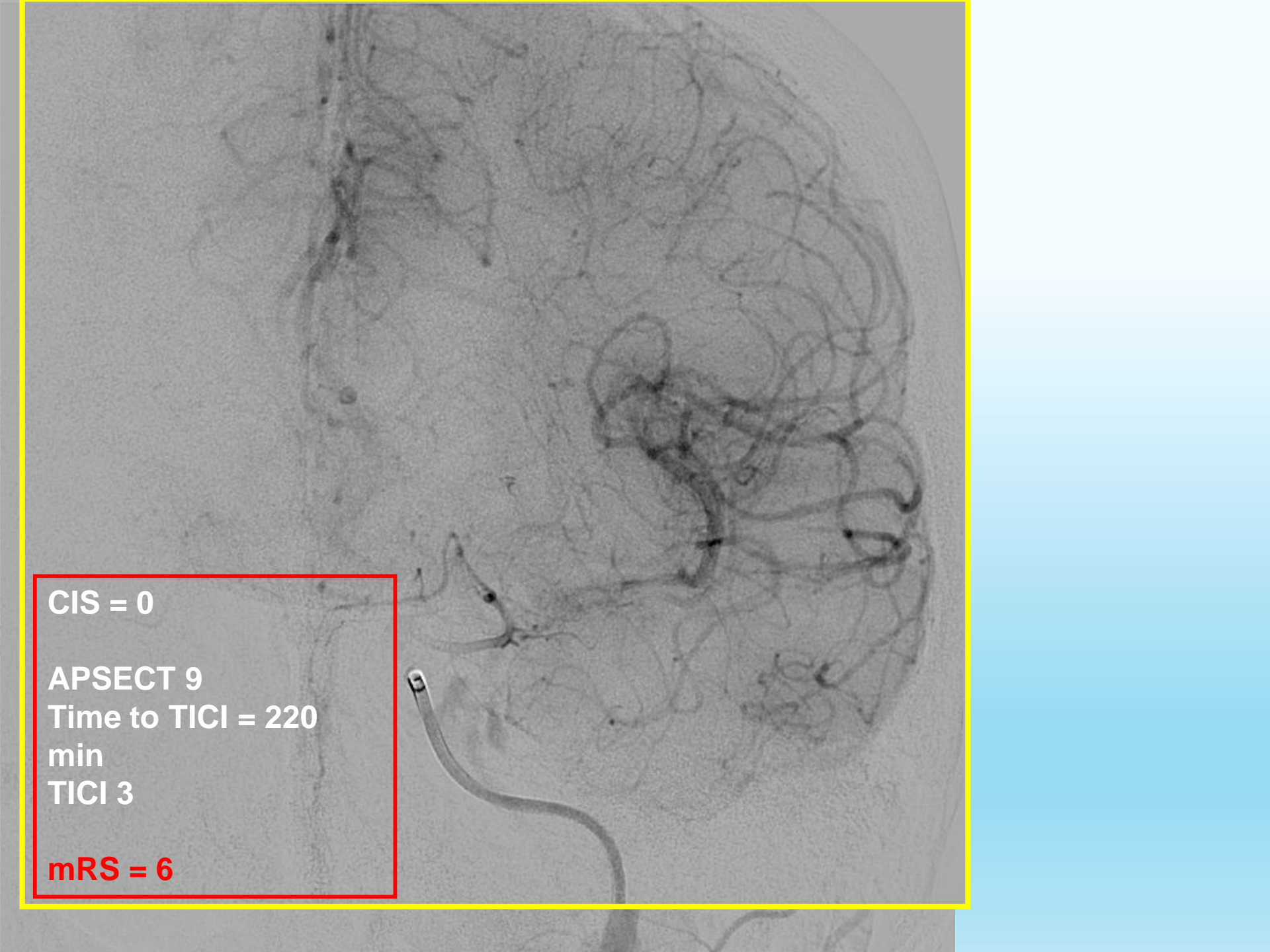


CIS = 0

CIS = 3







CIS = 0

APSECT 9

Time to TICI = 220  
min

TICI 3

**mRS = 6**

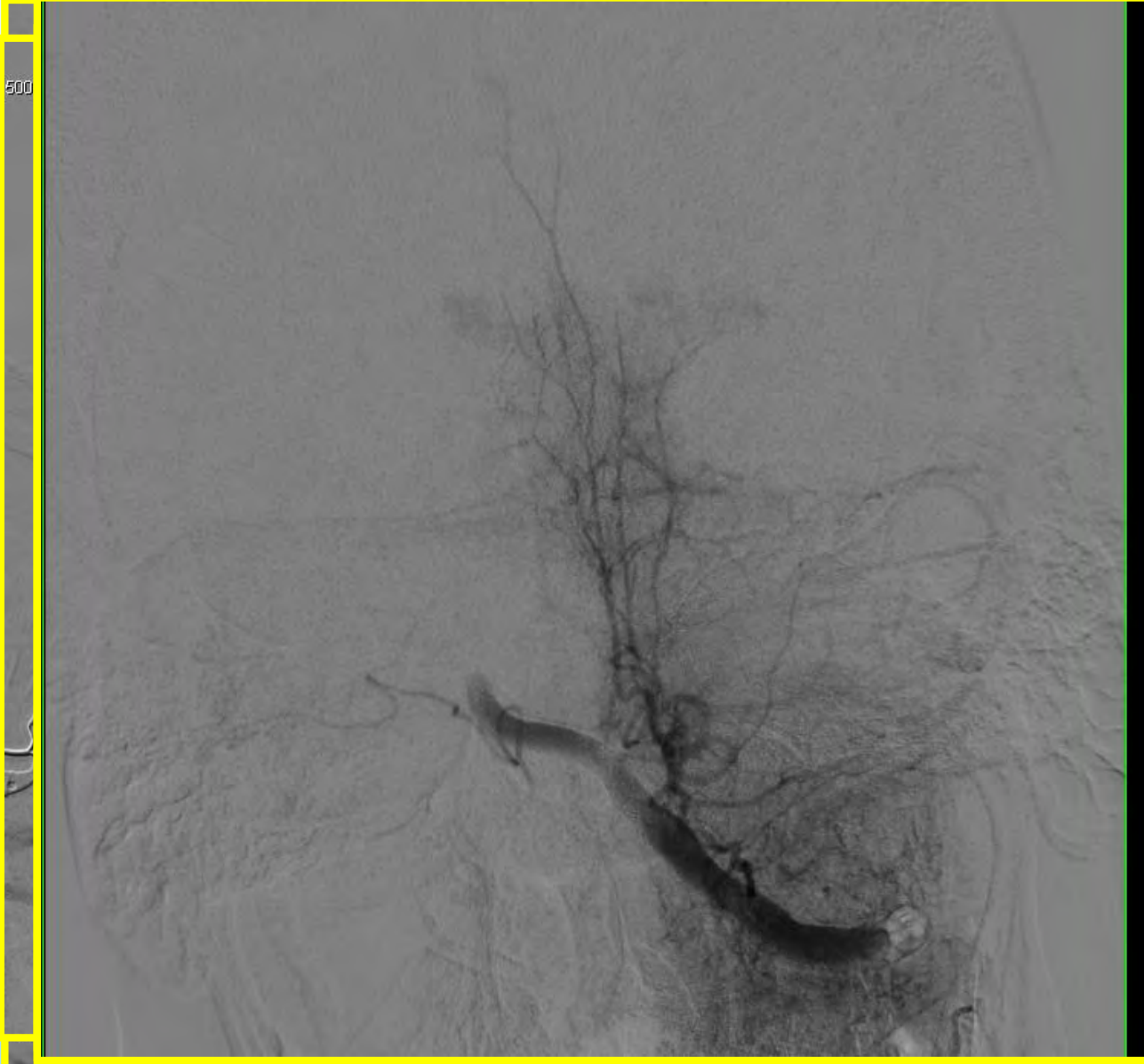


# BILAN COMPLET SI TRONC BASILAIRE

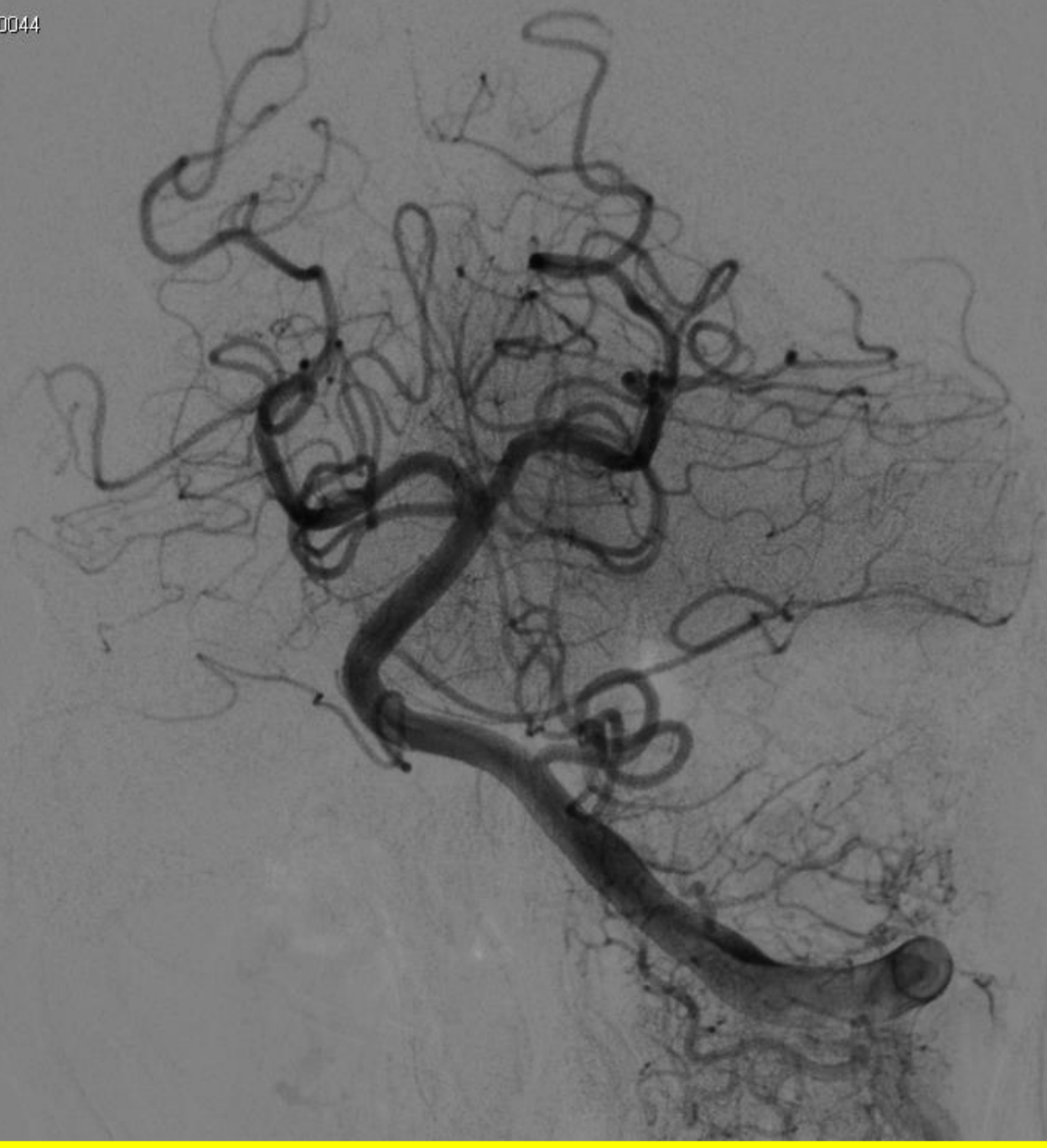


Coma brutal

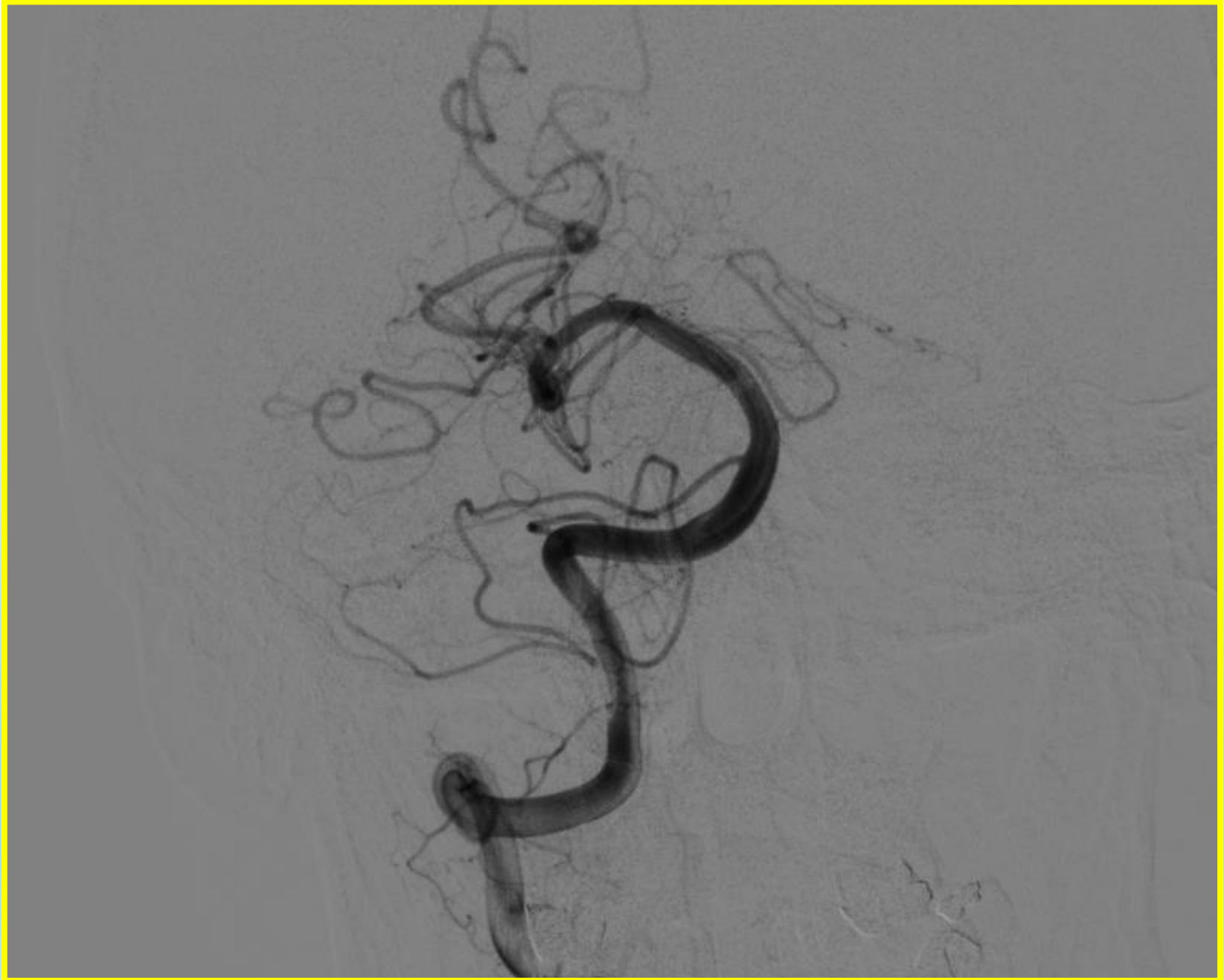
Tronc basilaire = > cervical + Willis



CCD + CCG + VD + VG



agénésie PI gauche





Aortographie

