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Expanding Single-Session ALI Thrombectomy at a High-Volume Center

A conversation with Dr. John Irish.

Interventional radiologist Dr. John Irish and his colleagues at Central Illinois Radiological Associates (CIRA) are the primary providers of acute limb salvage for the OSF St. Francis Medical Center in Peoria, Illinois. The tertiary care facility receives patients from a vast, largely rural catchment area whose radius reaches as far as Rockford, Illinois—135 miles north—and the Quad Cities of Illinois and Iowa, with occasional transfers from Missouri. Dr. Irish describes the severity and volume of limb ischemia cases at St. Francis Medical Center as “tremendous”—a situation exacerbated, he says, by the closing of rural hospitals in the region and a shortage of vascular surgeons in outlying areas. “There are quite a few folks that travel hours and hours” for care at the facility, he says. “Many of these patients just deal with their claudication until they throw a clot.”

Over the past year, Dr. Irish has used the Pounce™ Thrombectomy System (Surmodics, Inc.) to help restore limb flow for a growing share of his acute limb ischemia (ALI) patients. We spoke with Dr. Irish about why and how he uses the Pounce™ System.

You’ve been using the Pounce™ Thrombectomy System for nearly 1 year. Where does it fit into your toolkit?

For me, the sweet spot for this device is a patient who comes in with pre-existing peripheral artery disease and has an acute-on-chronic thrombus in a relatively short segment. We see a lot of these patients. Their clots are typically not soft and fresh but have a chronic component. These are Rutherford class 2a or early 2b patients, often with atrial fibrillation (AFib) issues.

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Using the Pounce™ System, we’ve had outstanding results removing emboli and getting improved flow down to the legs, often obviating the need for thrombolytic infusion and its associated risks and expense. If it’s hyperacute thrombus, that’s typically soft clot, and then we may change up the plan based on the total volume of thrombus. For a smaller volume of clot, we’ve had great results with the Pounce™ System, sometimes with aspiration for below-the-knee emboli. When the entire femoropopliteal segment is acutely occluded, these patients are often still getting overnight lysis.

Can you estimate how often you use the Pounce™ System in comparison with other approaches to ALI?

I would estimate we are using the Pounce™ System about 40% to 50% of the time as the first device off the shelf. At this point, surgical declotting has become fairly uncommon—maybe 5% to 10% of our cases. We are getting the first call for most of these cases. We have a great relationship with our vascular surgery partners. I was up most of the prior night for a ruptured abdominal aortic aneurysm that we repaired in combination. It’s a great collaborative environment; we can work without the turf issues you see elsewhere.

Other than that, we still use lysis as the primary approach for around 40% to 50% of cases. The rest I’m trying to do in a

DISRUPTING PERIPHERAL ARTERIAL THROMBECTOMY

The Impact of the Pounce™ Thrombectomy System: A Multispecialty Perspective.

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single session, pulling a Pounce™ device with perhaps a little suction involved.

How were you dealing with peripheral arterial clots prior to your use of the Pounce™ System?

When I joined CIRA in the summer of 2022, lysis was our predominant approach, with suction thrombectomy used occasionally. With suction, we found we often couldn’t clear out enough clot in those patients I described with AFib type material, something that’s a little more chronic. The Pounce™ System has been very helpful in this respect. In my experience, it will often just drag out most of the clot in a single pass. At that point, the segment is more or less clear, although we may choose to do a little suction afterward to clean it up. Then, we balloon, stent, perform atherectomy, or do whatever else we need to do.

Has the availability of the Pounce™ System impacted your use of thrombolytics?

I’ve reduced my lysis volume significantly—I’d say by half or even more. We still use it occasionally, especially for long lines of fresh clot. But, if you can avoid using lysis and take care of

the clot in a single session, that’s a tremendous advantage. We have a huge volume of cases, so reducing the number of patients coming back to our rooms after lysis is important.

There are also a lot of advantages for patients in avoiding lysis. Not just the expense. It’s safer for them, entails fewer procedures, and there’s less chance of catheters getting dislodged, bleeding, infection, access site problems, things like that.¹

The hospital is also dealing with a chronic shortage of beds—intensive care unit beds are precious. Eliminating the need to monitor people on lysis not only frees up a bed, it’s easier on nursing resources. COVID contributed to a lot of burnout—people working long hours, sick patients, people dying. We’re well-staffed here and have a great crew, but globally there are still staffing shortages. Some hospitals are still paying a lot of extra money to secure nurses. It’s probably better than it was 2 years ago, but it’s not where it needs to be. ■

1. Ebben HP, Jongkind V, Wisselink W, et al. Catheter directed thrombolysis protocols for peripheral arterial occlusions: a systematic review. *Eur Vasc Endovasc Surg.* 2019;57:667-675. doi: 10.1016/j.ejvs.2018.11.018



John Irish, MD

Interventional Radiologist
Central Illinois Radiological Associates
OSF St. Francis Medical Center
Peoria, Illinois

Disclosures: None.

Caution: Federal (US) law restricts the Pounce™ Thrombectomy System to sale by or on the order of a physician. Please refer to the product’s Instructions for Use for indications, contraindications, warnings, and precautions. SURMODICS, POUNCE, and SURMODICS and POUNCE logos are trademarks of Surmodics, Inc. and/or its affiliates. Third-party trademarks are the property of their respective owners.