SCEPTER MINI
INITIAL EXPERIENCE IN MAN

JASON WENDEROTH
PRINCE OF WALES AND LIVERPOOL HOSPITALS
SYDNEY, AUSTRALIA
JWENDEROTH@SNIS.COM.AU
Two cases of DAVF with challenging access
61 F – Cognard III, incidental
Final
42 F – Cognard III posterior fossa DAVF
Access
Revert to Scepter C
Revert to Scepter C
DEVICE – CAVEATS, DIFFERENCES AND LIMITATIONS

• Pros:
  • Soft, atraumatic
  • Flexible
  • Access to small, distal vessels
  • Potential for double-balloon, single intermediate cases
DEVICE – CAVEATS, DIFFERENCES AND LIMITATIONS

• Cons:
  • ↓stability/pushability
  • Loss of “convergence”/“divergent” tech
  • 0.007” wire – ↓torque/steer
  • Limit to distal access of wire beyond balloon
  • Can’t “pinch prep”
DEVELOP – CAVEATS, DIFFERENCES AND LIMITATIONS

• Caveats:
  • Preparation – care with handling; fragile; cannot “pinch-prep”.
  • Low volume device – care with inflation
  • Very short “nose” with no marker (unlike Scetper C/XC)
  • Can only lead with 6cm wire due to taper in 0.007” wires
  • Connecting syringes, turning stopcock can inflate balloon because of its low volume
THOUGHTS

• Interesting device – not a panacea
• Potential for use in distal pial circulation or straight-shot dural
• Limitation in more abrupt kinks and curves in dural circulation
  • Need to be able to lead >6cm of wire for stability
• ?Role for intermediate (0.010”) device