

Case Summary. The SFA antegrade approach for treating the multi-level lesions of peripheral artery disease always runs the risk of missing lesions. Moreover, the vessel access increases the chances of making the puncture site become stenotic. Despite this, the iatrogenic iliac artery dissection can be resolved easily by the metallic stent. We need to observe any of the patient's peri-operational symptoms carefully. Furthermore, the angiosome concept is very useful for treating multilevel and multi vessel peripheral artery disease especially in a patient with heart failure and renal insufficiency. For this kind of patient, we need to try our best to shorten the operation time and reduce the contrast amount.

TCTAP C-225

Complete Revascularization by Endovascular Treatment for CLI Patient After ALI



Naoki Hayakawa¹

¹Asahi General Hospital, Japan

[CLINICAL INFORMATION]

Patient initials or identifier number. I T

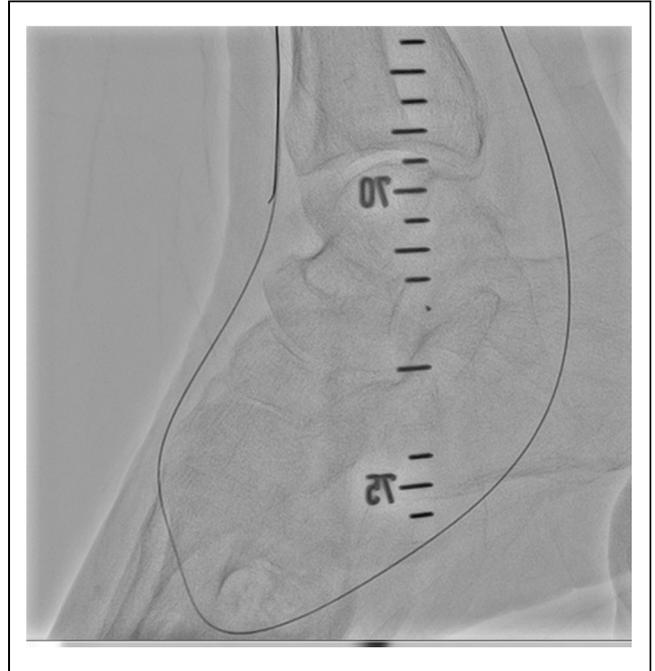
Relevant clinical history and physical exam. A 62 years old-male was referred for rest pain and pale of his right lower limbs. He felt rest pain of his right leg from two days ago. His peripheral arteries were not palpable from right popliteal artery. So he was introduced to our vascular surgery department.

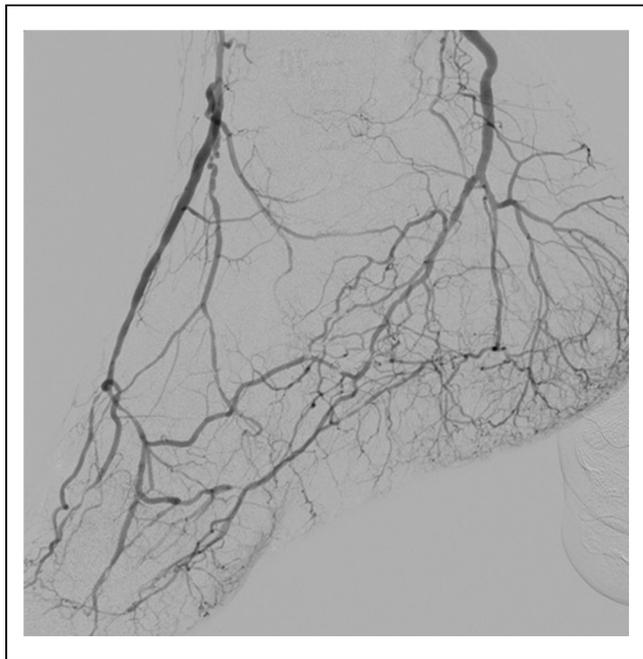
Relevant test results prior to catheterization. ECG showed sinus rhythm and UCG showed there were no thrombus in the left atrium. The enhanced CT showed total occlusion from his right popliteal artery. And there were atherosclerotic change in his BTK lesions. So it seemed to be acute occlusion of his right popliteal artery based on ASO. At first vascular surgeon tried to treat by Fogarty catheter. They could remove the thrombus, however his symptom got worse maybe because they didn't treat BTK lesion. So we decided to treat him by EVT.

Relevant catheterization findings. We started from left femoral approach, and control angiography showed a total occlusion from his right SFA ostium. Using Command wire with IVUScatheter, we could pass the lesion from SFA to PTA. IVUS showed a large amount of thrombus in his SFA to popliteal artery. After the aspiration we performed ballooning from BTK to SFA. Finally, we deployed two SMART stent in his SFA, and performed catheter thrombolysis. 2 days after the angiography showed the thrombus was almost disappeared.

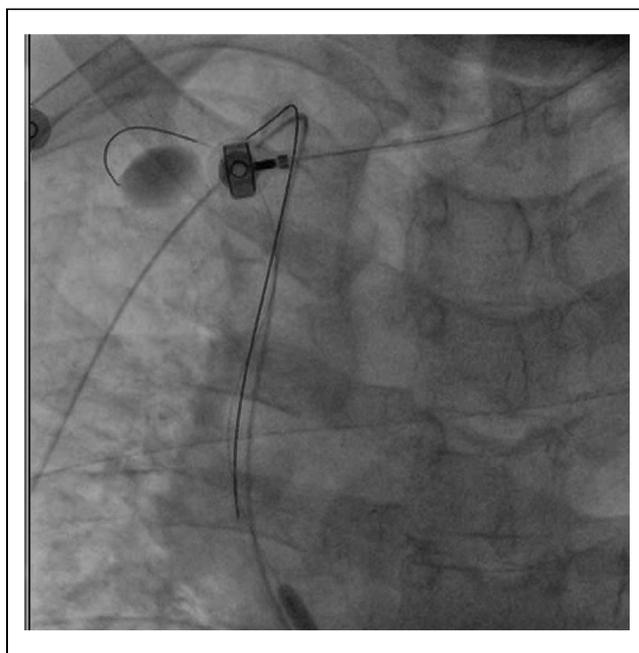
[INTERVENTIONAL MANAGEMENT]

Procedural step. His right leg was salvaged. However, 3 months after, large wound of his right leg was appeared and not healed, so we decided to perform the EVT for BTK lesions. We performed ipsilateral antegrade approach, and control angiography showed total occlusion of ATA and PTA. At first we tried to PTA CTO. We could choice PTA by Chevalier floppy wire with Prominent micro catheter. However, antegrade wire was advanced into subintimal space. We started retrograde approach, performing PTA puncture. After that we could achieve wire rendez-vous technique and could pass the lesion. We could get sufficient antegrade flow in his PTA. Next in the ATA, we suffered to advance the CTO lesion because the CTO was abrupt type from ostium. We used Astato XS9-12 with bending the tip and could penetrate. We advanced the antegrade wire with parallel wire technique but couldn't reach the distal true lumen. So we perform the retrograde approach by trans-pedal approach from PTA to plantar artery to dorsal artery. We used the Chevalier floppy wire with Prominent BTA micro-catheter and could reach the antegrade wire. Finally we could pass the lesion by kissing wire technique. We performed the long inflation by Cross perio 2.5/200 mm, we could get almost complete revascularization in his BTK. After the procedure, SPP was elevated dramatically.





balloon anchored between the narrowing SVC and Denver catheter, and a Miracle 3 guide wire advanced to cross the occluded segment of the Denver catheter, distal injection through the 1.5 x 20 mm over-the-wire balloon confirmed the distal occlusion of the Denver catheter. Subsequently, in addition to sequential intra-catheter balloon dilations, the inner lumen was evacuated by pulling back an inflated 4.0 x 20 mm balloon. The contrast injection via the tip of the Denver catheter revealed a fast flow and confirmed the patency of the inner lumen. After this, the critical stenosis of the SVC and in nominate veins dilated with 12 x 40 mm and 14 x 40 mm balloons sequentially, which finally lead to full luminal expansion with less than 20% residual stenosis.



Case Summary. Generally ALI should be treated by surgical treatment using Fogarty catheter. However, there are some cases when EVT is suitable due to including BTK lesions. In addition, we sometimes experience the case that is needed additional EVT for BTK and BTA lesion for CLI patient. In this case, we experienced almost complete revascularization for CLI patient after ALI. Additionally, most important thing is all procedure from ALI to CLI performed by only endovascular treatment.

TCTAP C-226

PTA is Limitless - A Cirrhosis Patient Suffered From Severe Ascites Due to Denver Shunt Obstruction and Accompanied with Superior Vena Cava Syndrome



Chih-Hung Lai,¹ Chieh-Shou Su,¹ Chi-Yao Huang¹
¹Taichung Veterans General Hospital, Taiwan

[CLINICAL INFORMATION]

Patient initials or identifier number. 001xx04xxA Mr. Lin

Relevant clinical history and physical exam. Mr. L, a 50-year-old male patient has past history of alcoholic liver cirrhosis in stage C (Child-Pugh classification). He received a peritoneovenous shunt (Denver shunt) for refractory ascites for 4 years. In recent 4 months, he suffered from progressive swelling of the face and bilateral upper arms, dyspnea on exertion, and increasing girth of waist. The chest CT scan revealed a huge thrombus that caused complete obstruction of SVC and Denver shunt. However, anticoagulation therapy failed.

Relevant test results prior to catheterization. The contrast-enhanced chest computed tomography revealed that a huge thrombus had caused complete obstruction of the superior vena cava, which also involved the tip of the Denver catheter; the result was the malfunction of the peritoneovenous shunt and blood drainage of the upper venous system through the azygous and collateral veins. With the diagnosis of SVC syndrome.

Relevant catheterization findings.

[INTERVENTIONAL MANAGEMENT]:

Procedural step. An approach from right femoral vein with Jukins Right 4/6Fr guiding catheter and it advanced to the proximal site of the lesion. The lesion successfully crossed by a Miracle 6 guide wire (AsahiIntecc, Aichi, Japan) supported by a 1.25 x 20 mm over-the-wire balloon catheter, and the lesion site was dilated by using a 4.0 x 20 mm balloon catheter. After dilation, an infusion catheter as Fountain was implanted. Thrombolytic therapy through the Fountain.

Two days later, the follow-up venography revealed some residual unresolved. Initially, in order to fix the Denver catheter, a 4.0 x 20 mm

