

Not a dying art! Transcatheter therapy can still be a valuable bailout to circumvent gangrene and limb loss. Meticulous attention to be paid to bleeding during overnight thrombolysis- CNS/ Groin puncture site/oral bleed/ haematoma, ooze at dissected segments during wire transversal.

Gp2b3a inhibitors and heparin need to be given in weight-adjusted dosages to prevent systemic bleeding complications.

#### TCTAP C-204

##### Complication Leads Simple to Complicated Procedure

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##### [Clinical Information]

##### Patient initials or identifier number:

SKM 91004476

##### Relevant clinical history and physical exam:

C/C: Lt claudication for 1 year

ABI 0.88/0.53

Past Hx: CVA, CRF, HBP

##### Relevant test results prior to catheterization:

MRA: Rt EIA Tight stenosis, Lt EIA CTO

##### Relevant catheterization findings:

Rt EIA stenosis with Tortuous artery and Lt EIA CTO from Internal iliac bifurcation and Collateral flow to CFA

##### [Interventional Management]

##### Procedural step:

Our primary target was Lt iliac artery CTO but during vascular approach, Guide wire made Rt EIA dissection at tortuous and most stenotic lesion.

And then we cannot pass any wire through the EIA. We struggled for 30 minutes to wire the vessel but we failed.

So we Punctured Lt Brachial artery for antegrade wiring and successfully cross the dissected lesion.

After balloon angioplasty and stenting, we achieved nice distal flow.

And then we can move to our target lesion, Lt EIA CTO.

We already punctured the Lt brachial artery so we decided to do antegrade approach. Lt EIA proximal CTO cap was very hard but we can pass the wire but failed to reenter the true lumen. We punctured the Lt Common femoral artery by micro puncture set and introduce Glide wire to cross the lesion retrograde. Fortunately wire meets the antegrade catheter.

We deployed single self expanding nitinol stent but CFA was still remains luminal narrowing. The Lt CFA was tricky. It was ecstatic artery and abrupt dilation after stenosis.

We applied another Self expanding nitinol stent and achieved better blood flow and minimal pressure gradient through the lesion.

##### Massage:

Sometimes, Simple looking procedure becomes complicated and disaster. Such Rt iliac stenosis, Experts instinctually knows its hazard but beginners frequently ignore the risk of dissection and push the wire without concern.

This case is quiet educating for young interventionist and also experts who are starting PTAs.

Devices: Brachial Guiding sheath: Contra IG 8Fr 95cm.

Lt: Admiral balloon 7\*60mm

Smart stent 9\*60mm

Smart stent 8\*60mm

Rt: P3 balloon 5\*80mm, P3 8\*60mm

Smart stent 8\*80mm

Complete stent 8\*60mm



##### Case Summary:

1. Primary target -Lt iliac artery CTO, Vascular approach Rt Femoral artery crossover
2. 0.035 Terumo Glide wire made Rt EIA dissection
3. Secondary vascular approach- Lt Brachial artery, 5Fr MP cath. with 0.014 Runthrough wire
4. Rt EIA - Balloon angioplasty by Cordis P3 5\*80mm
5. Rt EIA -Stenting by Smart stent 8\*80mm, Complete stent 8\*60mm
6. Lt EIA CTO antegrade wiring by 0.035 Terumo Glide wire from Lt brachial artery - Fail (Brachial Guiding sheath: Contra IG 8Fr 95cm)
7. Lt Femoral artery punctured by Micropuncture set (Cook) and retrograde wiring by 0.035 Terumo Glide wire
8. Balloon angioplasty by Admiral balloon 7\*60mm
9. Stenting by Smart stent 9\*60mm, Smart stent 8\*60mm

#### TCTAP C-205

##### Stenting of Spontaneous Dissection of the Superior Mesenteric Artery

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China Medical University Hospital, Taiwan

##### [Clinical Information]

##### Patient initials or identifier number:

ZRM

