Case Summary. We performed endovascular treatment using NBCA-LPD for type 2 endoleak after EVAR without any complications. Embolization with NBCA by a transarterial approach for type 2 endoleak appears technically feasible and clinically effective when coil embolization is difficult.

**TCTAP C-190**
**Endovascular Repair of Abdominal Aortic Aneurysm Combined with Huge Bilateral Iliac Arterial Aneurysms with Custom-Made Branched Stent Graft**
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1Gachon University Gil Hospital, Korea (Republic of)

[**CLINICAL INFORMATION**]
Patient initials or identifier number. 29337463
Relevant clinical history and physical exam. A 73-year-old man came to our hospital for evaluation of pulsatile abdominal mass. He was a smoker but denied history of hypertension or diabetes mellitus. Two years ago, he underwent stenting at left anterior descending artery for myocardial infarction. Afterward, he has been doing well.

Relevant test results prior to catheterization. Computed tomography showed fusiform aneurysmal dilatation in infra-renal abdominal aorta (60 mm in maximal diameter) and both iliac arteries (Fig. 1A-C). The size of right and left CIA was 45 mm, 44 mm in maximal diameter, respectively. Because AAA was combined with huge both CIA aneurysm, we decided to perform EVAR with branched iliac bifurcated stent graft than other techniques such as the bell bottom, snorkel or extra-anatomic bypass procedures.

[**INTERVENTIONAL MANAGEMENT**]
Procedural step. Initially, a custom-made 15-Fr delivery left internal iliac branched device (IIBD, SEAL Bifurcated stent graft, 12 x 100 mm, S&G Biotech, Seoul, Korea) was introduced in left femoral artery (FA) under fluoroscopic guidance. Afterward, a 0.035-inch guidewire was inserted through the branched limb under fluoroscopic guidance from the right FA. Prior to implantation of internal iliac stent graft (IISG, SEAL Branched limb extension, 12 x 80 mm, S&G biotech, Seoul, Korea), side branches of left internal iliac artery (IIA) was embolized by coil (Tornado® Embolization Coil, 5 x 2 mm, 6 x 2 mm, COOK Medical, Bloomington, IN). Through a stiff guidewire, an 8-Fr internal iliac stent graft was deployed in the left IIA. With the same technique, a custom-made 15-Fr delivery right IIBD was then placed from the right FA and IISG from the left FA. Afterward, conventional EVAR was performed in AAA. The final aortography showed abdominal aortic and both iliac arterial aneurysms were successfully excluded without any endoleak (Fig. 2A). Procedure time was 310 minutes and dose of contrast dye was 350 ml. Follow-up computed tomography after 1 week showed good patency in all stent grafts without evidence of endoleak (Fig. 2B-D). The patient was discharged without complications.
Case Summary. This case demonstrated that endovascular repair with custom-made IBD might be performed effectively and safely in selected cases of AAA combined with aneurysm of CIA. However, it remains critical to conduct further investigations to evaluate long-term safety and efficacy of this device.

TCTAP C-191
Successful Endovascular Therapy of Severe Calcified Lesion in Coronary Artery Disease and Peripheral Artery Disease
Hayato Ohtani1
1Seirei Mikatahara General Hospital, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. T.S
Relevant clinical history and physical exam. A 84-years-old women with diabetes had come to our hospital, and complained with intermittent claudication. The ABI value was 0.44 at right and 0.37 at left side. Duplex scan showed bilateral superficial femoral artery occlusion, therefore were commend femoral-popliteal artery bypass surgery. However, she rejected bypass surgery and wanted to endovascular treatment.

Relevant test results prior to catheterization. Computed tomography revealed SFA occlusion with severe calcification.

Relevant catheterization findings. Angiography showed the long CTO with diffuse and severe calcification in superficial femoral artery. CAG showed severe stenosis at mid LAD and proximal RCA.