Case Summary. Generally, TEVAR is limited for use between the subclavian and celiac arteries because of the presence of branch vessel compromise. Therefore, we created a bare metal stent, which could be deployed more distally. This method is very useful for enlarging the true lumen in patients with aortic dissection and malperfusion.

**TCTAP C-199**

*A Valid Combination of Crosser and Rendezvous Technique in Critical Limb Ischemia by Multi-Level Obstruction Lesions*  
Shinji Tayama

1JCHO Kumamoto General Hospital, Japan

**[CLINICAL INFORMATION]**

Patient initials or identifier number. 904023

Relevant clinical history and physical exam. The case was 60’s years old female who had transferred to our facility due to hypotension during dialysis and intractable ulcer of her toe. She had a history of chronic renal failure and received hemodialysis for twelve years. From three weeks before admission, she was aware of the sensation and pain at rest in her left lower limb.

- **BMI**: 16.9
- **BP**: 105/60, PR regular, HS systolic murmur 3/VI, LF no rales, Ext edema-, cyanosis+, ulcer at the left third toe

Relevant test results prior to catheterization. CTR 0.65, a small amount of pleural effusion on the left

- **ECG**: Sinus 70bpm, NAD, CLBBB
- **UCG**: Reduced contraction and brightness of posterior wall, LVDd 40.3, EF 44%, IVS/PW 8.5/7.4, E/e' 20.16
- **ABI**: right 0.58, left 0.40
- **CAG**: 3VD, Seg.2 90%, LMCA 75%, Seg.6 75%, Seg.11 CTO

Relevant catheterization findings. Angiography revealed that left superficial femoral artery is occluded from proximal portion, in the state from the popliteal artery and lower leg trifurcation also occlusion, peripheral one-third of the posterior tibial artery and peroneal artery is the contrast by collateral circulation.
[INTERVENTIONAL MANAGEMENT]

Procedural step. I underwent ipsilateral antegrade puncture into the left femoral artery by duplex guide. Advances the Parent 6F-23cm sheath to DFA, I proceeded the Chevalier Tapered 15 guide wire to the SFA by a combination of 4F-90cm CXI curved. Check the SFA passed with the EagleEye intravascular ultrasound, I allowed to pass through the SFA stent with the knuckle wire method. When tip injection in the popliteal artery, PTA inlet was occluded ATA and PA was unknown. Development of collateral circulation revealed by the contrast.

The Cruise guidewire in combination with Prominent proceeded to PTA peripheral with TCA method. Then, the guide wire in the distal puncture proceeded from PTA peripheral to proximal, however did not pass through the lesion. Finally I carried out the “Crosser” from the ostial lesion of the CTO lesion of the PTA. Crosser did not proceed until the true lumen of the PTA peripheral, however I was able to successfully advance the wire with rendezvous technique. The below the knee lesion was dilated with 2.0x220mm balloon, and SFA lesion was done with 6.0x150mm balloon. It was confirmed that the blood flow has become TIMI3.

Case Summary. In case of intractable ulcer due to overlap obstruction of multi-level vessel, it is necessary to endovascular treatment of simultaneous. Combination of the new device named Crosser to complex procedures such as TCA and Rendezvous method is reported for a case success has been difficult if not.

TCTAP C-200
Successful Complete Embolization for Type II Endoleak from Lumber Arteries After EVAR
Junichi Tazaki,1 Takeshi Kimura1
1Kyoto University Hospital, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. 37633075
Relevant clinical history and physical exam. 64 years old male admitted to our hospital due to AAA enlargement after EVAR. He underwent EVAR