Case Summary:
Emergent stent graft was indicated for a thoracic aortic dissection due to renal ischemic and right pleural effusion (expanding rupture). 1st piece of tapered stent graft was successful deployed cover the entry tear from left subclavian. However, 1 month after 1st TEVAR, patient come back with a patent false lumen at the distal end of the previous stent graft. 2nd and 3rd pieces of TEVAR were used to cover entire thoracic until celiac artery, with good results. So, follow-up after a successful TVBEAR is critical to find late complications.

Covering “entire dissected thoracic aorta” (i.e. from left subclavian to celiac artery) is sometime necessary to avoid late complication despite of increasing risk of spinal cord ischemia in early phase after TEVAR.

TCTAP C-211
Successful EVAR for Zenith AAA Endovascular Graft Disruption
Keisuke Nishizawa, Hiroaki Higami, Iyunichi Tazaki, Takera Makiyama, Takeshi Kimura
Kyoto University Graduate School of Medicine, Japan

[Clinical Information]
Patient initials or identifier number: E.F.

Recent clinical history and physical exam:
81-year old woman who undergo endovascular aneurysm repair (EVAR) coil embolization for left internal iliac artery (IIA) using Zenith Flex AAA (TFB-24-103) for infrarenal type abdominal aortic aneurysm (AAA) was admitted for revisional stent of the stent graft trouble 5 years after index EVAR. That trouble was stent graft disruption and the reason of the trouble was enlargement of AAA.

Relevant test results prior to catheterization:
Computed tomography (CT) showed migration and disruption of Zenith AAA endovascular leg graft from main body and enlargement of the AAA.

[Interventional Management]
Procedural step:
The approach side was bilateral common femoral artery with skin incision. At first step, 0.035” angle wire and 5 french JR catheter were inserted from 6 french sheath by right femoral artery (This was leg disruption side) and the wire was success to cross the contralateral main body. Sizing of length using pigtail catheter with marker was performed and Excluder leg graft (GORE PXL161207) was selected for implantation among migrated Zenith leg and main body. As migration of primary Zenith leg was shown, Zenith leg (TFLE-24-39) was deployed for common iliac artery. Finally, endoleak was disappeared.

Case Summary:
This case is the Zenith AAA endovascular leg graft migration. We performed re-EVAR with Excluder and Zenith AAA endovascular graft. Type III endoleak was vanished after re-EVAR.

TCTAP C-212
A Case of Successful EVAR with Snorkel Technique for Juxtarenal Abdominal Aortic Aneurysm
Keisuke Okuno, Osamu Iida
Kansai Rosai Hospital Cardiovascular Center, Japan

[Clinical Information]
Patient initials or identifier number: S.O

Recent clinical history and physical exam:
A 66-year-old man complained of having a pulsatile mass with abdominal pain. His family doctor detected a large abdominal aortic aneurysm (AAA) and he was referred to our hospital.

Computed tomography angiogram revealed a 7cm juxtarenal AAA. A vascular surgeon could not perform surgical repair because of operating another patient, endovascular aneurysm repair (EVAR) was planned.

Relevant test results prior to catheterization:
Computed tomography angiogram revealed a 7cm juxtarenal AAA. Proximal neck was 8mm, extremely short for proximal landing. EVAR was planned using the “snorkel technique” to preserve both renal artery flow and to obtain an adequate sealing zone. Bilateral access routes were large enough for an 18Fr sheath, binary CIA was long enough for distal landing.

Relevant catheterization findings:
Initial angiogram revealed large juxtarenal AAA. The aortic neck was flared and short as had revealed by the CT angiogram.

[Interventional Management]
Procedural step:
The procedure was performed under local anesthesia with nerve block. Bilateral common femoral arteries were exposed via bilateral inguinal incisions. Two 5Fr 10cm Radiloc sheaths (Terumo) were inserted from the right brachial artery. A 5Fr pig tail catheter (Terumo) was inserted from the brachial artery, and an initial angiogram was obtained.

The aortic neck was flared and short as had been revealed by the CT angiogram. 8Fr long sheaths (Terumo) were placed into the bilateral common femoral artery with insertion of 0.035inch J-tip RADIFOCUS stiff wires (Terumo).

Bilateral renal artery was then selected with a 0.014-inch Aguru Support guide wire from the brachial arterial. The left-side 8Fr sheath was exchanged to an 18Fr sheath (Gore). A 26mm*180mm Excluder main body (Gore) was inserted from the left common femoral artery. Since proximal neck of AAA was tortuous, we deployed the main body inferior to the left renal artery.

The right-side 8Fr sheath was exchanged for a 12Fr sheath (Gore), and a 14.5mm*140mm contralateral leg was deployed. A 14.5mm*70mm iliac extender was added to the left external iliac artery without covering the internal iliac artery.

Via the brachial artery, a 5*18mm Palmaz genesis (Johnon & Johnson) was placed at the left renal artery and a 6*18mm Palmaz genesis (Johnson & Johnson) was placed at the right renal artery.

To seal the proximal neck of AAA, we need 4 Aortic extenders (Gore) implantation and the proximal aortic extender was deployed intentionally covering the left renal artery. Bilateral renal stent expansion and touch up for Aortic extender with Coda balloon (Cook) was performed at the same time.

Final angiogram revealed complete exclusion of the aneurysm. After intervention, the patient had no complications such as worsening of renal function or surgical site infection. One week after the procedure, CT angiography revealed no endoleak and bilateral renal artery were patent.

Case Summary:
A 66-year-old man complained of having a pulsatile mass with abdominal pain. Computed tomography angiogram revealed a 7cm juxtarenal AAA. Proximal neck of AAA was 8mm, extremely short for proximal landing. Therefore, EVAR with “snorkel technique” was planned.

Relevant test results prior to catheterization:
Computed tomography (CT) showed migration and disruption of Zenith AAA endovascular leg graft from main body and enlargement of the AAA.

[Interventional Management]
Procedural step:
The approach side was bilateral common femoral artery with skin incision. At first step, 0.035” angle wire and 5 french JR catheter were inserted from 6 french sheath by right femoral artery (This was leg disruption side) and the wire was success to cross the contralateral main body. Sizing of length using pigtail catheter with marker was performed and Excluder leg graft (GORE PXL161207) was selected for implantation among migrated Zenith leg and main body. As migration of primary Zenith leg was shown, Zenith leg (TFLE-24-39) was deployed for common iliac artery. Finally, endoleak was disappeared.

Case Summary:
This case is the Zenith AAA endovascular leg graft migration. We performed re-EVAR with Excluder and Zenith AAA endovascular graft. Type III endoleak was vanished after re-EVAR.

TCTAP C-213
Successful Endovascular Therapy in a Case of Penile Gangrene with Life-threatening Pain
Yasuhiro Onda, Tatsumi Shiraki
Kansai Rosai Hospital Cardiovascular Center, Japan

[Clinical Information]
Patient initials or identifier number: T.Y.

Recent clinical history and physical exam:
A 76-year-old man, with diabetes mellitus (HbA1c 6.0%), and end-stage renal disease (ESRD) underwent endovascular aneurysm repair (EVAR) coil embolization for left common iliac artery (L.I.A), 5% stenosis of inferior gluteal artery (I.G.A), and (I.P.A) 99% stenosis of internal pudendal artery.

Relevant test results prior to catheterization:
Ankle-brachial index was 0.97, and Lt. 0.70, respectively.

Relevant catheterization findings:
Digital subtraction angiogram showed the 90% stenosis of left internal iliac artery (L.I.A), 75% stenosis of inferior gluteal artery (I.G.A), and (I.P.A) 99% stenosis of internal pudendal artery.

[Interventional Management]
Procedural step:
Right common femoral artery was punctured in retrograde fashion and a 6-F sheath placed. Left IPA revascularization was initially attempted. A 0.014-inch guidewire, however, did not cross the 99% stenosis of IPA because of severe calcification. A 2.5x 20 mm balloon was used for IPA stenosis. Bare metal stent (Express LD 7.0 X 27 mm) was finally implanted in the 90% stenosis of I.A ostial.