

Case Summary:

In conclusion, this case was complicated with pseudoaneurysm after stent implantation, subsequently fractured stent struts disrupted aneurysm. There is no report that rupture of pseudoaneurysm was complicated after SFA stenting.

TCTAP C-188**Renal Denervation in a Patient with Type B Aortic Dissection and Resistant Hypertension**

Martin Horváth, David Zemanek
Motol Hospital, Czech Republic

[Clinical Information]**Patient initials or identifier number:**

MM

Relevant clinical history and physical exam:

39-year-old male, caucasian.

No history of internal comorbidities

Admitted with back pain and transient lower limb plegia

A history of the same symptoms 4 weeks prior to examination

Relevant test results prior to catheterization:

CT scan: Stanford type B aortic dissection

Relevant catheterization findings:

renal angiography, two renal arteries without any significant stenosis

[Interventional Management]**Procedural step:**

Stentgraft implantation

After preparation of the left femoral artery a Lunderquist guidewire (Cook medical, Bloomington, IN) was implanted. After puncture of the right femoral artery with a 6F sheath a 5F pigtail catheter (Cook medical, Bloomington, IN) was implanted within the aortic arch. Subsequently a two segment stentgraft (Zenith TX2, Cook medical, Bloomington, IN) was deployed in a manner that it started right behind the origin of the left subclavian artery and ended just proximal to the origin of the coeliac trunk. Renal denervation.

After a diagnostic angiography a radiofrequency catheter (Simplicity, Medtronic, Minneapolis, MN) was inserted within the right renal artery via right femoral artery. Radiofrequency energy was applied five times. The catheter was then inserted in the left renal artery where four radiofrequency pulses were used. A control angiography revealed a spasm of the left renal artery, which resolved itself spontaneously.

**Case Summary:**

We report case of a 39-years old male patient without previous internal comorbidities admitted to our institution with a Stanford type B aortic dissection. At first a conservative approach with aggressive anti-hypertensive medication was chosen. A control CT scan revealed a progression of the dissection. We then performed an implantation of a two segment aortic stentgraft. Despite aggressive intravenous anti-hypertensive medication adequate blood pressure control was not possible. We decided to perform renal denervation. The procedure had an immediate effect. The patient's blood pressure quickly normalized.

TCTAP C-189**A Case of Chronic Limb Ischemia with Total Complex Popliteal Occlusion**

Chien-An Hsieh

Taipei Buddhist Tzu-Chi General Hospital, Taiwan

[Clinical Information]**Patient initials or identifier number:**

Hu Lam Suet

Relevant clinical history and physical exam:

88 years old woman has hypertension, dyslipidemia, chronic kidney disease and old stroke. She presented with gangrene change combined with ulceration and infection at left big toe for 3 week.

Relevant test results prior to catheterization:

Vascular ultrasonography and segmental pressure measurement exam revealed occlusion of left popliteal artery occlusion. The ankle-brachial index showed very severe stenosis on both lower extremities (Rt.0.49/ Lt.0.42). Therefore, we decided to perform angiography.

Relevant catheterization findings:

The angiography showed total occlusion of left distal popliteal artery, PTA, peroneal artery and anterior tibial artery. The circulation of foot was only dependent on the collateral flow. By chance, the dorsalis pedis and middle segment of peroneal artery was seen.

[Interventional Management]**Procedural step:**

A 6 French sheath was placed in the left common femoral artery by antegrade approach. The multipurpose catheter 6.0 Fr was advanced into the distal popliteal artery. The 0.014 inch PT II and Astato 30 guide wire with CXI microcatheter was successful to negotiate the totally peroneal lesion. After dilation popliteal artery and peroneal artery using Pacific 4.0*80mm, Pacific 2.0*120 mm and sprinter 3.0*15mm, the angiography showed real rout of the peroneal artery, also middle ATA was seen by better collateral circulation.

Then, we performed retrograde dorsal pedis puncture by fluoroscopy guide. We used Wire-balloon-only technique for avoid distal vessel trauma. Retrograde wire advanced to proximal ATA but it could not pass through the occlusion. Retrograde loop technique was performed with V-18 J-configuration under CXI support, but it couldn't re-entry into popliteal artery true lumen. Antegrade approach was done by wiring proximal subintimal ATA with a 0.014 miracle 6. CART technique was performed at proximal ATA with dual balloon dilation at antegrade and retrograde direction. After dissection membrane was interrupted, wire advanced smoothly to distal ATA. A 2.0*120 Pacific and another 3.5*40 amprion balloon were used for dilation ATA. A 4.0*12 mm drug eluting balloon was used for treating popliteal artery. Final, angiography revealed popliteal artery and ATA recanalization successful. Distal run off of left foot was improved.

