Case Summary. We experienced a case of long CTO which occluded from the EIA to the SFA. By TCA using one of collateral channels from the hypogastric artery to the proximal DFA, we successfully crossed the CTO segment between the EIA and the CFA. Generally speaking, hybrid therapy with end arterectomy of CFA and endovascular therapy of EIA is a first-line treatment. However, if we can find an interventional collateral channel and have a chance of establishment of bidirectional approach, endovascular alone treatment could be an option. In addition, IVUS is very helpful for confirming a guide wire passage in CTO segment. In our case, we were able to confirm the intra luminal guide wire passage in the CFA.

TCTAP C-197
Bilateral CTO from Superficial Femoral Artery to Popliteal Artery Treated by IVUS Guided Wiring, Trans-collateral Wiring, Distal Puncture at Anterior Tibial Artery and Guide Wire Rendez-vous Method
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[CLINICAL INFORMATION]
Patient initials or identifier number. S.S.
Relevant clinical history and physical exam. Case: 75 year-old-woman, Rutherford3
Chief Complaint: bilateral intermittent claudication
Risk Factors: hypertension, rheumatoid arthritis
Present Illness: She presented with bilateral claudication for several months. Ultra sonography and CT angiography revealed occlusion of bilateral superficial femoral artery and left popliteal artery.
Relevant test results prior to catheterization. ABI was 0.55 at right leg and 0.54 at left leg.
Relevant catheterization findings. Occlusion of bilateral superficial femoral artery and left popliteal artery
**Procedural step.** I performed EVT by ipsilateral approach. We can see the ostium of SFA. Sometimes ipsilateral approach makes the approach to SFA ostium difficult. Supported by angled 4Fr catheter, cruise with prominent NEO advanced to proximal SFA. Next I performed IVUS guided wiring. Fortunately Ruby HARD went through CTO lesion confirming by IVUS. Ruby HARD could advance to distal true and aspiration by TVAC was performed.

I couldn’t obtain antegrade flow and POBA by 5.0mm balloon was performed. After I implanted stents, I could get good blood flow. Next I tried switching back technique. Monitoring arterial pressure wave, first advance 0.014 wire with micro catheter to EIA and then turn around 0.035 wire. From distal it. SFA to popliteal artery were occluded.

**Case Summary.** In this case I treated chronic total occlusion of bilateral superficial artery and left popliteal artery by using various techniques such as IVUS guided wiring, switch back technique, trans-collateral angioplasty and distal puncture of below the knee artery. We performed these techniques by 0.014 inch wires. In tough cases these techniques will make our procedure success rate high. I report tips of these techniques with some considerations to perform procedures safely and precisely.