Relevant clinical history and physical exam: 
64-year-old hypertensive male, under regular medical treatment, suffered from syncope with vasovagal symptoms (nausea, vomiting, perspiration, relative hypotension) at lunch, after playing golf and alcohol consumption. Physical examinations were unremarkable at the emergency department except blood pressure of 99/74 mmHg. Aortic CT scan identified spontaneous dissection of superior mesenteric artery (SMA). His elder brother died from type-A aortic dissection at age 52 and he worked abroad frequently. That was why we decided to perform endovascular treatment on him.

Relevant test results prior to catherization: 
CT: r.106. Cholesterol=168. Triglyceride=156. HDL-C=42. LDL-C=94 (mg/dL).
Aortic CT scan: isolated dissection of the superior mesenteric artery (SMA).

Relevant catherization findings:
Coronary arteries were normal. Dissection of the SMA was noted. The tear located at 2 cm from the origin of SMA. All the divisions were opacified without apparent thrombus. The jejunal branches were supplied by the compressed true lumen, while other branches were supplied by the false lumen (with reentry).

[Interventional Management]
Procedural step:
Right femoral arterial approach. The SMA was engaged with a 8F RESS guiding catheter (renal curve, short standard, Boston Scientific). Each of the side branches and divisions was probed to establish its relationship with the true or the false lumen. Most of these branches were supplied by the false lumen, with two significant lesions at their re-entry points. One of the lesion was stented by a 7/12 mm Racer stent (Medtronic), and the other was treated by balloon angioplasty (6 mm Wanda balloon of Boston Scientific). The Racer stent was upsized by a 8 mm Wanda balloon over its proximal part. Proximal side branches (jejunal branches) of the SMA was supplied by the compressed true lumen. Fenestration of the intimal flap to connect proximal true with distal false lumen was performed mostly by a Provia-12 PTCA guidewire (Medtronic), supported by a Crusade microcatheter. The puncture hole was dilated with 1.5 mm Sprinter balloon (Medtronic) and 3.0 mm and 6.0 mm Wanda balloons (Boston Scientific). A 8/57 mm Express LD stent (Boston Scientific) was deployed from proximal SMA (with coverage of proximal tear) into distal SMA (with overlapping with the Race stent). Proximal portion of the stent was dilated further by a 10/40 mm Wanda balloon (Boston Scientific) at 10 Bar. Complete sealing of the dissection with brisk antegrade flow into all but one of its divisions was achieved. The hospital course was uneventful and he remained asymptomatic at 6-month’s follow-up.

TCTAP C-206
Serial Angiographic Evaluation of Paclitaxel-coated Nitinol Drug-eluting Stent Implanted in the Superficial Femoral Artery
Ryota Matsumoto, Osamu Iida
Kansai Rosai Hospital Cardiovascular Center, Japan

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

Relevant clinical history and physical exam:
Chief complaint: Claudication of rt.leg (Rutherford 3)
Relevant clinical history and physical exam:
Relevant clinical history and physical exam:
Relevant test results prior to catherization:
Relevant catherization findings:

[Interventional Management]

Procedural step:
TCTAP C-208
Invasive Physiological Assessment During Endovascular Therapy in the Superficial Femoral Artery
Kojiro Miki
Hyogo College of Medicine, Japan

[Clinical Information]
Patient initials or identifier number: 
Case Summary:
Rendezvous technique can also be applied in a peripheral chronic total occlusion. In this case, we perform rendezvous in the antegrade guiding catheter in order not to extend the length of false lumen.

TCTAP C-207
Rendezvous Technique in Recanalizing Chronic Total Occlusion of Subclavian Artery
Shih-Wei Meng, Mao Hsin Lin
National Taiwan University Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number: 
C.H. TSAI

Relevant clinical history and physical exam:
72-year-old man

DM. hypertension, hyperlipidemia, smoker
Discordance of blood pressure between two arms for many years
Dizziness during postural change in recent 3-4 months

[Interventional Management]

Procedural step:
1. Put 7Fr JR4 from right femoral artery to the proximal end of left subclavian artery. Put 6 Fr JR4 from left radial artery back to the distal end of left subclavian artery.
2. Try antegrade wiring using Conquest Pro 12 and Excelsior microcatheter but fail. Try antegrade wiring with Cook Approach CTO 18 and Excelsior but still fail.
3. Retrograde wiring using Cook Approach CTO 18 and Excelsior successfully to aorta then switch to Sion wire.
4. Balloon angioplasty with Maverick 2.0 x 20 mm and Sapphire II 3.0 x 20 mm subsequently.
5. Rendezvous technique in the antegrade guiding catheter and pass another Sion wire to distal left subclavian artery.
6. Switch to Cook 0.035 shuttle sheath and 300 cm Terumo wire.
7. Deploy Assurant Cobalt 7 x 30 mm to left subclavian artery.