PTA lesion, a 0.014 inch guide wire with micro-catheter was further advanced introdorsalis pedis artery (DPA) retrogradely. However, occlusion site of DPA was so hard that a stiff wire could easily advanced into subintimal space. We advanced another guide wire into ATA antegradely. Wire rendezvous technique was performed in the proximal DPA, followed by balloon angioplasty. Finally, complete revascularization of ATA and PTA including pedal arch was achieved.

**Case Summary.** Re-vascularization of below-the-knee (BTK) including BTA lesion has been reported to be helpful for limb salvage inpatients with critical limb ischemia (CLI). On the other hand, the efficacy of endovascular therapy (EVT) for collagen-vascular disease might be controversial. In this case, complete re-vascularization of BTA lesions might be effective for limb salvage of a collagen-vascular disease patient.

**TCTAP C-202**

Coil Embolization for Peripheral Vessel Perforation

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**[CLINICAL INFORMATION]**

Patient initials or identifier number. M.I

Relevant clinical history and physical exam. She was admitted for treatment of critical limb ischemia (Rutherford 4). Nitinol stent had been implanted for superficial femoral 6 months before. This time lower limb ischemia was recurrent. Coldness and rest pain appeared for her lower limb. Aortic pulsation could not be felt of her politeal, dorsal and posterior tibial artery.

Relevant catheterization findings. Total occlusion for superficial femoral artery was observed.

**[INTERVENTIONAL MANAGEMENT]**

Procedural step. EVT was done for total occlusion of superficial artery. Support catheter (JR 3.5) and guidewire (0.035 Radifocus) challenged to pass the lesion. (Figure se3) Although the guidewire could not pass through the occluded lesion. Then the procedure was unsuccessful and finished.

After several hours after EVT, she became hypotension and shock state. Angiography showed extravasation of contrast medium from deep femoral artery (Figure se9). Long balloon inflation for deep femoral artery challenged for stopping extravasation. Although extravasation did not stop, then we challenged coil embolization. Microcathether induced for extravasation site and pushed coil (Tornado) for extravasation site. Soon after coil embolisation, extra vasation disappeared (Figure se12) and successful hemostasis was achieved.
Case Summary. As for treatment of vessel perforation, proximal compression of balloon inflation, external compression and covered stent were challenged. In this case, proximal compression of balloon inflation could not success. External compression and covered stent could not be used of anatomical problem. Coil embolization is applicable when vessel perforation cannot be repaired by long balloon inflation in endovascular therapy.

TCTAP C-203
Endovascular Therapy of Superior Vena Cava Syndrome in a Uremic Patient Who Had an Occluded Bypass Graft to the Right Atrium
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[CLINICAL INFORMATION]
Patient initials or identifier number. CYL
Relevant clinical history and physical exam. This 33-year-old male was a case of uremia since 2006. He received peritoneal dialysis for 3 years before switched to hemodialysis in 2009. He received bypass surgery for superior vena cava (SVC) syndrome in 2011/MAY: a 18 mm PTFE graft from SVC to right auricle. He received surgery for stenosed AV fistula (AVF) over right forearm in 2013/DEC, and then suffered from symptoms of SVC syndrome again. Occlusion of the PTFE graft was confirmed by CTA in 2014/JAN. Symptoms got worse for 4 months.