Case Summary. We reported successful coil embolization to type II endoleak from lumber and sacral arteries after EVAR. To achieve complete exclusion, we should embolize inflow, sac, and outflow of type II endoleak after EVAR.

TCTAP C-201
Successful Limb Salvage in a CLI Patient with Scleroderma by Complete Revascularization of BTA Lesions
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[CLINICAL INFORMATION]
Patient initials or identifier number. 5065040
Relevant clinical history and physical exam. A patient was 70-year-old female with a past history of scleroderma (SSc), anginapectoris and hypertension was admitted to our hospital for 5th toe ulcer on the left foot (Rutherford category 5). The dorsalis ped is and the posterior tibial arteries were not palpable.

Relevant test results prior to catheterization. Despite the left ankle-brachial index (ABI) was normal, The skin perfusion pressure (SPP) in the left foot was 10/12 mmHg (dorsum/plantar foot), suggesting the presence of critical limb ischemia (CLI).

Relevant catheterization findings. Diagnostic angiography showed chronic total occlusion (CTO) of both anterior tibial artery (ATA) and posterior tibial artery (PTA). Distal run-off was also very poor; only plantar artery was partially visible in below-the-ankle (BTA) area.

[INTERVENTIONAL MANAGEMENT]
Procedural step. Firstly, we decided to reanalyze PTA to plantar artery. As a 0.014 inch guide wire with micro-catheter was advanced into subintimal space in the mid PTA, trans-collateral approach via peroneal artery was performed. After performing wire rendezvous technique in the mid PTA, we successfully achieve “one straight line” from PTA to plantar arch. However, complete wound healing was not obtained. 2nd EVT was performed 4 months after the 1st EVT. Angiography showed CTO of ATA and PTA reoclusion. After crossing the
PTA lesion, a 0.014 inch guide wire with micro-catheter was further advanced into dorsalis pedis artery (DPA) retrogradely. However, occlusion site of DPA was so hard that a stiff wire could easily advance into subintimal space. We advanced another guide wire into ATA antegrade. 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 in patients 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 sation disappeared (Figure se12) and successful hemostasis was achieved.