Stenting with Complete SE 8x100 mm, 10x60 mm, 10x 60 mm.

Final kissing iliac bifurcations with 8 x 60 mm Fox balloons.

Case Summary:
A 45-year-old man presented with a 1-year history of left leg claudication. The walking length was limited to 100 meters. A vascular Duplex found evidence suggestive of bilateral iliac artery flow limiting lesions. Angiography found total occlusion of left common iliac artery. The procedure was performed with bilateral femoral punctures with multiple attempts to recanalize the iliac occlusion. The recanalization process was nearly abandoned due to difficulty in reentry to the true lumen. The Outback catheter was not available at the time of the procedure. A JR4 catheter tip was shortened by scissors. Then a coronary CTO wire was used while the JR4 with shortened tip aiming at the correct direction for re-entry. The re-entry process was successful with reverse CART technique. The procedure was then completed with self-expandable stents to iliac bifurcations.

Relevant catheterization findings:
Angiography disclosed thrombus with total occlusion over right femoral vein.

Case Summary:
This 82 year old lady with a history of liver cirrhosis, HBV related, Child C was admitted due to right leg edema. Physical examination disclosed unilateral right leg edema.

Relevant test results prior to catheterization:
D-dimer was positive and vascular ultrasound disclosed thrombotic occlusion of right femoral vein.

TCTAP C-192
A 7 Fr sheath was inserted to left femoral vein and 42X retrievable IVC filter was implanted below renal vein and above iliac vein bifurcation. A 8 Fr Cook crossover sheath was advanced from left common femoral vein to right common femoral vein (RCVF). Targeted Adjustable Pharmaceutical Application System (TAPAS) balloon infusion catheter was inserted under assistance of a 0.14" PT2 300 cm wire. Thrombolysis over RCFV and proximal femoral vein was identified and isolated by two balloons inside TAPAS catheter. Heparin 3000 units, urokinase 48000 units were given for localized thrombolyis within TAPAS catheter. After drug retenison for 20 minutes, drug was removed. The residual thrombus was diluted with a 8.0/40 mm Admiral balloon at 6 atm, 12.0/40 mm Admiral balloon at 6 atm for fragmentation. A 8 Fr JR4 guiding catheter and RESS guiding catheter was used for thrombectomy. Mild residual thrombus was noted with adequate angiographic result and TIMI-3 flow achieved.

Case Summary:
This 82 year old lady with a history of liver cirrhosis, HBV related, Child C was admitted due to right leg edema for weeks and deep vein thrombosis was noted with much thrombus found over right femoral vein. Due to contra-indication for systemic thrombolysis, and also risky for catheter-directed thrombolysis (CDT), we use TAPAS catheter assisted thrombolyis to minimize bleeding complication. TAPAS catheters was successfully used with heparin 3000 units, urokinase 48000 units used. These drug were removed from body after local thrombolysis assisted by TAPAS catheter for 20 minutes. Successful PTA/catheter assisted thrombectomy was performed. Right leg edema improved in one day and no anticoagulation therapy was given after the index procedure without recurrence of DVT.

TCTAP C-194
A Successful Endovascular Stent Graft Treatment Case in Common Femoral Artery Rupture Induced During Femoral Catheterization

Case Summary:
This 75 years old male patient has the risk factors of diabetes, hypertension and dyslipidemia for many years. He had bilateral SFA occlusion and underwent bypass surgery 10 years ago. He had left foot chronic ulcer wound with resting pain for 3 weeks. Under the diagnosed of CLI, he admitted for further evaluation and treatment.

Relevant test results prior to catheterization:
ABE left leg 0.5; right leg 0.8

Relevant catheterization findings:
The left limbs angiography showed, vein-graft bypass from SFA to peroneal artery. However, stenosis at the SFA anastomosis & total occlusion at distal graft. The ATA showed moderate stenosis at proximal portion.

Case Summary:
This 75 years old male patient admitted due to left foot chronic ulcer wound with resting pain for 3 weeks. The angiography showed vein-graft bypass from SFA to peroneal artery with stenosis at the SFA anastomosis & total occlusion at distal graft. Another moderate stenosis at ATA. Angioplasty was done using 6Fr KSAB-RB-ANL2-HC guiding sheas inserted, and crossed over to left common femoral artery. We crossed the occlusion lesion with .018 V18 wire. Dilated the total occlusion part Pacific Xtreme balloon 4.0x120mm, inflated to 8atm. Two Zilver Flex stent 6.0x200mm and another 6.0/ 70mm stent was successfully deployed. Adjunctive balloonizing using Pacific Xtreme balloon 4.0x120mm was performed. Good patency was achieved in left SFA. Exchanged the wire to 014 CTO-18 (300cm). The Anterior tibial artery lesion was dilated by Amphirion balloon 2.5x40mm, inflated to 10atm for 2 min with adequate patenec after angioplasty.

Case Summary:
This 75 years old male patient admitted due to left foot chronic ulcer wound with resting pain for 3 weeks. The angiography showed vein-graft bypass from SFA to peroneal artery with stenosis at the SFA anastomosis & total occlusion at distal graft. Another moderate stenosis at ATA. Angioplasty was done using 6Fr KSAB-RB-ANL2-HC guiding sheas inserted, and crossed over to left common femoral artery. We crossed the occlusion lesion with .018 V18 wire. Dilated the total occlusion part Pacific Xtreme balloon 4.0x120mm, inflated to 8atm. Two Zilver Flex stent 6.0x200mm and another 6.0/70mm stent was successfully deployed. Adjunctive balloonizing using Pacific Xtreme balloon 4.0x120mm was performed. Good patency was achieved in left SFA. Exchanged the wire to 014 CTO-18 (300cm). The Anterior tibial artery lesion was dilated by Amphirion balloon 2.5x40mm, inflated to 10atm for 2 min with adequate patenec after angioplasty.