**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** First session for right SFA severe stenosis

We passed a wire (Hi-Torque Command, Abbott Vascular Japan) for the right SFA lesion with micro-catheter (Corsair 150cm, Asahi-Intecc), and expanded scoring balloon (Angio Sculpt 6mm/40mm, AngioScore) in this lesion, and next, performed stenting (SMART 6mm/150mm, 6mm/150mm, Cordis).

Second session for right SFA acute occlusion

We passed a wire (Radifocus 0.0335inch 300cm, Terumo) for the right SFA stent from left femoral artery.

Thrombus was eliminated by absorbing it from a guide catheter (Glidecath 5French, Terumo).

Next, we expanded the stent by balloon catheter (BARD RIVAL 5.0mm/150mm, Medicon) again. In result, blood flow was improved.

**Case Summary.** After four days, the patient got a fever of 38 degrees. CRP level was 38.1mg/dl. We suspected his fever was from infection. And his physical findings were abnormal, right femur was swollen with pain. He became sepsis.

Ultrasonography showed right SFA aneurysms. Right SFA was expanded to avoid a stent.

Infection did not calm down though the patient was under the medical treatment in antibiotic.

Therefore, we removed foreign material (STENT) from his femor.

In result blood flow were more worsen, therefore he was performed AK.

But, his infection was improved.

In this case, we experienced infectious aneurysm after EVT. We must consider this case, if patients after EVT got fever.

**TCTAP C-164**

**Non Contrast Stent Implantation to Superior Mesenteric Artery for Chronic Mesenteric Ischemia with Advanced Chronic Kidney Disease**

Keisuke Fukuda

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**[CLINICAL INFORMATION]**

Patient initials or identifier number. T.K.

**Relevant clinical history and physical exam.** An 81-year-old female was presented with postprandial abdominal pain and 10-kg body weight loss for the past 6 months. She developed sitophobia (fear of food). Her medical history included coronary stenting for effort angina five years previously and a long standing history of hypertension, dyslipidemia, and current smoking. She was also identified a shaving stage 4 chronic kidney disease (CKD) and advised to prepare for renal replacement therapy.
Relevant test results prior to catheterization. Duplex ultrasound showed severe stenosis of superior mesenteric artery and on the site, peak systolic velocity was accelerated to 367 cm/s. Magnetic resonance angiography clearly visualized severe stenosis of superior mesenteric artery.

Relevant catheterization findings. Because of her impaired kidney function, diagnostic angiography was not performed.

[Interventional Management]
Procedural step. A 4.5-Fr Sheath less guiding catheter (Parent Plus45; Medikit, Tokyo, Japan) was introduced via the left brachial artery. Under fluoroscopic guidance based on CT findings, the guiding catheter was manipulated to the ostium of the SMA. A 0.014-inch guide wire (Runthrough Ph; Terumo, Tokyo, Japan) was advanced into the SMA. Location of the guiding catheter and guide wire position in the SMA were verified by surface ultrasonography. The direction of the guide wire was concordant with the MRA images. IVUS was performed and the SMA ostial stenosis was confirmed. Reference diameter and lesion length was measured at 6 mm and 15 mm, respectively. A 0.014-inch pressure wire (Aeris; St Jude Medical, Inc, Saint Paul, MN, USA) was introduced to SMA and 22 mmHg of systolic pressure gradient across the lesion was revealed. Pre-dilatation was performed with a 4.0 × 20-mm balloon (Sterling; Boston Scientific, Natick, MA, USA); the balloon position was adjusted with reference to IVUS marking and calcification at the lesion under fluoroscopy. After balloon dilatation, a 6.0 × 18-mm balloon-expandable stent (Express Vascular SD; Boston Scientific, Natick, MA, USA) was introduced by the same technique of balloon dilatation. The stent was implanted at 8 ATM. Post stenting, IVUS showed a fully expanded stent exactly at the intended location with no dissection. DUS performed on site showed that PSV had decreased to 185 cm/s. No complication was encountered throughout the procedure.
Case Summary. Non-contrast endovascular treatment was performed on the SMA in a patient with CMI. Information from plain CT, MRA, and surface ultrasonography assisted in engaging the guiding catheter and inserting the wire into the target vessel of the SMA. The stent was successfully implanted using IVUS, pressure wire, and surface ultrasonography. Non-contrast intervention has wide applicability to patients with ESRD and/or those allergic to iodinated contrast media.

TCTAP C-165
Percutaneous Transluminal Angioplasty and Stenting of Celiac Artery Stenosis with Thrombus in the Treatment of Mesenteric Angina
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[CLINICAL INFORMATION]
Patient initials or identifier number. A 37 years male
Relevant clinical history and physical exam. A 37 years old gentleman, presented with postprandial colicky abdominal pain for past 6 months. This was associated with weight loss of about 20Kg in past 6 months. His past medical history revealed he is a smoker with ischemic heart disease (old AWMI).
Relevant test results prior to catheterization. Extensive gastrointestinal investigations were done in last 6 months & were normal. A CT angiogram of abdomen was done showing Celiac and Superior mesenteric artery stenosis. In view of patients past medical history and CT finding, a provisional diagnosis of mesenteric angina was made and planned to proceed for mesenteric angiography and stenting.
Relevant catheterization findings. PAG was carried out and revealed occlusion of IMA, 90% stenosis of SMA and 75% stenosis of celiac artery with thrombus. In view of convincing history of CMI, weight loss, it was decided to proceed to PTA and stenting.

INTERVENTIONAL MANAGEMENT
Procedural step. The procedure was approached accessing via right femoral A and left brachial A approach. A 6 F short sheath was inserted to right femoral artery and another 6F hydrophilic sheath inserted through left brachial artery after skin infiltration of lignocaine LA, Heparin 5000 IU IV was given. The femoral sheath was used for monitoring and non-selective angiography, while brachial sheath for delivering balloon and stent. A 4mm PTCA balloon was passed over 0.014 guide wire and dilatation of ostial-proximal segment of celiac artery done. A 5.0 X12mm DES stent mounted on a balloon was inserted and inflated just below burst pressure and kept for 30 seconds. An angiography conducted after the procedure showed a diameter equal to the nearby normal segment. Guide wire could not be passed through Superior mesenteric artery, hence could not be stented and was left. Brachial sheath was removed immediately and haemostasis secured, femoral sheath removed after 4 hours. There was no post-operative complications. Patient was discharged on the 3rd day with aspirin and clopidogrel, subsequent follow up after 2 weeks /2 months and 6 months no post-prandial abdominal pain. Patient gained 10 kg weight in 6 months.