Case Summary. We report a case of long SFA CTO with severe calcification succeeded true lumen crossing with 0.014 inch wire and CROSSER. Nevertheless severe diffuse calcification, good stent expansion was obtained thanks to the debulking effect of CROSSER.

TCTAP C-177 Successful Endovascular Treatment of Ruptured Pancreaticoduodenal Artery Aneurysm with Fistula to Duodenum in a Patient After Ruptured TEVAR
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[CLINICAL INFORMATION]
Patient initials or identifier number. DP
Relevant clinical history and physical exam. We are presenting 41 year old man with history of arterial hypertension and cocaine abuse. Otherwise healthy with no other comorbidities. No family history of vascular pathology. Hypertension been controlled with one medication. Patient arrived in emergency room with symptoms of acute severe back pain and difficulties to breath.
On examination tachycardia 100 beats per minute, hypotension, diminished breathing in right side was observed. Palpable pulse on femoral arteries been tested.
Relevant test results prior to catheterization. On CT angiography Type B aortic dissection with 8 cm thoracic aneurysm with a rupture was found. Additional CTA founding was: haemothorax, occluded coeliac trunk and 4 cm pancreatic-duodenal aneurysm. No specific blood test abnormalities was found. Patient underwent TEVAR using Valent Captiva (Medtronix) stent graft. Femoral artery approach was used, placing device just after left subclavian artery. Patient recovered and was discharged from the hospital.

Relevant catheterization findings. In 3 weeks patient arrived in Emergency room repeatedly with acute bleeding from gastroduodenal tract. Gastroscopy reviled duodenal bleeding. Local homeostasis with clips was unsuccessful. On CT angiography and selective angiography rupture of pancreaticoduodenal aneurysm was found.
INTERVENTIONAL MANAGEMENT

Procedural step. At the second acute admission embolization of ruptured pancreaticoduodenal aneurysm was done using right femoral artery approach. Difficulties were to access all aneurysm feeding vessels as patient had occluded coeliac trunk. Embolisation using micro catheters was done with spiral coils. Bleeding stopped. Patient recovered and was discharged from the hospital.

2 year follow-up CT angiography showed enlargement and aneurysmatic common iliac artery. Therefore open surgery to treat iliac aneurysm and prevent rupture was successfully done.

Case Summary. Patients with chronic aortic dissections may present challenging management due to aneurysm formation and rupture. Cocain-induced aneurysm rupture should be taken into account when evaluating patients. Aneurysms should be treated effectively on elective bases to avoid ruptures and potential patient deaths.

CLINICAL INFORMATION

Patient initials or identifier number. Mrs. NHT

Relevant clinical history and physical exam. Mrs. NHT, a 65 year old lady, admitted due to abdominal pain and hypogastric pulsatile mass. Her CVD risk factors were untreated hypertension and hypercholesterolemia. Her blood test results were nearly normal. Her resting EKG showed no specific ST changes. Her echocardiography showed normal LV EF.

Relevant test results prior to catheterization. MSCT findings showed big AAA with very angulate neck.

Relevant catheterization findings. Endovascular approach for this symptomatic AAA was decided. First angio image confirmed MSCT images.

Bailout Solution for AAA with Acute Neck and Renal Artery Stenosis

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