Case Summary. The aims of therapy are to: 1) achieve symptomatic resolution, 2) prevent bowel infarction and resultant morbidity and mortality and 3) prevent and treat malnutrition. Some groups also recommend prophylactic revascularization even in a symptomatic patients who are due for an operation in the aorta (e.g. aneurysm, coarctation, etc.) or before being scheduled for major abdominal surgery that might jeopardize the collateral circulation. As SMA and IMA was still occluded, but there was dramatic improvement of symptoms post stenting of celiac artery, which supplied the remaining abdominal vessels.

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Successful Percutaneous Fogarty Balloon Catheter Embolectomy in a Centenarian Patient with Subacute Limb Ischemia
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[CLINICAL INFORMATION]
Patient initials or identifier number. I.T
Relevant clinical history and physical exam. A 100-year-old female, who had the history of atrial fibrillation, visited our hospital because of right lower-leg pain and pallor for several weeks. Enhanced computed tomography showed total occlusion of the right superficial femoral artery (SFA) orifice, and the patient was diagnosed with sub acute limb ischemia. Anticoagulant and thrombolytic agents were used as an initial treatment. Although these agents were used for two days, there was no significant symptom improvement.

Relevant catheterization findings. Initial angiography showed total occlusion of the right SFA.
**Procedural step.** We performed percutaneous Fogarty balloon catheter embolectomy for thrombotic occlusion of the right SFA. This method involves thrombectomy that draws the thrombus through a Fogarty balloon catheter, followed by aspiration via a large-bore sheath, eliminating the need for vessel incision. A 6-Fr cross over sheath introduced via the left common femoral artery (CFA) was placed in the right external iliac artery (EIA). The occluded segment was traversed by a 0.035-inch hydrophilic-coated guidewire. Further, balloon angioplasty was performed for the right proximal SFA to enable antegrade introduction of a 12-Fr sheath into the right CFA, which was eventually placed in the right proximal SFA. The Fogarty thru-lumen catheter was inserted via the 12-Fr sheath into the popliteal artery and was subsequently retracted, resulting in the withdrawal of the thrombus to the proximal SFA. A large thrombus was removed by a 10-Fr child sheath, which was inserted into the 12-Fr sheath. Several thrombectomies were performed using a similar technique, and all the thrombi in the femoropopliteal artery were removed. A few thrombi were observed below the knee arteries, and these were aspirated using a 7-Fr TVAC II catheter and balloon angioplasty. A self-expandable stent was finally deployed for the residual thrombus in the right EIA. Final angiography showed that almost all the thrombi were removed. The 12-Fr sheath was removed by a pre-closure technique.

**Case Summary.** Compared with other catheter treatments, such as catheter-directed thrombolysis, percutaneous aspiration thrombectomy, or percutaneous mechanical thrombectomy, this method has the advantages of enabling the removal of massive thrombi, reduced procedure time, and less frequent use of thrombolytic agents. Moreover, compared with surgical embolectomy, this method has the advantages of no requirement for vessel incision and simultaneous endovascular treatment for distal embolization or residual stenosis. We believe that this method will be one of the effective treatments of acute or sub-acute limb ischemia.