**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** Therefore, we continued the extra-vascular compression with elastic bandage overnight. Tomorrow morning, we evaluate the puncture site with duplex. Fortunately, continuous bleeding was not observed in puncture site. However, five days after EVT, follow-up duplex examination pointed out a large pseudoaneurysm in his right calf. Percutaneous trans-catheter embolization was attempted for this large pseudoaneurysm. 4-Fr 50cm sheath was inserted to his common femoral artery. Control angiogram disclosed large pseudoaneurysm at PA. If the thrombotic complication was happened to this PA (it’s only one patent artery) during the embolic procedure, his foot condition became worth. Therefore, we treat the occluded ATA before the embolization. ATA was dilated with 2.5/3.0mm tapered balloon. After the ATA revascularization, coil embolization for pseudoaneurysm was done. Hydrophilic polymer-jacketed guidewire was carefully advanced into the pseudoaneurysm with a back-up support of microcatheter. Sixteen detachable coils were inserted to the pseudoaneurysm. And long time (5 minutes) dilatation with 2.0mm long balloon for PA was performed (balloon assisted hemostatic procedure). After the procedure, the pseudoaneurysm was completely disappeared.

**Case Summary.** Bi-directional wiring is effective strategy to negotiate the complex BTK occlusion. There is several retrograde access techniques to establish a bi-directional approach. PA puncture is one of the good options. However, PA is located in deep from the skin, he-mostatic procedure is slightly difficult. Then, puncture site complication after PA puncture is sometimes observed. Injection of Thrombin or other embolic agents are well-known reasonable strategy for pseudoaneurysm. However, it contains some risk of thrombotic complication. And for patients with CLI, these complication cause miserable result. Coil embolization for puncture site pseudoaneurysm might be a reasonable option for CLI patients.

**TCTAP C-207**

**Successful Coil Embolization for Type 2 Endoleak After EVAR**

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**[CLINICAL INFORMATION]**

Patient initials or identifier number: S.Y

**Relevant clinical history and physical exam.** A 56-year-old man, with chronic kidney disease and stomach cancer (postlaparotomy), underwent endovascular aneurysm repair (EVAR) of an asymptomatic abdominal aortic aneurysm (AAA), 53 mm in maximum diameter, detected by contrast-enhanced computed tomography (CT). However, AAA gradually expanded over 2 years to a maximum diameter of 60mm due to type II endoleak from left IIA as diagnosed by contrast-enhanced CT.
Relevant test results prior to catheterization. AAA gradually expanded to a maximum diameter of 60mm due to type II endoleak from left IIA as diagnosed by contrast-enhanced CT.
Relevant catheterization findings. Type II endoleak due to collateral circulation from left IIA.

[Interventional Management]

Procedural step. Coil embolization of collateral circulation from the left IIA was conducted because of rupture risk.

Right brachial artery was punctured and 4.5F guiding catheter (Parent Plus, Medikit) was inserted under local anesthesia. A 0.035-inch J wire accompanied by a 5F Judkins’ right guiding catheter was used to select the left IIA. A 0.014-inch guidewire with micro-catheter (Corsair, Asahiintec) was used to reach the source lumbar artery, which was occluded with coil embolization (CERECYTE, Goodman 3mm*2, 4mm*3).
**Case Summary.** Coil embolization of collateral circulation from the left IIA was conducted because of rupture risk.

We successfully performed coil embolization for type 2 endoleak.

Contrast enhanced CT on day 1 after coil embolization showed complete resolution of type 2 endoleak.

The patient will undergo close our patient CT follow-up to assess for AAA expansion.

**TCTAP C-208**

The Success Case of Hybrid Treatment for Type A Acute Aortic Dissection with Multiorgan Ischemia

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**[CLINICAL INFORMATION]**

Patient initials or identifier number. S.M.

Relevant clinical history and physical exam. A 57-year-old man was admitted to our institution complaining of abdominal pain. He had a history of laparotomy for harvesting the right gastroepiploic artery (rGEA) and had previously received coronary artery bypass grafting using the left internal thoracic artery (LITA) bypassed to the first diagonal branch and rGEA to the left anterior descending artery (LAD) through mid-line sternotomy.

Relevant test results prior to catheterization. On admission, the ECG showed ST segment depression in anterior leads. Contrast-enhanced computed tomography scan revealed Stanford type A aortic dissection extending from the ascending aorta to the iliac bifurcation. The celiac artery (CA), the superior mesenteric artery (SMA), and the left renal artery were compressed by a false lumen. The CA and the SMA were perfused from the true lumen. The maximum diameter of the superior mesenteric vein was significantly narrower than that of the SMA.