Ischemic bowel disease remained challenging in the current era. Comorbidities of these patients suffer from bowel ischemia prevent them from satisfactory outcomes. Our patient already received emergent exploratory laparotomy with resection of necrotic segment, but there were still symptoms and signs of bowel ischemia (profound and medically refractory ileus). Repeated operation was not possible thus we tried to treat her disease with endovascular method and succeed.

TCTAP C-184
A Chronic Heart Failure Case with Left Brachiocephalic Vein Occlusion After Cardiac Resynchronization Therapy Device Implantation
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[CLINICAL INFORMATION]
Patient initials or identifier number. Toyama 2015

Relevant clinical history and physical exam. A case was a 60 late-year-old male with a chronic heart failure due to ischemic cardiomyopathy. He had sirolimus-eluting stent implantation 8 years prior to admission. On 2013, he had the cardiac re-synchronization therapy (CRT) device implantation, because he experienced repeat hospitalization by heart failure. After three months, he admitted by heart failure worsening and ventricular fibrillation (Vf) storm.

Relevant test results prior to catheterization. Chest X-ray revealed that the left ventricular pacing lead dislodged from the coronary lateral vein until the superior vena cava. Echocardiography revealed enlargement and diffuse hypokinesis of left ventricle (LVEF 22.7%). The coronary angiography showed in-stent restenosis at the distal of right coronary artery and the mid of left anterior descending artery. After coronary intervention, Vf storm and heart failure was improved.

Relevant catheterization findings. Seven months after the CRT device implantation, we performed 2nd CRT device operation (Fig 1). We planned the re-operation step, first the guidewire passed through the guidewire lumen in the dislodged left ventricular pacing lead, next the pacing lead was removed, finally the guiding catheter passed along the guidewire and the new left ventricular pacing lead implanted.

[INTERVENTIONAL MANAGEMENT]
Procedural step. This procedure was performed under general anesthesia. We tried to advance the guidewire lumen, however this lumen was occluded (Fig 2) and 0.014-inch soft guidewire could not pass. Although the tissue of occluded site was hard and the lesion length was 6 cm, 0.014-inch Treasure 12g guidewire passed using drilling technique. Next, the dislodged left ventricular pacing lead removed from the superior vena cava. However 4Fr sheath could not passed at the left brachiocephalic vein despite dilating 2 mm balloon catheter. The tissues in the mid left brachiocephalic vein and the subclavian vein were very hard. Additional balloon dilation using 4 mm balloon catheter was performed (Fig 3). Maximum balloon dilation pressure needed 12 atm for nothing of balloon indentation. After balloon dilation several times, 8 Fr sheath passed into the left brachiocephalic vein. I concerned about injure of pacing leads and vein perforation, but these did not occurred. Finally, the guiding catheter inserted into the coronary lateral vein and the new left ventricular pacing lead succeed to implant (Fig 4). When the left ventricular pacing lead advanced into the coronary lateral vein, the guiding catheter could not keep enough backup force. The backup force of guiding catheter was gained. As a result of the double guidewire technique what the second guidewire advanced the coronary anterior vein.
Case Summary. This chronic heart failure case undergoing the CRT device implantation occurred the left ventricular lead dislodgement and the left brachiocephalic vein occlusion. We succeeded the CRT device re-operation using cardiovascular intervention techniques.

TCTAP C-185
Successful Endovascular Intervention for Below-the-Knee Arteries Using Various Bailout Techniques
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[CLINICAL INFORMATION]
Patient initials or identifier number. T.O
Relevant clinical history and physical exam. We present the case of a 60’s female with hypertension, dyslipidemia and hemodialysis due to diabetes mellitus. She presented rest pain of her right leg and was admitted to our hospital in August 2014.

Relevant test results prior to catheterization. Baseline skin perfusion pressures were 38 mmHg at the dorsal area and 30 mmHg at the planter area.

Relevant catheterization findings. Baseline lower-limb angiography showed severe stenosis at right popliteal artery (POP) and total occlusion at below the knee (BK) arteries. We could see only distal peroneal artery (PA) through bridge collaterals from proximal PA.