aorta to right CIA and was inflated at 08 ATM. Stent strut was re crossed with Filder FC wire from right CIA to left CIA across bifurcation of abdominal aorta. Stent strut was open by serial balloon dilatation with 2.5mm X 10 mm balloon & 04.5mm x 15mm balloon at 10 ATM. Under catheter guidance Terumo regular hydrophilic wire was passed from left side & and was changed to Filder FC wire. Further balloon dilatation was done with 04.5mm x 15mm balloon at 10 ATM. Another 08 mm x 30 mm balloon expandable stent was placed from left CIA to bifurcation of abdominal aorta with minimal protrusion into first stent & was inflated at 08 ATM. Final kissing was done at 10 X 60 mm & 08 x 30mm balloon at 6 ATM. ATM.

Case Summary:
This 55 years old male, hypertensive, diabetic, dyslipidaemic and smoker, presented with intermittent claudication pain with weakness of both lower limb (Left> Right). Peripheral angiogram revealed 70% stenosis of infra-renal abdominal aorta with eccentric plaque causing 95% stenosis of abdominal aorta just above bifurcation to CIA. Bilateral femoral access was established. Lesion was crossed with Terumo regular hydrophilic wire from both sides. One 10 mm X 60 mm balloon expandable stent was placed across the lesion from infra renal abdominal aorta to right CIA and was inflated at 08 ATM. Stent strut was re crossed with Filder FC wire from right CIA to left CIA across bifurcation of abdominal aorta. Stent strut was open by serial balloon dilatation. Under catheter guidance Terumo regular hydrophilic wire was passed from left side & and was changed to Filder FC wire and further balloon dilatation was done from left side. Another 08 mm x 30 mm balloon expandable stent was placed from left CIA to bifurcation of abdominal aorta with minimal protrusion into first stent & was inflated at 08 ATM. Final kissing was done at 10 X 60 mm & 08 x 30 mm balloon at 6 ATM. Good distal flow was established.

TCTAP C-196
Management of Superior Mesenteric Artery Dissecting Aneurysm Presenting as Acute Abdomen by Transradial Route
Rajagopal Jambunathan, Arjun R. Adnaik, Satish A. Rao, Vikram B. Kolhari
Columbia Asia Hospital, India

[Clinical Information]
Patient initials or identifier number:
ISM
Relevant clinical history and physical exam:
A 60 year old male diabetic, non hypertensive person was admitted with severe pain abdomen of 2 days duration. His initial investigations including CT abdomen revealed paralytic ileus with no evidence of intestinal obstruction. He was managed conservatively for next 2 days, during which his pain became worse.

Relevant test results prior to catheterization:
CT Aortic angiogram was done, which revealed multiple dissections in the Superior Mesenteric Artery with a huge pseudo aneurysm compressing upon the true lumen producing ischemia.

Relevant catheterization findings:
Superior Mesenteric artery was hooked from the left radial artery route with a Judkins Right guide catheter. Injections revealed a large false lumen with absent distal flow. There were 3 points of entry of the false lumen with dissections.

[Interventional Management]
Procedural step:
A 0.014 " Whisper wire was used to gain entry into the true lumen distally. In spite of repeated attempts, the wire followed the path of the dissection. However entry into the true lumen was facilitated by retraction of the guide into the aorta. The artery was serially dilated with a 3x24 mm semi compliant balloon in order to expand the true lumen. The distal dissection end was sealed with a 4x40 mm Cobalt Chromium coronary stent (M-Sure Cr, Multimedics). Following this, antegrade flow was re-established into the distal arteries. However the proximal edge of the pseudo aneurysm appeared to have a distinct re entry site. This was sealed with a self expanding stent 6x40 mm (EPIC, Boston Scientific). Tacking up of the true lumen edges was done with low pressure balloon dilatations. Brisk flow was restored with sealing off of the false lumen. A third site of leak was noticed at the junction of the 2 stents, which was left alone. A Patient made a quick clinical recovery with bowel movements returning by 2nd day. Patient was discharged in a symptomatic status after 5 days. Follow up CT angio after 2 weeks showed absence of any leak with patent stents.
CASES

TCTAP C-197
Successful Management of Wandering Stent from the Common Iliac Artery
Masataka Kajiwara, Yoshiaki Shintani
Shin-Koga Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
K.F.
Relevant clinical history and physical exam:
An 84 year-old-man suffered from intermittent claudication (Rutherford 2) in his right leg. His absolute claudication distance (ACD) was 90 m. His right popliteal artery and dorsal artery were weakly palpable.

Relevant test results prior to catheterization:
Ankle brachial index (ABI) was 1.03/1.07 (right/left). Post-exercise measurement of ABI was decreased into 0.79/1.11 with claudication in his right leg. Ultrasonography showed 77% diameter stenosis in the right common iliac artery and elevated peak systolic velocity (PSV) of 3.69 m/sec.

Relevant catheterization findings:
Angiography showed the stenosis in his right common iliac artery with dissection. Peak to peak pressure gradient was 19 mmHg.

[Interventional Management]
Procedural step:
We performed endovascular treatment (EVT) with bi-directional approach from bilateral femoral artery. We selected balloon expandable stent (Express LD 7.0 x 57 mm, Boston Scientific) for the accurate positioning and the stent was successfully placed just proximal of the right common iliac artery. Intravascular ultrasound (IVUS) images showed the larger vessel diameter 8.9 mm than the stent size.

Therefore, we planned to post dilatation. When we tried to pass the stent balloon, unfortunately, we pushed the stent strut and the stent slipped distally into aorta. We managed to pass the device by exchanging for another wire and crossing the outer sheath through the stent. The stent was successfully pulled back with holding by dilated balloon. Although the stent wandered back and forth, it could be placed in the accurate position. And then, self-expanding nitinol stent (S.M.A.R.T. 8.0 x 80 mm, Cordis) was placed to cover the existing stent not for slipping again. Final angiogram showed that the stent had good patency without malapposition and the flow to pseudo lumen was decreased.

Case Summary:
We describe Trans Radial approach to treat a Superior Mesenteric artery dissecting aneurysm presenting as acute abdomen and Mesenteric ischemia. Access to the true lumen was gained by use of smaller catheters and hydrophobic wires. A distal coronary stent (3x40mm) and a proximal self expanding stent (6x40 mm) were deployed in succession to seal the false lumen and restore perfusion into the intestines. It was followed by rapid and uneventful recovery.