Not a dying art! Transcatheter therapy can still be a valuable bailout to circumvent gangrene and limb loss. Meticulous attention to be paid to bleeding during overnight thrombolysis. CNS/ Groin puncture site/ oral bleed/ haematoma/ oozing at dissected segments during wire transversal. Gp2b3a inhibitors and heparin need to be given in weight-adjusted dosages to prevent systemic bleeding complications.

TCTAP C-204
Complication Leads Simple to Complicated Procedure
Seon-Won Lee, Chang-Bea Son
Busan Veterans Hospital, Korea (Republic of)

[Clinical Information]
Patient initials or identifier number:
SKM 91004476
Relevant clinical history and physical exam:
C/C: Lt claudication for 1 year
ABI 0.88/0.53
Past Hx: CVA, CRF, HBP
Relevant test results prior to catheterization:
MRA: Rt EIA Tight stenosis, Lt EIA CTO
Relevant catheterization findings:
Rt EIA stenosis with Tortuous artery and Lt EIA CTO from Internal iliac bifercation and Collateral flow to CFA
[Interventional Management]
Procedural step:
Our primary target was Lt iliac artery CTO but during vascular approach, Guide wire made Rt EIA dissection at tortuous and most stenotic lesion. And then we cannot pass any wire through the EIA. We struggled for 30 minutes to wire the vessel but we failed. So we Punctured Lt Brachial artery for antegrade wiring and successfully cross the dissected lesion. After balloon angioplasty and stenting, we achieved nice distal flow. And then we can move to our target lesion, Lt EIA CTO. We already punctured the Lt brachial artery so we decided to do antegrade approach. Lt EIA proximal CTO cap was very hard but we can pass the wire but failed to reenter the true lumen. We punctured the Lt Common femoral artery by micro puncture set and introduce Glide wire to cross the lesion retrograde. Fortunately wire meets the antegrade catheter. We deployed single self expanding nitinol stent but CFA was still remains luminal narrowing. The Lt CFA was tricky. It was ecstatic artery and abrupt dilation after stenosis. We applied another Self expanding nitinol stent and achieved better blood flow and minimal pressure gradient through the lesion.
Massage:
Sometimes, Simple looking procedure becomes complicated and disaster. Such Rt iliac stenosis, Experts instinctually knows its hazard but beginners frequently ignore the risk of dissection and pass the wire without concern. This case is quiet educating for young interventionist and also experts who are starting PTAs.
Devices:
Brachial Guiding sheath: Contra IG 8Fr 95cm.
Lt: Admiral balloon 7*60mm
Smart stent 9*60mm
Smart stent 8*60mm
Rt: P3 balloon 5*80mm, P3 8*60mm
Smart stent 8*80mm
Complete stent 8*60mm

Case Summary:
1. Primary target -Lt iliac artery CTO, Vascular approach Rt Femoral artery crossover
2. 0.035 Terumo Glide wire made Rt EIA dissection
3. Secondary vascular approach- Lt Brachial artery, 5Fr MP cath. with 0.014 Runthrough wire
4. Rt EIA - Balloon angioplasty by Cordis P3 5*80mm
5. Rt EIA - Stenting by Smart stent 8*80mm, Complete stent 8*60mm
6. Lt EIA CTO antegrade wiring by 0.035 Terumo Glide wire from Lt brachial artery - Fail (Brachial Guiding sheath: Contra IG 8Fr 95cm)
7. Lt Femoral artery punctured by Micropuncture set (Cook) and retrograde wiring by 0.035 Terumo Glide wire
8. Balloon angioplasty by Admiral balloon 7*60mm
9. Stenting by Smart stent 9*60mm, Smart stent 8*60mm

TCTAP C-205
Stenting of Spontaneous Dissection of the Superior Mesenteric Artery
Ping-Han Lo
China Medical University Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number:
ZRM

CASES
19th CardioVascular Summit: TCTAP 2014
[Clinical Information]
Patient initials or identifier number: H.C. TSAI

[Relevant clinical history and physical exam:]
72-year-old man
DM, hypertension, hyperlipidemia, smoker
Dizziness due to postural change in recent 3-4 months

[Interventional Management]
Procedural step:
1. Put 7Fr JR4 from right femoral artery to the proximal end of left subclavian artery. Put 6 Fr JR4 from left radial artery back to the distal end of left subclavian artery.
2. Try antegrade wiring using Conquest Pro 12 and Excelsior microcatheter but fail. Try antegrade wiring with Cook Approach CTO 18 and Excelsior but still fail.
3. Retrograde wiring using Cook Approach CTO 18 and Excelsior successfully to aorta then switch to Sion wire.
4. Balloon angioplasty with Maverick 2.0 x 20 mm and Sapphire II 3.0 x 20 mm subsequently.
5. Rendezvous technique in the antegrade guiding catheter and pass another Sion wire to distal left subclavian artery.
6. Switch to Cook 0.035 shuttle sheath and 300 cm Terumo wire.
7. Deploy Assurant Cobalt 7 x 30 mm to left subclavian artery.

TCTAP C-208
Invasive Physiological Assessment During Endovascular Therapy in the Superficial Femoral Artery
Kojiro Miki
Hyojo College of Medicine, Japan

[Case Summary:]
Rendezvous technique can also be applied in a peripheral chronic total occlusion
In this case, we perform rendezvous in antegrade guiding catheter in order not to extend the length of false lumen.

TCTAP C-207
Rendezvous Technique in Recanalizing Chronic Total Occlusion of Subclavian Artery
Shih-Wei Meng, Mao Hsin Lin
National Taiwan University Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number: C.H. TSAI

[Relevant clinical history and physical exam:]
61-year-old hypertensive male, under regular medical treatment, suffered from syncope with vasovagal symptoms (nausea, vomiting, perspiration, relative hypotension) at lunch, after playing golf and alcohol consumption. Physical examinations were unremarkable at the emergency department except blood pressure of 99/74 mmHg. Aortic CT scan identified spontaneous dissection of superior mesenteric artery (SMA). His elder brother died from type-A aortic dissection at age 52 and he worked abroad frequently. That is why we decided to perform endovascular treatment on him.

[Relevant test results prior to catheterization:]
Ct:1.09, Cholesterol:168, Triglyceride:156, HDL-C:42, LDL-C:94 (mg/dl).
Aortic CT scan: isolated dissection of the superior mesenteric artery (SMA).

[Relevant catheterization findings:]
Coronary arteries were normal. Dissection of the SMA was noted. The tear located at 2 cm from the origin of SMA. All the divisions were opacified without apparent thrombus. The jejunal branches were supplied by the compressed true lumen, while other branches were supplied by the false lumen (with reentry).

[Interventional Management]
Procedural step:
Right femoral arterial approach. The SMA was engaged with a 8Fr RESS guiding catheter (renal curve, short standard, Boston Scientific). Each of the side branches and divisions was probed to establish its relationship with the true or the false lumen. Most of these branches were supplied by the false lumen, with two significant lesions at their re-entry points. One of the lesion was stented by a 7/12 mm Racer stent (Medtronic), and the other was treated by balloon angioplasty (6 mm Wanda balloon of Boston Scientific). The Racer stent was upsized by a 8 mm Wanda balloon over its proximal part. Proximal side branches (jejunal branches) of the SMA was supplied by the compressed true lumen. Fenestration of the intimal flap to connect proximal true with distal false lumen was performed proximally by a Provia-12 PTCA guidewire (Medtronic), supported by a Crusade microcatheter. The puncture hole was dilated with 1.5 mm Sprinter balloon (Medtronic) and 3.0 mm and 6.0 mm Wanda balloons (Boston Scientific). A 8/57 mm Express LD stent (Boston Scientific) was deployed from proximal SMA (with coverage of proximal tear) into distal SMA (with reentry with the Racer stent). Proximal portion of the stent was upsized further by a 10/40 mm Wanda balloon (Boston Scientific) at 10 Bar. Complete sealing of the dissection with brisk antegrade flow into all but one of its divisions was achieved. The hospital course was uneventful and he remained asymptomatic at 6-month’s follow-up.

TCTAP C-206
Serial Angioscopic Evaluation of Paclitaxel-coated Nitinol Drug-eluting Stent Implanted in the Superficial Femoral Artery
Ryota Matsumoto, Osamu Iida
Kansai Rosai Hospital Cardiovascular Center, Japan

[Case Summary:]
Late-stent thrombosis (LST) happened 36 days after Zilver PTX implantation because of interrupting DAPT due to hematoma.
We could recanalize the LST lesion by aspiration and trombolysis. Angioscopy evaluation 6 months after Zilver PTX implantation showed three types of morphology; large thrombus, vascular intima, and bare stent-strut.

Twelve months after Zilver PTX implantation, large thrombus was disappeared, but visible struts with red thrombus adhesion were observed.