received BVS, 4 (7.4%) of them were multiple. 3 patients received 2 scaffolds in 2 vessels while 1 patient received 2 scaffolds in the same vessel. The mean age was 57.3 ± 9.7 years. The location of the lesions was LAD (32), LCx (11) and RCA (14). The length of devices most frequently used included 18 mm (29), 28 mm (28) and 38 mm (1). Procedural success was obtained in 53 cases. The diameter of devices most frequently used included 2.5 mm (27), 3.0 mm (22) and 3.5 mm (9). One patient had a slow flow phenomenon (final TIMI flow 2). At 6-month follow-up, one late stent thrombosis was reported in one patient 60 days after PCI requiring re-PCI.

Conclusions: BVS implantation can be successfully performed with a high procedural success rate and encouraging midterm outcomes. Larger randomized trails and longer follow-up are needed to access the potential clinical benefit of BVS versus new generation DES as these results are from a single center.

Clinical, angiographic profile and endovascular management of Takayasu's arteritis – Single center prospective study

H.S. Natraj Setty*, C.N. Manjunath

Sri Jayadeva Institute of Cardiovascular Sciences and Research, Bangalore, Karnataka, India

Objective: Aim of the study was to evaluate demographic, clinical, angiographic profile and endovascular management of Takayasu's arteritis.

Background: Takayasu's arteritis is a chronic inflammatory vasculitis affecting the aorta and its major branches. Although it is more prevalent in Asia, the distribution of the disease is worldwide with different vascular involvement patterns and clinical manifestations.

Methods: In this prospective study, a total of 50 consecutive patients who were reported as having Takayasu's arteritis between January 2010 and April 2014 were evaluated. Detailed demographic profile, clinical presentation, and angiograms of all patients were analyzed.

Results: A total of 50 patients were analyzed during study period. Among 50 patients, 43 (86%) were female and 7 (14%) were male. Average age of presentation was 26.92 years. Most common clinical presentation was claudication (74%) followed by, musculoskeletal symptoms (48%), fatigue (46%), weight loss (22%), headache (22%), visual disturbances (16%), syncope (10%), and dyspnea (20%). Most common features were absent/diminished pulses (80%), difference in blood pressure (80%), followed by bruit (70%) hypertension (64%), cerebrovascular accident (8%), heart failure (8%) and aortic regurgitation (4%). According to the new angiographic classification, angiographic type I (40%) was encountered most frequently, followed by type III (30%), type V (16%), type IIb (8%), type IIa (2%), and type IV was (4%). Angioplasty was the main stay of treatment in 66% of the patients, remaining 34% of them were treated medically either with corticosteroids or methotrexate.

Conclusion: Takayasu's arteritis is a rare disease, affects mainly women, manifestations range from asymptomatic disease, found as a result of impalpable pulses or bruits, to catastrophic neurological impairment. TA is the common cause of renovascular hypertension. Angiography remains the gold standard for diagnosis. Angiographic evaluation and percutaneous transluminal angioplasty with stenting is useful in selected cases.

Mesenteric artery stenosis presenting as severe erosive gastroduodenitis: A rare case report with long-term follow-up

H.S. Natraj Setty*, C.N. Manjunath

Sri Jayadeva Institute of Cardiovascular Sciences and Research, Bangalore, Karnataka, India

Superior mesenteric artery ischemia is a rare condition with serious clinical consequences. It may be caused by either mechanical or non mechanical obstruction of the artery. These patients usually present with recurrent abdominal pain usually occurring after meals. We report a 45-yr male patient presented with pain abdomen and epigastric burning sensation, which increases with food consumption since 6 months. Patient was evaluated and was found to have severe erosive gastroduodenitis and was secondary to superior mesenteric artery stenosis diagnosed on CT Abdomen. Patient underwent successful SMA stenting. Repeat upper GI endoscopy during follow-up after 1 month showed complete resolution of the duodenal mucosa and symptom free clinically.

Background: Superior mesenteric artery arises from abdominal aorta distal to celiac trunk. Superior mesenteric artery ischemia is a rare condition with serious clinical consequences. It may be caused by either mechanical or non-mechanical obstruction of the artery. Atherosclerotic mesenteric stenoses usually are focal and most often located at the ostium or the proximal portion of these vessels. These patients usually present with recurrent abdominal pain usually occurring after meals. Therapeutic options include surgical reconstruction and percutaneous transluminal angioplasty with or without stenting.

Case report: We report a case of 45-yr-old gentleman who came with complaints of epigastric burning sensation and pain in upper abdomen which increased after consumption of food since 6 months. He had consulted some clinics for his problem and was advised antacids but was not relieved. He even underwent cardiac evaluation for postprandial angina, which was normal. He was subjected to upper GI endoscopy, which showed erosive gastroduodenitis. He was continued with antacids and proton pump inhibitors. Since his symptoms continued to worsen, he consulted a multispecialty hospital. He underwent repeat upper GI endoscopy, which showed worsening of the erosive Gastroduodenitis (Fig. 1). The cause of which was suspected to be of ischemic origin. He was subjected to CT Abdomen, which showed superior mesenteric artery occlusion (Fig. 2). He was referred to our institute for further management. Through right femoral artery approach, abdominal aortic angiogram was done which showed total occlusion of SMA in its ostioproximal segment. A 6F selective SIM lateral guiding catheter and pilot PTA guide wire was used. Lesion was predilated followed by stenting with 7 mm × 29 mm GENESIS peripheral stent, which was deployed at 6 ATM (Fig. 3). Patient was discharged on 3rd day in a stable state. On one-month follow-up, he was asymptomatic and his upper GI endoscopy showed healing of the mucosal erosions and also CT abdomen (Fig. 4) showed patent stented segment. His 2 yrs follow-up with upper GI endoscopy showed normal gastroduodenal mucosa (Fig. 5).

Discussion: The superior mesenteric artery (SMA) arises from the anterior surface of the abdominal aorta, 1 cm below the celiac trunk and is at the lower border of the L1 vertebra in an adult. It supplies the intestine from the lower part of the duodenum through two-thirds of the transverse colon, as well as the pancreas. Mesenteric artery stenosis is a common finding in the elderly patients with atherosclerotic disease, with a prevalence of 17.5% in patients aged 65 yrs and above.[1] Atherosclerotic mesenteric stenosis usually are focal and most often are located at the ostium or ostioproximal segments of these vessels.[2] Symptoms being