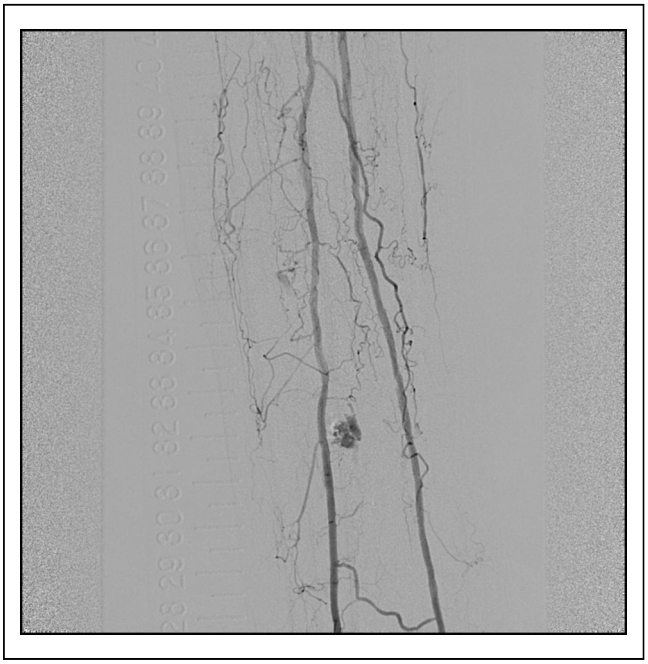
**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** We performed endovascular intervention for right POP-BK arteries. After a 4.5Fr guiding sheath inserted antegradely into the right proximal POP artery, control angiogram showed that the only remaining distal PA flow was disappeared because of wire dissection at distal POP. So we performed antegrade wiring immediately, but the wire could not cross the lesion. We tried to perform high PA direct puncture under pretty poor angiogram guidance to build bi-directional approach. Fortunately, we were successful in this puncture and wire rendez-vous technique was performed. Finally PA was recanalized. Furthermore, trans-collateral angioplasty was performed through perforator branch from distal PA and we got posterior tibial artery. But, after these procedures, angiogram showed several bleeding points from mid PA. One of those due to wire perforation was stopped with wedging microcatheter into feeding branches and the other due to PA direct puncture was obliged to be stopped using thrombin injection around bleeding points. The final angiogram showed perfect result.



**Case Summary.** We performed additional procedure to get anterior tibial artery after a few days and perfect re-vascularization was achieved. After all procedure, she was completely free from symptoms. We report a case of successful endovascular intervention for BK arteries using various bailout techniques.

## TCTAP C-186

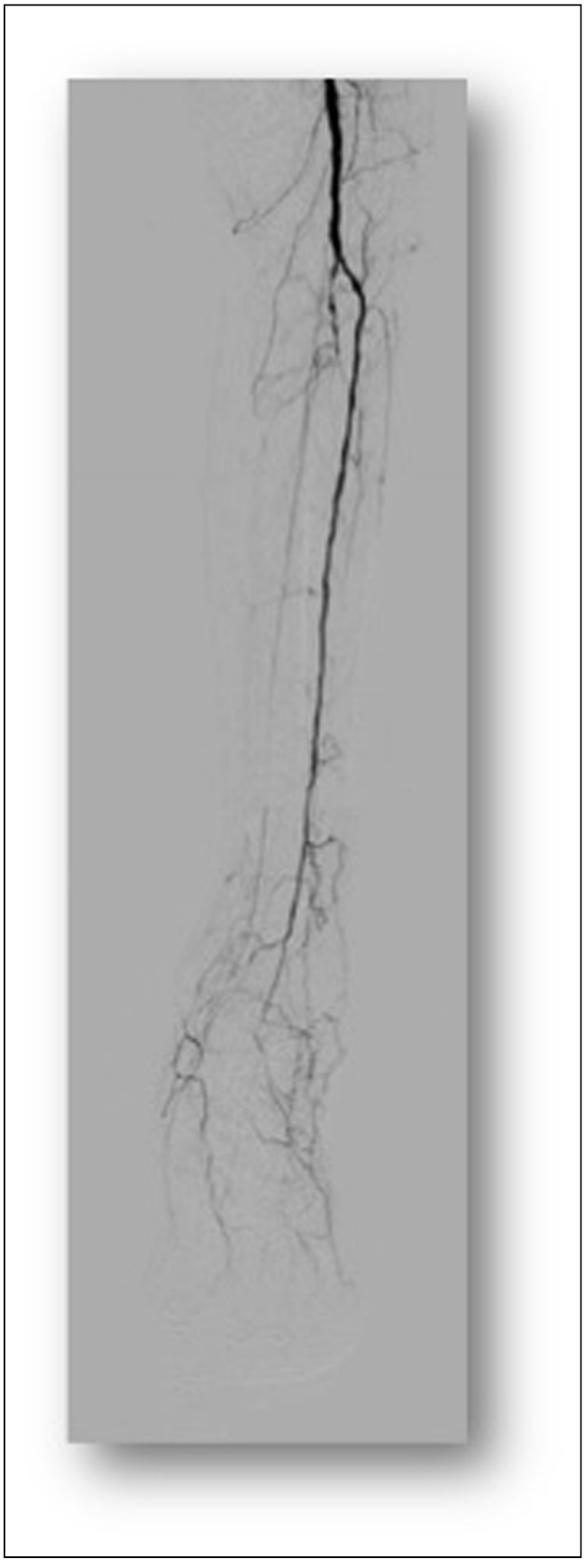
### Novel Retrograde Access for Recanalization of Below-the-Knee Arteries; Medial Plantar Artery Puncture (Sole Puncture) Technique

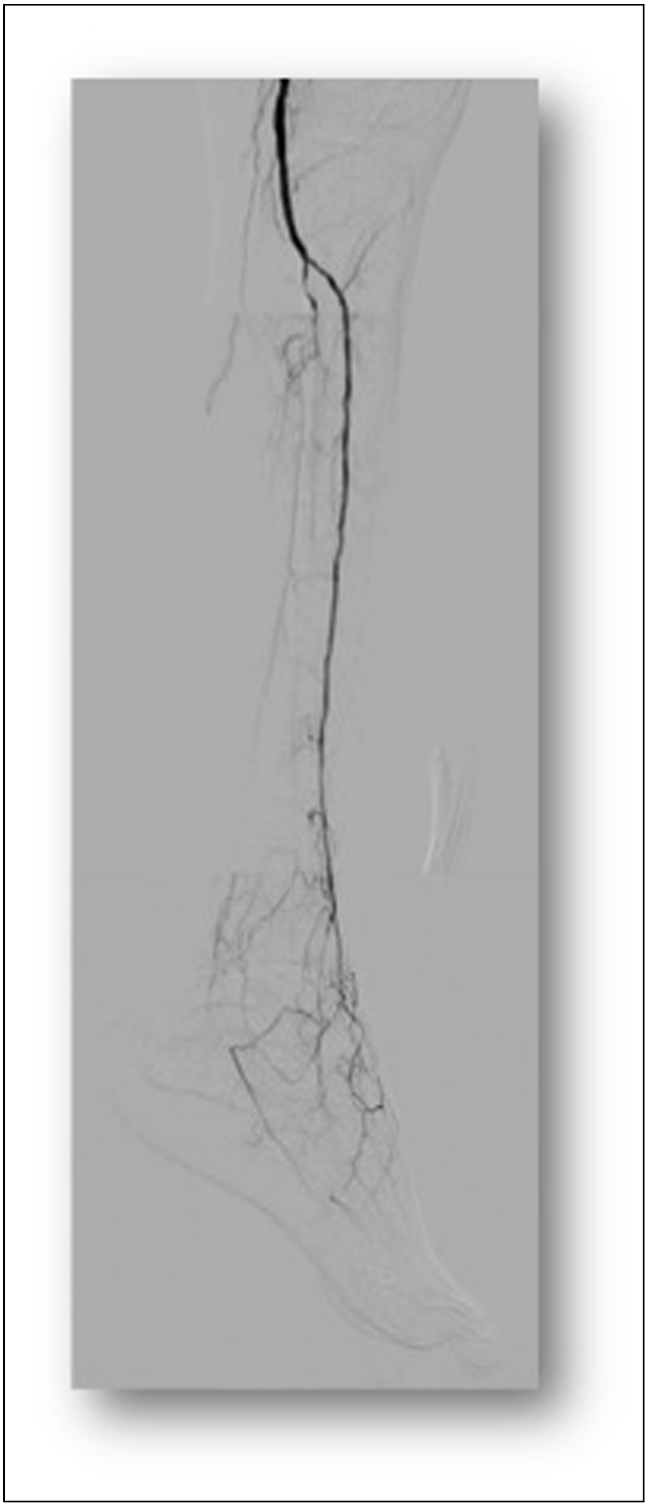
Tatsuya Nakama,[1] Yoshisato Shibata,[1] Youhei Yanagita[1]
[1]Miyazaki Medical Association Hospital, Japan

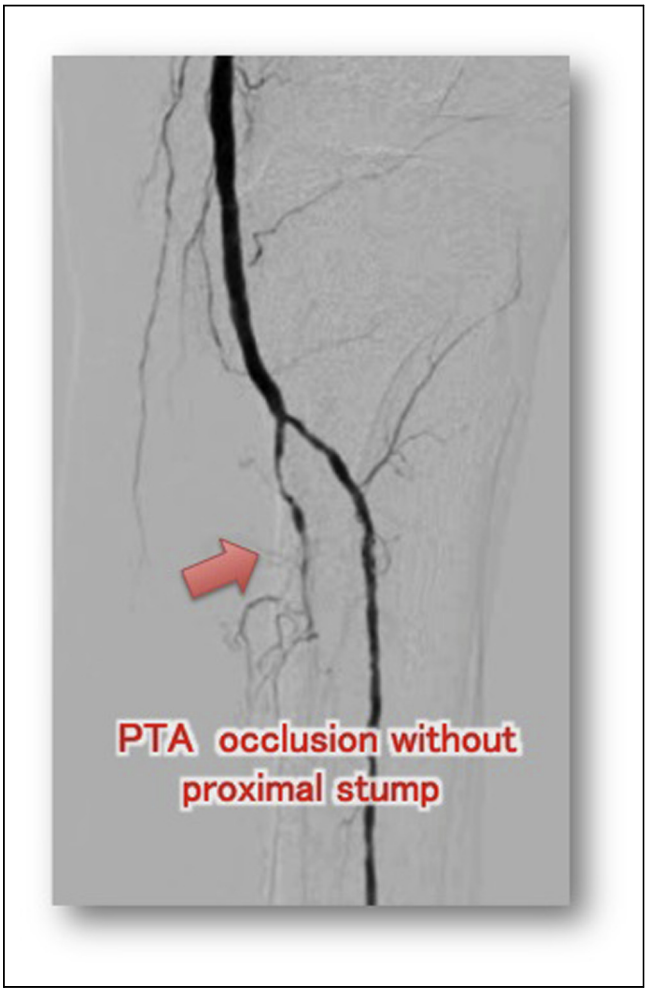
**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** SK

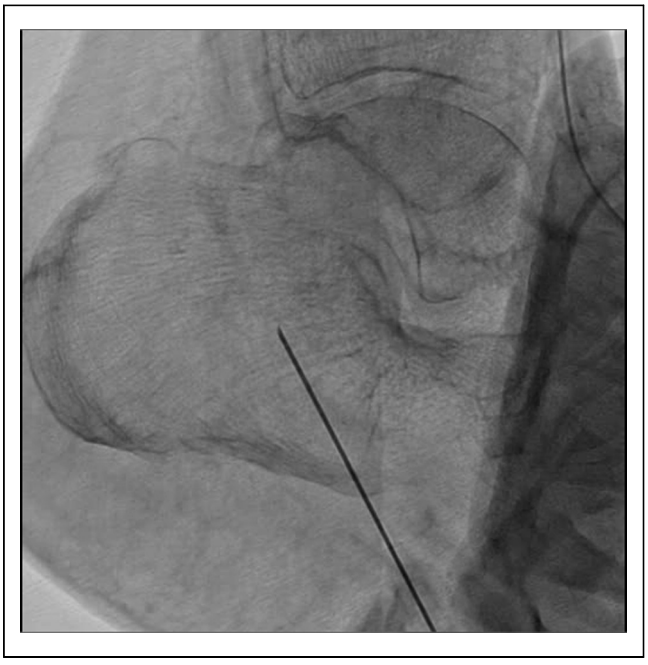
**Relevant clinical history and physical exam.** A 80s diabetic male was on dialysis, was admitted to our hospital due to a non-healed, infected wounds on his left 5th toe. Skin perfusion pressure was remarkably reduced (dorsal: 12mmHg, plantar: 10mmHg). Endovascular therapy was done for limb salvage.



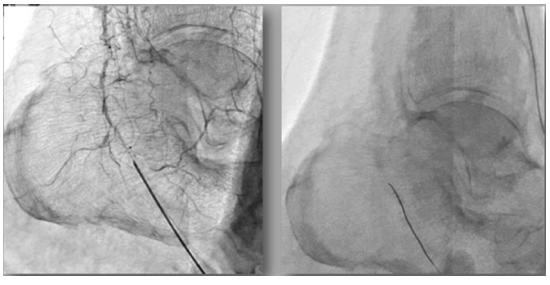





**Relevant test results prior to catheterization.** Ankle brachial pressure index (ABI): could not be measured
Skin perfusion pressure (SPP): dorsal: 12mmHg, Plantar: 10mmHg
Control angiogram showed in Figures.

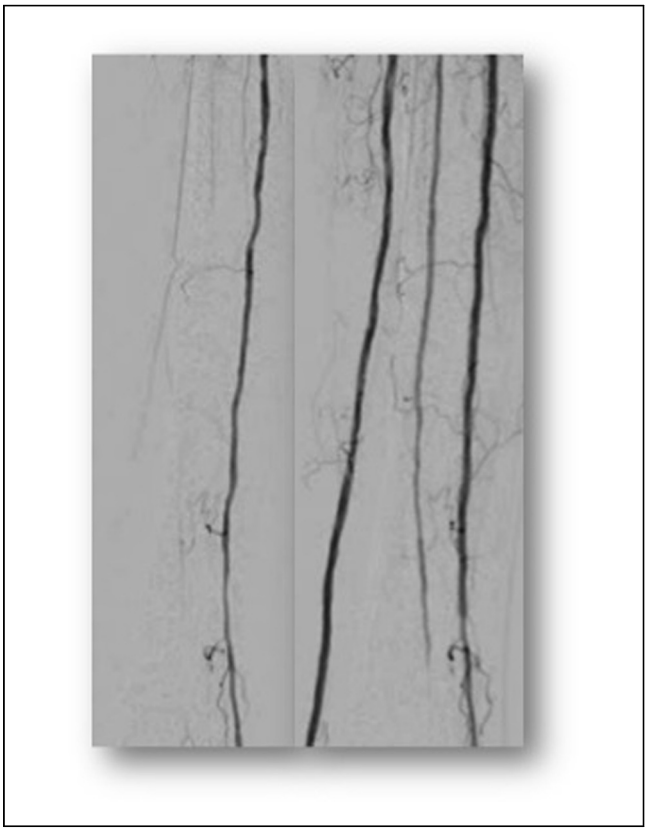


**Relevant catheterization findings.** 5-Fr 50cm sheath was inserted to his common femoral artery antegradely. Control angiogram was performed, and it disclosed patent anterior trial artery, occluded peroneal artery and posterior tibial artery. There was no proximal stump of occluded posterior tibial artery. It seemed impossible to advance the guidewire into occlusive posterior tibial artery with only conventional antegrade approach.



**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** At first, we tried to cross the guidewrie with only conventional antegrade approach. However, there was no stump of posterior tibial artery. It was impossible to cross the guidewrire to this occluded posterior tibial artery with only conventional technique. Then we tried to insert a retrograde access. However, there is no conventional retrograde puncture site. Only medial plantar artery was observed in ankle level. Then, we tried to puncture the medial plantar artery for retrograde access. Under the local anesthesia, medial plantar artery was punctured with 22G needle. Extreme puncture was succeeded, and we could finally insert the retrograde guidewire to this occluded posterior tibial artery. Polymer jacketed, hydrophiliTCTAP C-coated guidewire was carefully advanced and finally the guidewire could be crossed the occlusive posterior tibial artery. After the guidewire crossing, we externalized the retrograde guidewire with wire rendezvous technique. After the achieving a rendezvous, we dilated the occluded posterior tibial artery with 2.5/3.0mm tapered long balloon with 3 minutes.After the balloon dilatation, posterior tibial artery was nicely opened. Final angiogram disclosed nice result. We ended the procedure with satisfactory result. After the EVT, minor amputation surgery was performed immediately. Few weeks after the procedure, his wounds cured.



**Case Summary.** We named this medial plantar puncture technique as "sole puncture" technique. This extreme, extra-conventional pedal artery puncture is good optional technique for complex below-the-knee and below-the-ankle occlusive lesion, and might have a possibility to increase procedural success rate of complex endovascular therapy

## TCTAP C-187

### A SFA CTO Case with Ruptured Balloon Disparted in the Vessel Successfully Retrieved but Caused Late Phase Malapposition

Shinsuke Nakano,[1] Amane Kozuki,[1] Junya Shite[1]
[1]Osaka Saiseikai Nakatsu hospital, Japan

**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** F.S.

**Relevant clinical history and physical exam.** 64 years old female with claudication underwent due to SFA occlusion underwent EVT. Her comorbidity were anginapectoris, old cerebral infarction, diabetic mellitus, hypertension, and dyslipidemia. EVT was successfully performed as follow. Her claudication disappeared and underwent follow-up angiogram 8 months later. There were no in stent restenosis, however, optical coherence showed stent malposition with rarely seen after bare metal implantation at this time point.

**Relevant catheterization findings.** Lt SFA short CTO lesion.

**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** Under 6Fr Mach 1 guiding catheter support, antegrade IVUS guided wiring with 0.018 inch Astato passed the CTO sight. After predilation with Jackal 4 mm * 40 mm, 3 Misago stents (6 * 100 mm, 7 * 100 mm,and 7 * 100 mm) were implanted. We post dilated with Jackal 5 * 80 mm balloon but could not attain full expansion. Balloon finally ruptured at the pressure of 26 atm. With great resistance, only the shaft of the balloon catheter was pulled out. We managed to grab the disparted balloon part with snare, however,the tip of the balloon hooked into the strut and deformed some struts. Finally,pulling the snare catheter, balloon was successfully retrieved.

The 8 months follow up angiogram showed no restenosis.OCT was performed and stent malapposition was detected at the sight of strutdeformation.We performed second follow up 6 months later (14 months after implantation) and OCT showed the disappearance of stent malapposition without restenosis.