And then, tibial - peroneal trunk was performed with a kissing balloon technique (2/200mm balloon catheter was placed in ATA and 2/200mm balloon catheter was placed in tibial – peroneal trunk). Final angiogram confirmed acceptable ATA and tibial distal dilatation. This case was required the plaque debulking such as rotational atherectomy in the treatment of heavily calcified tibial - peroneal trunk lesion because balloon angioplasty couldn't prevent restenosis. We referred to other hospital which rotational atherectomy was possible.

Fourth, they performed similarly approach. Rotational passed the lesion and rotational atherectomy was performed with a 1.5 mm burr at 150,000 rpm. After successful rotational atherectomy, balloon angioplasty using 2.5/ 450mm balloon catheter to AT and 4.5/150mm catheter to ATA and tibial - peroneal trunk was performed. We could get the good blood flow in the ATA. After procedure, his rest pain was disappeared within a day. The ABI value was significantly improved to 1.25 at right side.

But few months later, ulcers were formed on a right little toe and glans. The lesions worsened progressively and he became septic. So, minor amputation of right little toe and glans was performed. Biopsy revealed intramural calcium deposition in small- and medium-sized blood-vessel within the ulcerated skin of the right little toe and glans. He was diagnosed as calciaphaxis.

**Case Summary:**
We experienced one case of Critical limb ischemia by Calciaphaxis. Endovascular treatment made it possible for him to avoid major amputation.

**TCTAP C-218**

**Impact of Staged Gradual Revascularization Combined with Thrombolysis for Acute Limb Ischemia with Massive Thrombus**

**Takashi Takamura, Taketetsu Tsuchiya**

Kanazawa Medical University, Japan

**[Clinical Information]**
**Patient initials or identifier number:** KT

**Relevant clinical history and physical exam:** When he was 37 years old, acute pulmonary embolism occurred and he was diagnosed protein C deficiency. When he was 55 years old, he underwent femoro-popliteal bypass for claudication due to occlusion of right superficial femoral artery (SFA). Three years later, bypass was redone using saphenous vein because of occlusion of prior bypass. He had been free from symptom for 14 years but claudication recurred this year. One month later from recurrence, numbness and pain occurred slowly. The vascular surgeon diagnosed acute limb ischemia due to thrombotic occlusion of bypass and thrombectomy using a Fogarty catheter and replacement of degenerative part of bypass was done. But re-occlusion of bypass occurred on the next day and he was transferred to our division. On physical examination, his right lower limb showed cyanosis and pulsus absent from popliteal to distal was examined.

**Relevant test results prior to catheterization:** Ultrasound sonography and enhanced CT showed occlusion through right F-P bypass to arteries below the knee.

**[Interventional Management]**
**Procedural step:** Initial angiography through 6 French Destination guiding sheath (Terumo, Japan) inserted by contra-lateral approach revealed entire occlusion from ostium of bypass to arteries below the knee. For massive thrombus, staged gradual revascularization combined with thrombolysis might be thought the optimal strategy. After proceeding of 0.018 Treasure guide wire (SJM, US) through bypass, careful dilatation using undersized balloons (2.0-100mm and 6.0-100mm Jackal, Kaneka, Japan) and repetitive aspiration using TVAC catheter (Mistique, Merit, US) was left at the end of second session in the expectation of thrombolysis below the knee. After another continuous 48 hrs intra-arterial urokinase (240000 U/day) and heparin (10000 U/day) infusion, initial angiography of the third session revealed recurrent thrombus in distal part of bypass graft and reperfusion of anterior tibial artery (ATA). Proceeding of 0.014 Aguru guide wire (Boston, US) through bypass graft into ATA was successful and dilatation using undersized balloon (6.0-100mm Sterling, Boston, US) for bypass graft was done initially. Next, ATA was diluted carefully by 2.5-120mm Armoda balloon (Abbott, US) and good enough blood flow from CFA to ATA through bypass graft could be obtained without distal embolism at the end of the third session. Pulsation at dorsalis pedis became palpable just after this session and he could discharge on foot without peroneal nerve palsy after rehabilitation for a few weeks.

**TCTAP C-219**

**Endovascular Revascularization of Complicated Popliteal Artery Occlusion via Trans Collateral Approach**

Shinti Tayama

Kumamoto University Hospital, Japan

**[Clinical Information]**
**Patient initials or identifier number:** KU 99098184

**Relevant clinical history and physical exam:** A 50’s earlier year old non-diabetic, normotensive current-smoker male was admitted with critical limb ischemia manifested as non-healing ulcers on toes with optimal medical therapy.

**Relevant test results prior to catheterization:** ABI was decreased to 0.41/0.65, and duplex revealed occlusion from right popliteal to mid posterior tibial artery. The echocardiography was normal, and no apparent ischaemia was detected by SPECT.

**Relevant catheterization findings:** Angiography confirmed the normal right superficial femoral artery with a blunt long, up to 24cm, total occlusion of the popliteal and posterior tibial arteries. And single vessel run-off to the right foot through the posterior tibial artery.

**[Interventional Management]**
**Procedural step:** Ipsilateral ante grade access was obtained at right common femoral artery. Using the 4 French 55cm parent guide sheath, a retrograde micro catheter was advanced over a guidewire tracking the collateral channel from the descending genicular artery. Antegrade micro catheter (CXI straight 2.6f-90cm) and retrograde guide wire (Cruise 014-230cm) were aligned inside the occluded lesion. An retrograde wire was then advanced to ante grade micro catheter with well known rendezvous technique. Then, the ante grade micro catheter was advanced further down through the retrograde guide wire. Finally, guide wire was advanced to distal portion of post tibial artery. CTO lesion of PTA was crossed with Shiden 2.0x40mm balloon, sequential dilatation was done by Coyote 2.5x150mm balloon. CTO lesion of popliteal lesion was dilated by peripheral cutting balloon 3.0x15 and Sterling 4.5x40mm balloon. TIMI III flow was established in PTA. Final angiography of the popliteal and post tibial arteries following balloon dilatation demonstrated a satisfactory result, without evidence of significant residual stenoses or flow-limiting dissections.

**TCTAP C-220**

**Bail-out of Acute Arterial Occlusion at Puncture Site After Closure Device Use**

Junichi Tuzuki

Kyoto University Hospital, Japan

**[Clinical Information]**
**Patient initials or identifier number:** C/O 226/03220

**Relevant clinical history and physical exam:** A 80 years old female admitted to our hospital due to intermittent claudication since 1 month ago. She had history of hypertension and smoking. Bilateral femoral arteries were palpable. But bilateral popliteal arteries were not palpable.

**Relevant test results prior to catheterization:** ABI was Rr 0.46/ Lt 0.51 CT angiography showed moderate stenosis at bilateral EIA and total occlusion at bilateral SFA lesion.