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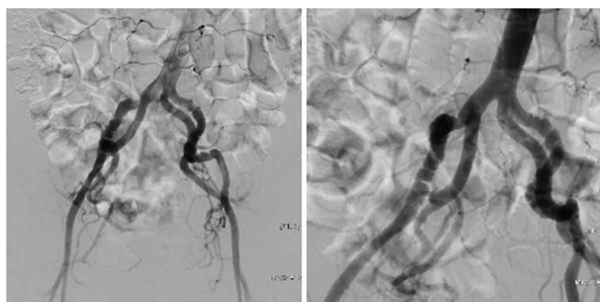
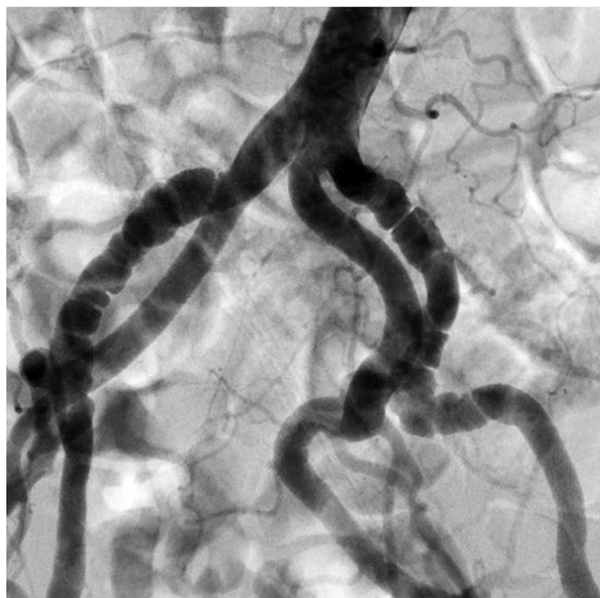
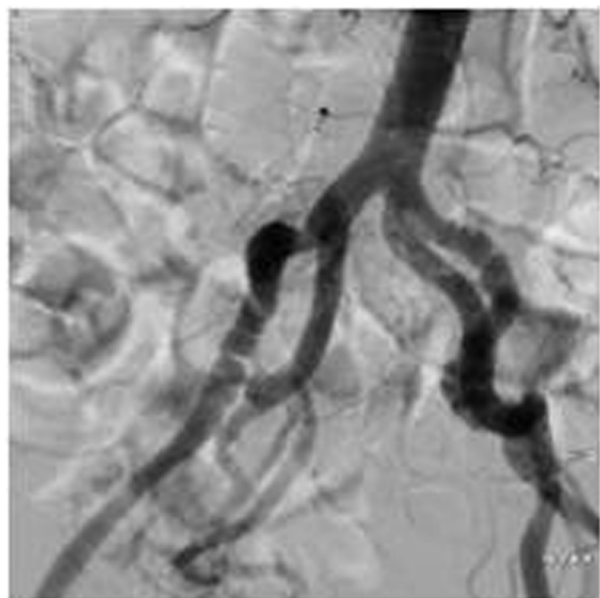






TCTAP C-183

Successful Treatment Using Rotablator for a Heavily Calcified Lesion Distal to Anastomosis of Bypass Graft in Superficial Artery

Keisuke Fukuda
Kishiwada Tokusyukai Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
30694962

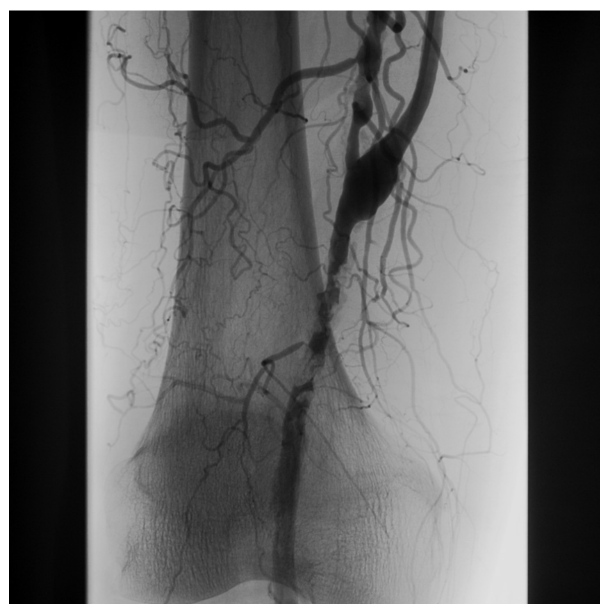
Relevant clinical history and physical exam:
He had a history of right F-P bypass in Oct. 2011 and free of claudication. He began to have right lower limb claudication for the last 3 months.
Physical examination: A weak pulse on the right popliteal, tibial and dorsalis pedis arteries.

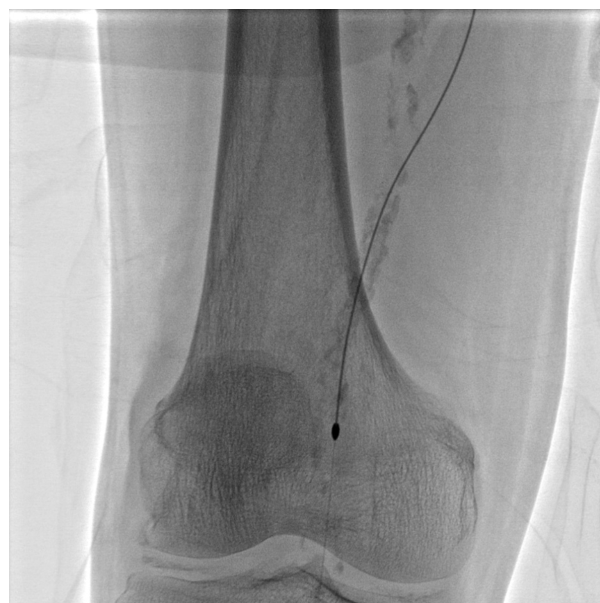
Relevant test results prior to catheterization:
ABI: right 0.21 left 0.87
Duplex ultrasonography: Stenosis of right distal SFA located to distalanastomotic site. PSV accelerated to 420cm/s at lesion

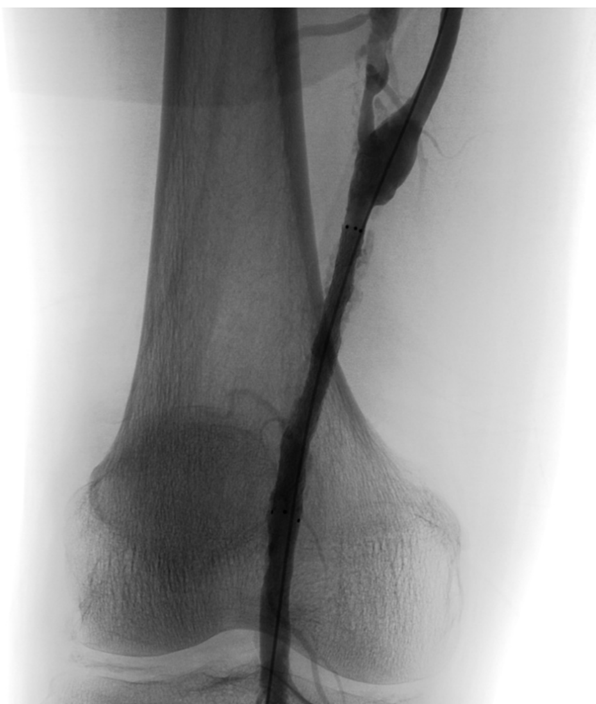
Relevant catheterization findings:
New calcified stenosis in distal to anastomosis of F-P bypass graft in SFA

[Interventional Management]
Procedural step:

1. Contralateral approach: 6Fr Cross-oversheath
2. 0.018inc guide wire with microcatheter in 5Fr Multipurpose catheter could be crossed lesion
3. Failure to 5.0 x 40mm monorail balloon passage
4. Rotational atherectomy using rotablator
5. Success to cross the lesion of balloon
6. After dilation of 5 x 40mm balloon, followed by dissection and residual stenosis
7. 6x60mm self-expandable stent was implanted
8. Post dilation by 5x40mm balloon was performed







TCTAP C-184

Percutaneous Closure of an Overworking AV Fistula in a Patient with Chronic Kidney Disease with a Hugely Swollen Arm and in Congestive Cardiac Failure

Ramesh Gadepalli
Nizam's Institute of Medical Sciences, India

[Clinical Information]
Patient initials or identifier number:
G
Relevant clinical history and physical exam:
42 years old male, Hypertensive, Chronic kidney disease – Was on hemodialysis till 1 yr back, presently on CAPD, Had an Radio -cephalic AV Fistula done 3 yrs back, Now Presented with Gradual, Massive enlargement of (L) Arm, Forearm Since 1 year Patient had Symptoms of CCF since 3 months
On Examination
PR- 104/min BP – 150/60 mmHg JVP – raised Pedal edema
(L) arm/forearm - Grossly swollen ,thrill of AV Fistula
CVS – Normal heart sounds, faint systolic murmur, RS – normal
Relevant test results prior to catheterization:
ECG – NSR, N axis, LVH with strain 2D Echo – Conc LVH, Mildly dilated Cardiac chambers, Gr 1 Diastolic dysfunction, Good LV Systolic function (LVEF-55%).
Relevant catheterization findings:
Cardiac Cath+Fistulogram Cardiac output – 9.5lit/m2.
Fistulogram shows filling of the radial artery with a rapid run-off in to the cephalic vein.
Diagnosis- High output Cardiac failure, RV failure due to an Overworking AV Fistula
Plan- Closure of AV Fistula with a stent graft.
[Interventional Management]
Procedural step:

1) Initially a 9Fr cordis sheath was inserted in to the brachial artery in a antegrade manner.
2) A 0035 " J tip terumo wire (terumo corp, japan) was used to cross the fistula.
3) The fistula site was dilated with a balloon to allow for the placement of stent graft, followed by placement of a self expanding nitinol stent graft Fluency plus vascular 10*40 (Bard Inc, NJ) at the site of AV fistula.
4) Injection post stent graft deployement revealed a good arterial flow with no venous run-off i;e the AV fistula was successfully closed.

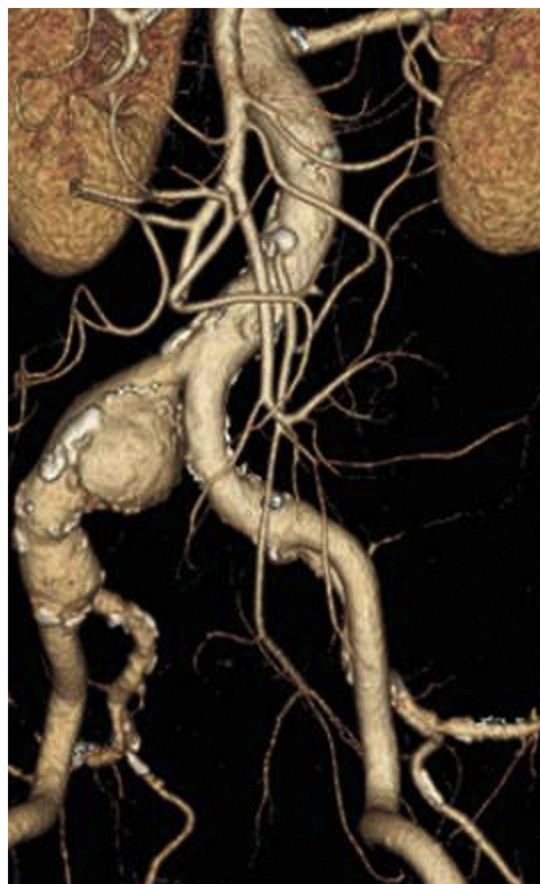
The patient was discharged after few days.
Post AV fistula closure the patient's symptoms improved, there was no evidence of CCF, the fore arm/arm swelling dramatically reduced and the size returned to near normal size.

TCTAP C-185

Successful Endovascular Treatment for Isolated Iliac Artery Aneurysm with a Small Aortic Bifurcation

Sung-Jin Hong, Do Yun Lee, Donghoon Choi
Severance Cardiovascular Hospital, Korea (Republic of)

[Clinical Information]
Patient initials or identifier number:
NSH
Relevant clinical history and physical exam:
A 70-year old man was referred for isolated iliac artery aneurysm (IIAA). He complained the incidentally found pulsatile abdominal mass at the right lower quadrant. He was heavy smoker and had diabetes. On physical examination, a 4 cm- sized pulsatile mass at the right lower abdomen was palpated.
Relevant test results prior to catheterization:
Computed tomography (CT) angiography showed a 40 mm-sized IIAA at right common iliac artery (CIA). It was originated less than 10 mm from the aortic bifurcation level. However, it was confined to the right CIA, not extended to the external iliac artery. Also, the aortic diameter at the bifurcation level was small with 16 mm.



Relevant catheterization findings:
Right CIA angiography showed the similar findings with the CT angiography. A 40-mm sized aneurysm at right CIA was noted and it was originated less than 10 mm from the aortic bifurcation.