TCTAP C-062

Type 2 Endoleak Required Repeated Embolization for Different Feeding Vessels

Kaoru Hirose,[1] Yoshimitsu Soga[1]
[1]Kokura Memorial Hospital, Japan

[CLINICAL INFORMATION]

Patient initials or identifier number. S.O

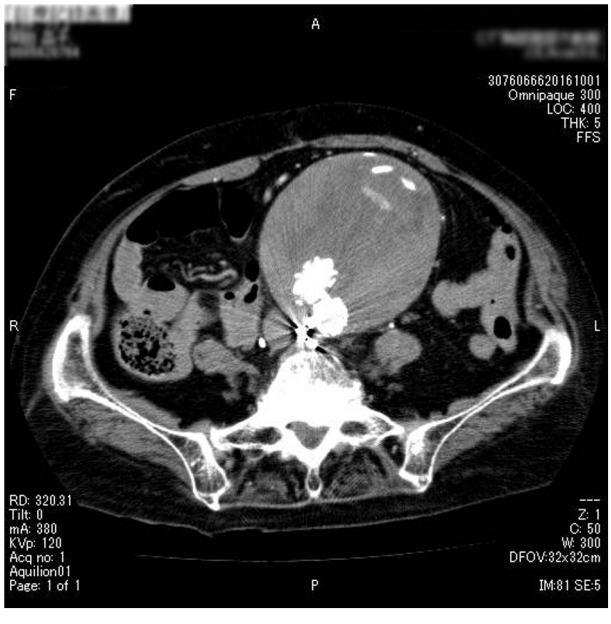
Relevant clinical history and physical exam. An 84-year-old female received endovascular aneurysm repair (EVAR) for abdominal aortic aneurysm (AAA) expanded to a diameter of 74 mm. The size of an aneurysm enlarged to 82 mm in diameter 1 year later. Angiography revealed that the bilateral lumbar arteries fed an aneurysm, and then we performed embolization for them at the level of L4 by using coils. After 2 years of EVAR, however, the size of an aneurysm expanded to a diameter of 90 mm. Thus, we tried to embolize collateral arteries again.

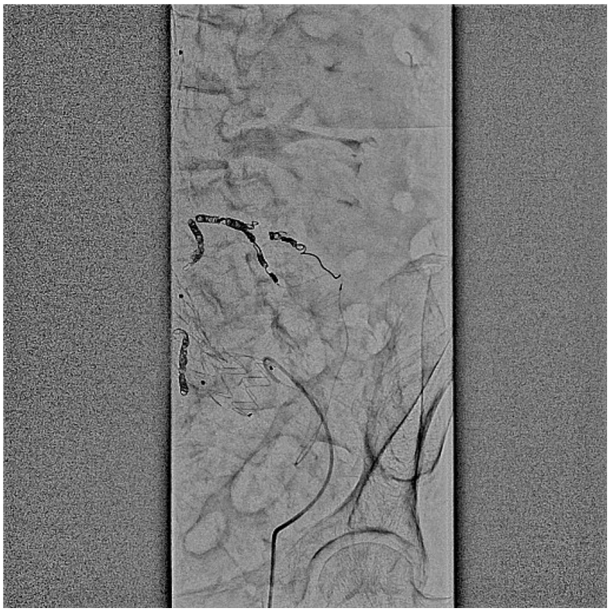
Relevant test results prior to catheterization. Although, after 1 year of first embolization, enhanced CT showed the inflow of contrast, the original arteries can not be identified. In addition; a signal of blood flow from the graft to an aneurysm was not detected by ultrasonography. Therefore, we suspected the presence of the feeding artery that is type 2 endoleak, although CT could not reveal that.

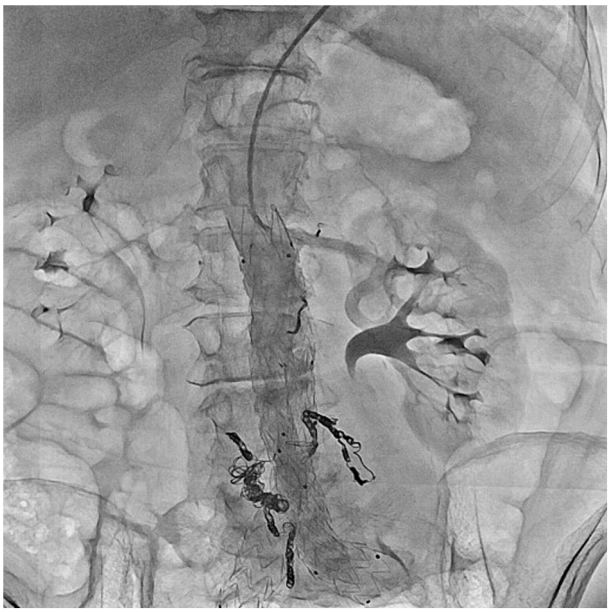
Relevant catheterization findings:

[INTERVENTIONAL MANAGEMENT]

Procedural step. We performed angiography at both lumbar arteries which had already embolized before and noted the flow of left lumbar artery into AAA. Therefore, we performed embolization of that feeding artery and confirmed disappearance of the flow into AAA by final angiography. However, enhanced-CT also showed an inflow of contrast in an aneurysm next day. Because enhanced CT could not identify collateral sources, we performed angiography again to detect original arteries of collateral sources. It was difficult to identify the feeding artery, although we performed selective angiography for major arteries arising from the abdominal aorta. Eventually, we noticed that the small and narrow collateral artery fed an aneurysm. We embolized the collateral sources using coils and confirmed the endoleak was disappeared.







Case Summary. Type 2 endoleak is not interfered positively in general because it often regresses by itself. When it gets larger, CT helps us to identify the origin of collateral. However, CT is useless when the feeding artery is small like this case. In this case, We engaged catheter in each side branch of aortic artery and a small vessel arising directly from the abdominal aorta and succeeded in embolizing it.

BIFURCATION/LEFT MAIN DISEASES AND INTERVENTION (TCTAP C-063 TO TCTAP C-078)

TCTAP C-063

How to Make a Deal with Distal Left Main Coronary Artery Type A Trifurcation Lesion

Yusra Pintaningrum,[1] Yudi Her Oktaviono,[2]
Budi Baktijasa Dharmadjati[2]
[1]Faculty of Medicine, Mataram University, Indonesia; [2]RSUD Dr. Soetomo hospital, Indonesia

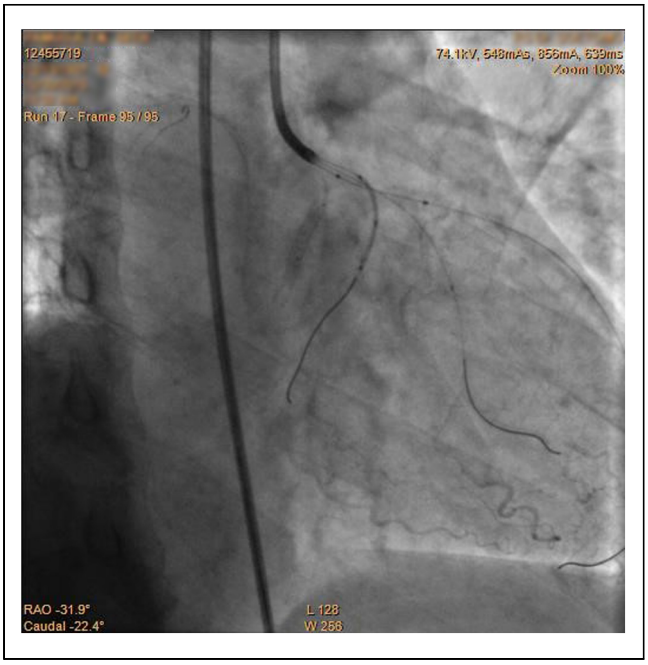
[CLINICAL INFORMATION]
Patient initials or identifier number. P

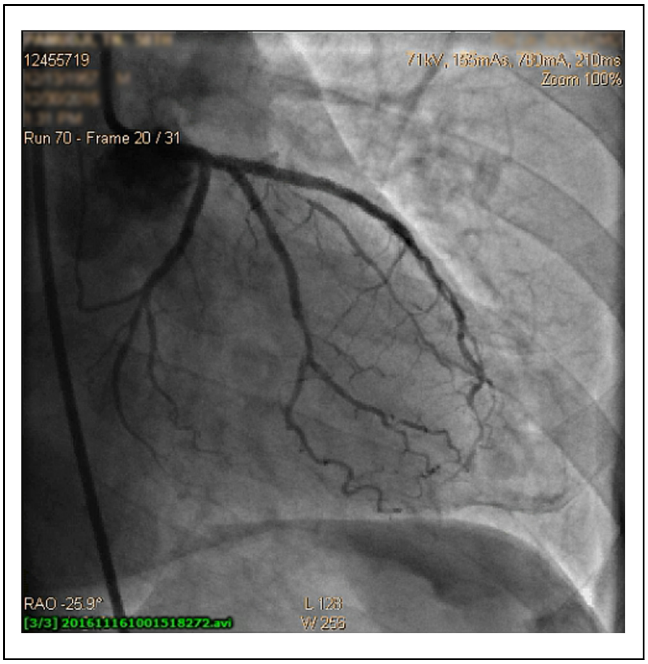
Relevant clinical history and physical exam. A 57-year-old- man admitted to RSUD DR. Soetomo Surabaya because of progressively increasing chest pain for minimal efforts. He had unregulated diabetes for 5 years and was a heavy smoker. This patient hospitalized 1 month ago with inferior myocardial infarction and underwent primary PCI. His blood pressure was 130/80 mmHg, heart rate 90 bpm, and respiratory rate 20 times per minute.

Relevant test results prior to catheterization. The electrocardiogram showed sinus rhythm 67 bpm with inferior old myocardin fraction. A transthoracic echocardiography revealed normal left ventricular (LV) systolic function (Ejection fraction 62%) with normokynesia of segmentalLV.

Relevant catheterization findings. A coronary angiography via right femoral artery approach showed significant stenosis 60% at distal LM with type A subtype A2b trifurcation lesion with modified media classification 1101. it showed diffuse disease from osteal to distal LAD with maximal stenosis up to 80% at ostial-proximal LAD, stenosis 60% at proximal-mid ramus intermediate (RM), and stenosis up to 70% at ostial-proximal nondominant LCX. There was old patent stent at proximal-mid RCA, Syntax score 40.

[INTERVENTIONAL MANAGEMENT]
Procedural step. Trifurcating wires were used to cross LCX (BMW wire), ramus intermediate (BMW wire), and LAD (run through NS hyper coat wire). Using crush technique, predilatation with Across HP balloon 2.5 x 20 mm in the proximal and ostial LAD at 18 atm, pulled out, was placed in the ostial proximal LCX and dilated at 18 atm, then was placed in the distal LM - ostial proximal LAD. In the next step, the first stent was the 2.75 mm x 25 mm Cre-8 DES Stent, deployed into the ostial-proximal LCX at 9 atm as side branch, protruded into LM. Across HP balloon pulled out. The second stent was the 3.5 mm x 24 mm Biomime DES Stent which placed in the LM-ostial-proximal LAD, deployed at 9 atm, post dilated at 16 atm. Saphire balloon II 1.5 x 12 mm was dilated at proximal - mid LAD at 14 atm, followed by Across Hp balloon 2.5 x 20 mm at proximal LAD 10 atm. The stent DES Biomime 2.75 x 48 mm at proximal - mid LAD overlapped with stent above, deployed at 18 atm. We tried to insert the 2.5 mm x 38 mm Cre-8 DES stent inside STO1 and placed to RM, but failed. Predilated with the 2.75 x 25 mm Cre-8 ex-stent balloon 12 atm at proximal - mid RM. Then, the stent DES Cre-8 2.5 x 38 mm inside STO1 catheter placed at proximal - mid intermediate and deployed at 12 atm with mother-and-child method. Triple kissing balloon with Cre-8ex-stent balloon 2.5 x 38 mm at ostial proximal LAD, Mozec balloon 2.0 x 9 mm at proximal-mid intermedius, and, Mozec balloon 2.0 x 9 mm at ostial LCX, dilated at 6 atm. Good final result.





Case Summary. We reported a 57-year-old man with distal LMCA type A subtype A2b trifurcation lesion with modified medina classification 1101. Our strategy was a step-crush technique to treat left main distal trifurcation with additional stenting in ramus intermedius provisionally using modified double guiding catheter mother-and-child techniques. A procedure was closed by a triple kissing balloon with good final result without residual stenosis (TIMI flow grade III).

TCTAP C-064
LMCA Stenting in a Dissection Look a Like Acute Plaque Rupture

Jabir Abdullakutty,[1] Jimmy George P[1]
[1]Lisie Heart Institute, Kochi, India

[CLINICAL INFORMATION]
Patient initials or identifier number. 60-year-old male