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## Case Report

# Balloon angioplasty with secondary stenting for chronically occluded abdominal aorta in a symptomatic patient



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## ABSTRACT

A case of chronic total occlusion with disabling claudication of both lower limb and buttocks. Procedure was done by endovascular method.

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## 1. Case report

A 49-year-old male presented with history of B/L lower limb claudication and pain over buttocks of 2 years duration. He is a chronic smoker, normotensive, and nondiabetic. He underwent MR angio 1 year ago, which revealed total occlusion of abdominal aorta juxtarenal over a length of 60 mm (Figs. 1 and 2).

On physical examination, lower limb pulses were absent bilaterally, and bruit was heard over abdomen. His ECG was normal and echo revealed good LV with no RWMA. Blood investigations – haemogram, FBS, RFT, and TFT – were normal. His FLP showed hyperlipidemia with hypertriglyceridemia. He underwent abdominal aortogram through right radial route which revealed totally occluded infrarenal abdominal aorta (TASC Type D). Both renal arteries were normal. Common iliac arteries seen filling through collaterals showed proximal diffuse stenosis. EIA and IIA, SFA, PA, and leg arteries were normal (Figs. 3 and 4).

## 2. Procedure

B/L femoral access with retrograde approach was using 7F sheaths and left radial antegrade approach was with 6F sheath. 6F Judkins GC was parked distally before the stump and tried to cross the lesion with 0.0035 glide GW but failed. Finally, the CTO segment was crossed retrogradely using 0.014 approach CTO wire (cooks) from right femoral route (Fig. 5). True lumen entry was confirmed by injecting the contrast through the catheter. Balloon dilatation was done with 2.5 × 20 balloon. 0.014 GW was exchanged with 0.035 wire and subsequently kissing balloon technique was performed with 3.5 × 40 balloon (Fig. 6). Check angio was done and two balloon expandable stents were deployed simultaneously (8 × 57, 8 × 57 (EXPRESS-BOSTON)) at the CTO segment just distal to the renal arteries (Figs. 7 and 8) and SKS was done at proximal CIA using 8 × 60 EPIC stents (self-expanding BOSTON). Kissing balloon dilatation was done at low pressure (Fig. 9). Check angio revealed no residual

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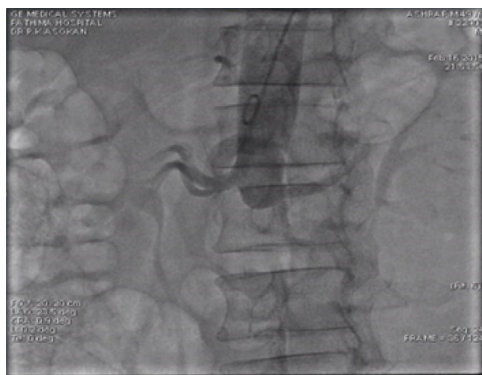
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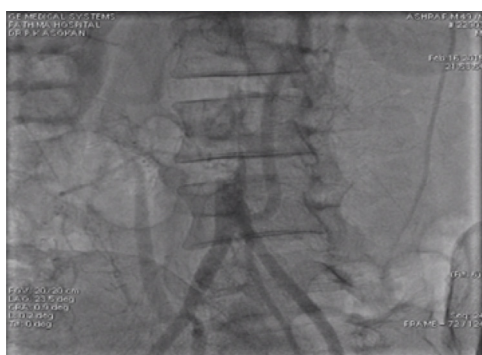
**Fig. 1 – MRA of abdominal AO LL arteries.**



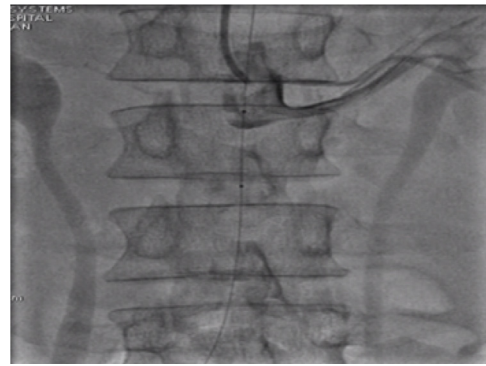
**Fig. 2 – MRA of abdominal AO LL arteries.**



**Fig. 3 – Abdominal aortogram through trans radial route.**



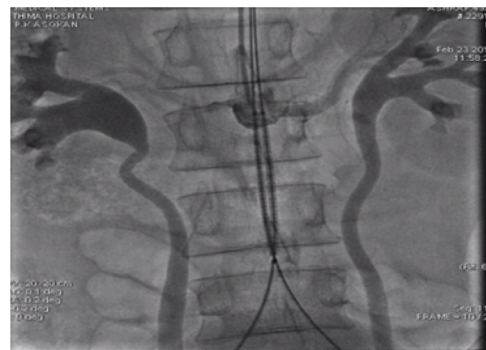
**Fig. 4 – Abdominal aortogram through trans radial route.**



**Fig. 5 – Retrogradely from RFA approach CTO wire.**



**Fig. 6 – 3.5 x 40 Kissing bal.**



**Fig. 7 – 8 x 57 Express-stent positioning.**



**Fig. 9 – 8 x 60 Epic stent.**

stenosis at CTO site with well-expanded stents at distal abdominal aorta and common iliac arteries with good distal flow in both lower leg arteries (Fig. 10). Pressure gradient was measured across the stented segment.

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