A 87-year-old woman, having an episode of hypertension, suffered from coldness of her each finger every winter. This ambulatory woman had rest pain in her right foot 2 months ago, and referred to our hospital with a deeply erythematous on her right foot. At clinical examination, her right leg was extremely painful and edematous, and intractable skin ulcers emerged on from her 2nd to 4th fingers. Skin perfusion pressure (SPP) of her right plantar was 7 mmHg. Based on positive anti-centromere, anti-SSA and anti-SSB antibody test, we made a diagnosis of limited cutaneous systemic sclerosis (lcSSc) with Sjogren's syndrome.

Initial angiogram showed around 15 cm occlusion of right superficial femoral artery (SFA), total occlusion of right anterior tibialis (ATA), posterior tibialis (PTA), and peroneal artery (PA), and severe stenosis of tibioperoneal trunk (TPT) supplied collateral flow to pedal artery, resulted in very little pedal filling. We could perform balloon angioplasty at the SFA and PA occlusive lesion and severe stenosis of TPT, but failed to cross the ATA long occlusive lesion. SPPs at her right dorsal and plantar on the day after EVT were 21 and 14 mmHg, respectively. At 9 days after lumbar sympathetic nerve blockade, her rest pain was relieved and SPPs increased to 35 and 45 mmHg. Finally, the tips of all her right toes turned to black, which resulted in metatarsal amputation inevitably. Six months later, she walked to our clinic without training wheels.

Combination with EVT and lumbar sympathetic nerve blockade could escape from major amputation for patients suffered from critical limb ischemia with poor runoff artery to below the ankle lesion, especially concomitant with collagen disease, such as systemic sclerosis.