1111 **A Complex Case Requiring Report Revascularization for Severe Calcified Femoro-Popliteal Artery Lesion during a Short Period**

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The patient was a 70s-years old male complaining of severe claudication. He underwent endovascular therapy (EVT) for the bilateral femoro-popliteal (FP) artery lesion at the other hospital 6 years before, however, guide wire could not be passed due to severe calcification. A bypass surgery was considered, but the attending doctor hoped to keep saphenous vein graft because his all coronary arteries had moderate narrowing not but significant ischemia. At first, we treated bilateral FP lesions with stent graft. Subsequently, popliteal artery (PopA) including below the knee lesion was treated in two phases.

After treating right PopA, we try to treat the left PopA. He received drug-coated balloon (DCB) strategy 2 months before, but the initial angiography revealed the left PopA already occluded. Wire bias was not so good with intravascular ultrasound (IVUS) examination, and we employed DCB and debulking with Jetstream? SC only. Final IVUS image revealed minimum lumen area was 7.8 mm2. Unfortunately, ultrasound image showed a loss of blood flow of all left FP artery. Thrombosis was developed up to the proximal edge of VIABAHN in FP artery. A large volume of thrombus was aspirated with Indigo/CAT8?, recoil due to severe calcification was confirmed, and it leaded to acute occlusion. Therefore, we employed the CRACK and PAVE technique and implanted a stent graft and interwoven bare nitinol stent for PopA. We achieved a good blood flow and finished the procedure. We confirmed keeping patency and added a direct oral anticoagulant. He discharged on the third postoperative day.

Calcification is maximum enemy of FP EVT, but there is some limitation for PopA imvolvement. We will present here on this challenging case with the details of the procedure.