A 69-year-old man admitted to our hospital with unstable angina pectoris and claudication involving both lower extremities. His emergent coronary angiogram showed severe stenosis in the left main trunk and an unstable lesion was treated with stent successfully. Fortunately, we could avoid an emergent coronary bypass surgery in this case. A month later, an abdominal aortogram showed subtotal occlusion of his right superficial femoral artery, but his left common iliac artery (CIA) was not visualized despite his ankle–brachial index was 0.7. To evaluate the collateral into his left CIA, enhanced 64-slice computed tomography (CT) (Siemens, Munich, Germany) was performed after injection of contrast covering the cervical and thoracic areas, the abdomen, and upper portion of the lower limbs. Volume rendering images satisfactorily visualized his left CIA filled through Winslow’s pathway.

Winslow’s pathway is a collateral circulation from the subclavian artery via the internal mammary artery (IMA), the superior epigastric artery, and the inferior epigastric artery into the external iliac artery. This pathway is one of the collaterals supplying blood flow to the lower extremity in aortoiliac occlusive disease.

To detect Winslow’s pathway is important because the use of IMA as a coronary bypass graft would cause lower extremity ischaemia. As Winslow’s pathway is not the only collateral in the aortoiliac occlusive disease, multi-slice CT seems useful to detect other collaterals.