TCTAP C-103
Successfully Treating Outside Interlayer and Hematoma After Opening RCA CTO
Anlin LV
Fourth Military Medical University, China

[Clinical Information]
Patient initials or identifier number: Male, 64 years, chest depressed pain for 2 years, aggravation 7 days
Relevant clinical history and physical exam:
UCG: EF50%; MS (mild); LV large
X-RAY: More lung texture, breadth of mind 0.55
Relevant test results prior to catheterization:
Brain CT: Stroke mild, change of lacking blood
Normality of liver and kidney function
Relevant catheterization findings:
RCA CTO at the middle

[Interventional Management]
Procedural step:
JL3.5 settling the supporting power
Mini-catheter make wire passing through curved vessel
Change pilot200 through CTO bending part
Balloon depressed outside hematoma and interlayer
Strategy of stent

TCTAP C-104
Sheathless Transradial Reverse CART Intervention for Tortuous RCA CTO
Goma Maung, Chiung-Jen Wu
Chang Gung Memorial Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number: Shih Pi Yun 6117641
Relevant clinical history and physical exam:
A 67 years old female
Known to have CAD s/p PCI to mid LAD and proximal RCA July 2008
Referred from other hospital after failedRCA CTO wiring attempt May 2013
Complaint of chest pain on exertion
Risk factors: - Hyperlipidemia
NIDDM HTN
Parkinson’s disease

Relevant test results prior to catheterization:
Echo: No regional wall motion abnormalities
Thallium scan: Ischemia at apical and inferior segment

Relevant catheterization findings:
= Angiographic finding =
Coronary angiogram:
LM: No stenosis
LAD: The prior stented mid segment had 36% ISR (MLD/ref: 1.78/2.79mm)
LCx: Mild luminal irregularities
RCA: The prior stented ostium and proximal segment had 63% ISR (MLD/ref: 1.05/2.81mm); the mid segment had 72% stenosis (MLD/ref: 0.70/2.55mm); the distal segment is CTO

[Interventional Management]
Procedural step:
<PCI to RCA CTO via antegrade and retrograde approach>
0.014" Runthrough NS guidewire was advanced to the d-LAD and another 0.014"
Runthrough Floppy wire with Finecross microcatheter advanced to septal branch
successfully; then changed to Sion wire which failed to cross the 1st septal collaterals
and resulted in a small vessel wall hematoma. A NC Trek 3x15mm balloon was
inflated at LAD stent with a maximum atm of 16. The Runthrough GW loaded on
Finecross microcatheter was advanced to the 2nd septal branch and was able to cross
to the PDA branch of RCA, then it was exchanged to Fielder FC GW.
and was advanced to the d-RCA. Antegradely, the 5F GC was exchanged to AL1 ST
with side holes, and was engaged to RCA os and pressure damping and hypotension
was noted due to para ostial lesion. A 0.014 Runthrough Floppy wire loaded on a
Finecross microcatheter was advanced to the lesion and was changed to Fielder FC the
the Athlete 3 GW which was able to cross the lesion. "Reverse CART" was tried with a
Mini-Trek 1.5 balloon but the poor backup support make the GC to jump out to the
Aorta. A NC Trek 3x15mm balloon was inflated at the proximal RCA up to the ostium
with a maximum atm of 26. The "Reverse CART" was tried again but failed again and the
GC disengaged into the aorta. "Reverse CART" was successful after another Finecross
GW was advanced to the Conus branch and with anchoring using a Trek
2.0x20mm balloon in the conus branch. The "Reverse CART" was done using a
Mini-Trek 1.5x12mm balloon inflated up to 20 atm at the lesion. Then a Mini-Trek
2.5x12mm balloon inflated up to 20 atm at the lesion. Then a Mini-Trek 2.5x12mm
balloon inflated up to 20 atm at the lesion. Another NC Trek 3x15mm balloon was inflated at
the lesion with a maximum atm of 18 atm. The Retrograde wire was successfully advanced
to the RCA GC and anchoring inside the GC was done using a Mini-Trek 2.5x20mm
was done and Fine Cross MC was advanced to the GC. Then, externalization was
successfully done using a 0.010" x330 cm RG-3 guidewire. IVUS(lab) was done and showed the GW in true-false-true with a very small segment in false lumen and showed ostial very tight stenosis (MLA=4.56 mm²) inside the old stent and presence
of instant dissection flap. A NC Trek 3x15mm balloon was inflated at mid to os RCA
with a maximum atm of 20. Two DES were deployed from distal to mid RCA to cover
the CTO segment (Xience Prime 2.75x38mm and 3x38mm) with a maximum atm of
16. For a residual stenosis of 67% (MLD/ref: 0.86/2.58mm) at m-RCA a DES (Xience
Prime 3.5x38mm) was deployed at the lesion with a maximum atm of 16 and for a residual stenosis of 48% (MLD/ref: 1.58/3.06mm) at m-RCA a DES (Xience Prime
3.5x38mm) was deployed at the lesion with a maximum atm of 20. Final IVUS showed well deployment of all stents except the distal part of m-RCA stent; so further
dilatation was done with a NC Trek 3.5x15mm balloon was inflated at mid to os RCA
with a maximum atm of 20.

TCTAP C-105
Minimum Contrast PCI to Multivessel CTOs
Tsutomu Murakami, Naoki Masuda
Tokai University Cardiology of Medicine, Japan

[Clinical Information]
Patient initials or identifier number: H.S
Relevant clinical history and physical exam:
A 64-years old male who underwent coronary artery bypass graft 11 years ago was
admitted to our hospital complaints of chest discomfort at effort.
The grafts were bypassed through left internal mammary artery (LIMA) anastomosed to
left anterior descending artery (LAD), ascending aorta to right coronary artery
(RCA) using saphenous vein grafts (SVG).

Relevant test results prior to catheterization:

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