**TCTAP C-050**

**Left Main Coronary Artery Stenting and Right Common Carotid Artery Stenting in a Single Procedure Using Brachial Artery Approach in a High-risk Patient with Leriche’s Syndrome**

Jakub Honek, Josef Veselka  
Motol University Hospital, Czech Republic

[**Clinical Information**]

Patient initials or identifier number: RP  
Relevant clinical history and physical exam:  
Female, 71 years, smoker  
Ischemic heart disease - CCS III, NYHA III  
- 3/2009 coronary angiography - chronic total occlusion of the right coronary artery, conservative approach  
Leriche’s syndrome – Fontaine Ia  
Cerebrovascular disease – ischemic stroke 2007  
- asymptomatic 80% right common carotid artery stenosis  
Arterial hypertension, dyslipidemia  
Chronic obstructive pulmonary disease – GOLD IIb  
Physical exam: loud systolic bruit above right common carotid artery, femoral arteries non-palpable  

**Relevant test results prior to catheterization:**  
Duplex ultrasonography: significant stenosis of the right common carotid artery  
Echocardiography: good systolic function of the left ventricle, no valvular disease  

**Relevant catheterization findings:**  
Chronic total subrenal occlusion of abdominal aorta  
Long 80% stenosis of the right common carotid artery, 50% stenosis of the right internal carotid artery  
80% ostial stenosis of the left main coronary artery, 50% ramus intermedius stenosis  
Heterocollaterals to right coronary artery (previously known chronic total occlusion)

[**Interventional Management**]

**Procedural step:**  
Right brachial artery approach with the AVANTI® Introducer (Cordis Corporation, Miami, FL) was introduced to the right external carotid artery. A VascuFlex 8/40 mm stent (B. Braun, Bella Vista, Australia) was implanted directly in the RCCA. 3x postdilatation with 4x11, 5.5x20 and 7x15 mm balloon catheters (Falcon grande, INVATEC, Roncadelle, Italy) was performed. Angiography of the left common carotid artery was then performed with the ESU 3.5, 6 F Access guiding catheter (Innovative technologies, Barcelona, Spain). A Biomatrix 4x11 mm stent (Biosensors interventional Technologies, Singapore) was implanted directly in the left main coronary artery (LMCA). 2x postdilatation with 5x8 mm balloon Sprinter (Medtronic, Minneapolis, MN) was performed.

**Case Summary:**  
We report a case of a 71-year old female patient admitted for exertional chest pain and dyspnea and a known asymptomatic stenosis of right common carotid artery (RCCA). The patient was previously diagnosed with Leriche’s syndrome (subrenal total occlusion of abdominal aorta). RCCA intervention and coronary angiography were planned in a single procedure using right brachial artery approach.  
RCCA angiography confirmed a long 80% RCCA stenosis, direct stenting was performed, with no residual stenosis. Coronary angiography revealed an 80% ostial stenosis of the left main coronary artery (LMCA), 50% stenosis of ramus intermedius and heterocollaterals to right coronary artery (previously known chronic total occlusion). Direct stenting of LMCA was performed, with no residual stenosis. There were no procedural complications. The patient was free of exertional chest pain and dyspnea on the follow-up visit. In summary we performed LMCA and RCCA intervention in a single procedure using right brachial artery approach in a high-risk patient with Leriche’s syndrome.

**TCTAP C-051**

**How to Manage Thrombus When PCI in ACS patients**

Cheng Chung Hung, Wei-Chun Huang  
Pingtung Branch, Kaohsiung Veteran General Hospital, Taiwan

[**Clinical Information**]

Patient initials or identifier number: 14091408  
Relevant clinical history and physical exam:  
A 50-year-old man was admitted to our hospital with chest pain while driving his car. On admission, his systolic blood pressure was 70 mmHg by palpation, his heart rate was 30 bpm and the respiratory rate was 30 / min.

**Interventional Management**

**Procedural step:**  
The first case was a 35-year-old man with history of LM, TVD s/p CABG, patent LIMA to LAD but occluded RIMA to RCA/LCX. Due to ACS, we considered to arrange PCI for LCx. Initially the EBU guid catheter 3.5/6f was engaged to RCA. The LCx orifice CTO lesion was crossed with an Ultimate bro 3.014” wire under Finercross microcatheter support, and PTCA was done with 1.0/6mm, 1.5/20mm, and 2.0/20mm balloon. Further kissing balloon technique over LM bifurcation was done, but LCX still no reflow. Thrombus was aspirated out. The flow regained. The second case was a 53-year-old man who suffered from STEMI and CAG showed thrombus over bifurcation of PL and PDA. Initially Ikari left 3.5/6f guid catheter was used to engage RCA orifice, and RCA-PL lesion was passed with Fielder FC wire. Massive thrombus aspiration over PL/PDA bifurcation was done. After that, TIMI 3 flow regained, and no more PTCA or stent needed. The following CAG with IVUS and virtual histology showed stable plaque. The third case was a STEMI case, anterior wall, and CAG showed thrombus over LAD-M. The Ikari left 3.5/6f guid catheter was used to engage LCA orifice. Thrombus aspiration was done initially, but little thrombus was aspirated. A 3.0/20 mm balloon was inflated over the plaque. After PTCA, no-reflow phenomenon occurred due to distal thrombus obstruction. We used Thrombaster again and lots of thrombus were aspirated out. Finally, still TIMI0 flow noted.

**Case Summary:**  
These cases demonstrated the importance of thrombus aspiration before PTCA or stenting. The first case aspirated thrombus before PTCA and stenting, and the procedure was smooth without no-reflow phenomenon. The second case aspirated all the thrombus out and no PTCA or stent needed. The following IVUS and virtual histology 3 months later showed TIMI 3 flow and stable plaque. The third case suffered from no reflow phenomenon after PTCA due to inadequate thrombus aspiration initially.

**TCTAP C-052**

**Trans-radial Intervention Under Extracorporeal Life Support for the ACS Patient with the Anomalous Origin of the Left Main Coronary Artery**

Kohki Ishida, Kei Yamamoto, Shingo Yamamoto, Shin-Ichi Momomura, Takeshi Ishida, Tomohiro Nakamura, Yusuke Adachi  
Saitama Medical Center, Japan

[**Clinical Information**]

Patient initials or identifier number: N.S(617461)  
Relevant clinical history and physical exam:  
A 50-year old woman admitted to our hospital with chest pain while driving his car. He had a history of type 2 diabetes mellitus. On admission, his systolic blood pressure was 70 mmHg by palpation, his heart rate was 30 bpm and the respiratory rate was 30 / min.