Case Summary:
The patient is a case of successful retrograde PCI for RCA CTO lesion. Unfortunately, repetitive subacute reocclusion were noted even after another 2 times PCI. The possible reasons of repetitive reocclusion might be due to anatomy, long stent, inadequate distal runoff, diabetes mellitus, inadequate stent expansion or massive chronic thrombus over CTO lesion.

TCTAP C-090
A Case of PCI to LAD CTO After Coil Embolization for Coronary Perforation
Takemori Ikoma, Hayato Ohtani
Saiseikouhara General Hospital, Japan

[Clinical Information]
Patient initials or identifier number: M.H.

Relevant clinical history and physical exam:
A 62 years old woman with diabetes came to our hospital for sudden onset dyspnea.

Relevant test results prior to catheterization:
Chest roentgen showed cardiomegaly and pulmonary edema. The ECG showed ST elevation in precordial leads and cardiac enzymes elevated. Echocardiogram showed reduced wall motion at LAD and RCA territory.

[Interventional Management]
Procedural step:
Emergent CAG showed LMT disease, CTO of LAD, diffuse stenosis of RCA and subtotal occlusion of LCX.

[Interventional Management]
Procedural step:
After PCI to LMT and mechanical support, hemodynamic state was stable therefore she recovered from pulmonary edema. However she complained severe dyspnea, we tried second session of PCI. 7Fr SAL 1.0 was engaged to RCA from left femoral artery, 7Fr SL 3.5 was engaged to left coronary artery. At first, Nobori was implanted to LMT and post dilatation with NC balloon. We tried antegrade procedure under contra-lateral injection from RCA. XT-R and Sion blue could not passed to LAD CTO, therefore we selected Conquest Pro 12. However, Conquest Pro was passed false lumen with coronary perforation. Hemostasis was tried by micro-cather aspiration, but bleeding was continued. Therefore coil was inserted to false lumen of LAD CTO embolization. After coil embolization, bleeding was stopped. We give up PCI to LAD-CTO.

After PCI to LMT and mechanical support, hemodynamic state was stable therefore she suffered from cariogenic shock, therefore we decided emergent PCI at IABP and PCPS support. Fielder PC was not passed to distal LCX but to LCX-OM branch, therefore Runthrough NS Hypercoart was inserted with Crusade. Nobori 3.5mm was implanted to LMT-LAD and Nobori 2.5mm was implanted to LMT-LCX and final KBT was performed. Final angiography showed good dilatation of LMT, diagonal branch and LCX and good collateral flow from RCA to LAD.

Case Summary:
She suffered from cariogenic shock, therefore we decided emergent PCI at IABP and PCPS support. Conquest Pro was passed false lumen with coronary perforation. Coil embolization was need for hemostasis. She recovered from pulmonary edema but heart failure was repeated. We tried second session of PCI. However the PCI to LAD CTO could not success because of coil embolization.

TCTAP C-091
In Stent Occlusion Is Not Always Easy
Shiechi Ishizuka, Kenya Nasu
Toyoohachi Heart Center, Japan

[Clinical Information]
Patient initials or identifier number: M.H.

Relevant catheterization findings:
This was 2nd attempt for RCA in stent occlusive lesion. 1 year before, 1st attempt was failed antegrade in other hospital.

[Interventional Management]
Procedural step:
Baseline coronary angiogram showed in stent occlusion at proximal RCA and collaterals from distal LCX and LAD. Firstly, right coronary was cannulated with an 8 Fr SAL 1.0 guiding catheter and left coronary was positioned with 7 Fr SPB 3.5 guiding catheter. Initially, the antegrade guidewire (Gaia 2nd with Corsair 2.6fr microcather, Miracle 12g, Gaia 3rd and Confinza 8-20, in turn) from RCA was failed to advance to the arterial lumen distal to the CTO lesion in spite of parallel wire technique. So, we moved to the retrograde approach using the collateral branch from LCX to distal RCA. There was tight lesion at distal LCX so that ST elevation and chest pain appeared while microcather crossing. We treated this lesion using rotational atherecomy and balloon. And then we advanced retrograde wire to distal RCA successfully. After balloon dilatation antegrade, we succeeded to advance the retrograde wire to SAL 1.0 guiding catheter. However, corsair of retrograde was stuck on stent. So we advanced retrograde wire to aortic arch in antegrade guiding catheter, at that place we advanced retrograde wire into the corsair of antegrade. Thereafter, corsair of antegrade passed CTO lesion and succeeded in externalization. After predilatations, we deployed everolimus eluting stent (3.5*28) at RCA. The final angiogram showed successful recanalization at RCA CTO lesion.

TCTAP C-092
Trapped and Damaged Wire During CTO PCI
Se Yong Jang, Hun Sik Park
Kyungpook National University Hospital, Korea (Republic of)

[Clinical Information]
Patient initials or identifier number: JGM

Relevant clinical history and physical exam:
A 76-year-old male suffered myocardial infarction 1 year ago. CAG showed left main disease and CTO in RCA. He underwent PCI with stenting at left main at that time. He had been treated for chronic heart failure and ischemic cardiomyopathy. He visited ER for heart failure symptom recently.

Relevant test results prior to catheterization:
Echocardiography showed that his LVEF was 25-30%.

Relevant catheterization findings:
RCA still had CTO lesion in the CAG. Left main stenting was patent.

[Interventional Management]
Procedural step:
To approach the RCA CTO lesion, 6Fr AL 1 guiding catheter was used via right radial artery. CTO lesion start from the very proximal portion of the RCA and Fielder XT wire was chosen with corsair backup. The CTO lesion was severely calcified and we need a stiffer wire soon and Conquest9 and Conquest12 were used in turn. Conquest12 seemed to traverse the CTO lesion. Corsair tracking was necessary to get through it. We changed the wire to a more conformable wire and used Conquest12. After Conquest12 was inserted, it was still stuck in the CTO lesion. We tried antegrade guidewire (Gaia 2nd with Corsair 2.6fr microcather, Miracle 12g, Gaia 3rd and Confinza 8-20, in turn) from RCA. XT-R and conquest Pro 12 were not passed to distal portion of LMT-CTO coil, but Corsair and IVUS not passed. Angiography showed coronary perforation from diagonal branch of distal portion of LAD-CTO coil, therefore we gave up PCI to LAD-CTO. We changed to PCI to LMT bifurcation and LCX. Fielder PC was not passed to distal LCX but to LCX-OM branch, therefore Runthrough NS Hypercoart was inserted with Crusade. Nobori 3.5mm was implanted to LMT-LAD and Nobori 2.5mm was implanted to LMT-LCX and final KBT was performed. Final angiography showed good dilatation of LMT, diagonal branch and LCX and good collateral flow from RCA to LAD.

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Se Yong Jang, Young Seok Kim
Kyungpook National University Hospital, Korea (Republic of)

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