

**TCTAP C-134****Successful Retrieval of Right Coronary Artery Stent Dislodgement with Small Balloon Supported with Heartrail Catheter**

*You-Mi Hwang, Keon-Woong Moon*  
St. Vincent's Hospital, Korea (Republic of)

**[Clinical Information]****Patient initials or identifier number:**

SY Kim

**Relevant clinical history and physical exam:**

A 71 years old female, known to have stable angina and had previous PCI at mid RCA, proximal LAD, and ostium of LCX, admitted because of recurrent exertional chest pain for one month.

**Relevant test results prior to catheterization:**

Coronary CT angiography

**Relevant catheterization findings:**

Follow up CAG showed progression of distal RCA stenosis approximately 90% with heavy calcification through mid to distal RCA.

**[Interventional Management]****Procedural step:**

Elective PCI was attempted with 6 Fr JR 4 transradial approach. However, stent passage failed over and over, several times of balloon dilation with 2.0 x 20 mm Ikazuchi (Kaneka Medix Corporation) and 2.5 x 20 mm Ryujin™ Plus (Terumo Europe N.V.) was done through mid to distal RCA repeatedly. In spite of multiple balloon dilation, 2.5 x 14 mm Zotarolimus coated stent (Resolute integrity®, Medtronic) passage repetitively failed owing to proximal angulation and irregular calcification of the lesion. For the better support to approach the target lesion, we changed to femoral 7 Fr AR 1 guiding, however, there still was difficulty in passing stent through mid RCA. Accordingly, another 2.5 x 20 mm drug eluting stent coated with Everolimus (PROMUS™ Element™®, Boston Scientific) was deployed at mid RCA. Furthermore, buddy wire with anchor balloon technique was attempted. Despite every endeavor, stent penetration was unsuccessful, what is more, repeated ballooning caused rupture of the balloon, consequently led to distal RCA dissection. To make it worse, while retrieving stent catheter, unexpanded stent was caught at proximal RCA without occlusion of RCA. As a result, only balloon catheter was evacuated. To regain the dislodged stent, we used a 5 Fr Heartrail catheter and a small balloon catheter, size of 1.25mm, when inflated to 10atm. After passage of the balloon through the peeled off stent, we cautiously inflated the balloon up to 10atm and trapped the stent with the balloon, then gently pulled out into the Heartrail catheter. Enclosed within the Heartrail catheter, dislocated stent was successfully removed. Furthermore, final attempt of PCI to distal RCA with 2.5 x 14-mm Resolute integrity® stent succeeded but with TIMI 1 flow at PD branch.

**TCTAP C-135****Late Catch up Two Years After Sirolimus-eluting Stent Deployment in Left Main Coronary Artery**

*Yoshiaki Idemoto, Yoshinobu Murasato*  
Shinyukuhashi Hospital, Japan

**[Clinical Information]****Patient initials or identifier number:**

initial:K.K

male 59 years old

**Relevant clinical history and physical exam:**

The patient was admitted due to unstable angina in December, 2007. The CAG showed 90% stenosis with ruptured plaque in the LMCA shaft. An SES 3.5/13mm stent was deployed in the lesion. There was no restenosis found in the 18-months follow up CAG. The patient was admitted again due to the recurrence of effort angina in August, 2012.

**Relevant catheterization findings:**

A CAG showed 90% in-stent restenosis in the previously treated LMCA.

**[Interventional Management]****Procedural step:**

We expanded the lesion with NC trek 2.5/8mm and deployed Xience V 3.5/8mm.

**Case Summary:**

In the OCT image before PCI in the LMCA, there was ruptured plaque which had a fibrous plaque cap with partial break with no intimal coverage of DES strut in the ruptured site. And the OCT showed two layer zones, a superficial zone with high intensity along with a deep zone with low intensity. This suggests they were composed of different components. In the present case, a late catch up was observed 5years after SES deployment in the LMCA. OCT findings suggested another matrix (for example: proteoglycan) accumulation and persistent peri-strut inflammation were the main mechanisms of the late catch up phenomenon.

**TCTAP C-136****A Coronary Artery Aneurysm with In-stent Chronic Total Occlusion 4 Years After Implantation of Drug Eluting Stent**

*Mi-Hyang Jung, Keon-Woong Moon*  
St. Vincent's Hospital, Korea (Republic of)

**[Clinical Information]****Patient initials or identifier number:**

YDC

**Relevant clinical history and physical exam:**

An 83-year-old male visited emergency room for recurrent syncope.

**Relevant test results prior to catheterization:**

The initial electrocardiogram (ECG) showed SA block with the longest pause of 5.6 seconds. The patient had a prior history of non-ST segment elevation myocardial infarction requiring PCI in 2009. At that time, coronary angiography (CAG) revealed two culprit lesions; pLCX was in near total occlusion with a thrombus was and mRCA had total occlusion with a collateral blood supply from LCX. The patient underwent successful PCI with a sirolimus-eluting stent (SES) (Cypher, 2.5\*23mm, maximal inflating pressure of 23 atm) at pLCX.

**Relevant catheterization findings:**

Although the patient did not complain chest discomfort, ischemic involvement of SA node was highly suspected given his history of chronic RCA occlusion and a known collateral supply to SA node from LCX. Therefore, decision was made to perform CAG to further identify etiology of syncope secondary to sinus block. CAG demonstrated near total occlusion of the proximal and mid portion of the previous stent. Notably, CAG also identified a coronary artery aneurysm looking like a collateral vessel.