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 Izakuchi (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
Shinshu University 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. Procedural step:

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:
initial: YDC

Relevant clinical history and physical exam:
An 83-year-old man visited emergency room for recurrent syncope.

Relevant test results prior to catheterization:
Coronary CT angiography