Runthrough guidewire was forwarded into LAD and the stent strut was predilated with a 2.5mm×13mm balloon @ 22atm. Final kissing dilatation was achieved with 4.0mm×12mm non-compliant balloon in LCX @ 12atm and 3.0mm×15mm non-compliant balloon in LAD @ 12atm.
In summary, we succeeded PCI to the RCA CTO lesion with the Reverse CART technique. We made the wire injury at the side branch caused by the antegrade wiring for the acute angle side branch. We could cross the wire to the acute angle side branch with the Reverse wire technique after the stent implantation in the main branch. In conclusion, the Reverse wire technique is useful for the side branch PCI even after the stent implantation in the main branch.

TCTAP C-076

A High Risk Patient with Multi-bifurcation Lesions Treated with Different Strategies Guided by IVUS/FFR

Junjie Zhang
Nanjing First Hospital, China

[Clinical Information]
Patient initials or identifier number: XLW
Relevant clinical history and physical exam:
58 years old female
Risk Factors: EH, 2-DM
Clinical Diagnosis: Old anterior MI
LVEF: 53%
Relevant test results prior to catheterization:
LVEF: 53%
Cardiac Biomarker: Normal
Relevant catheterization findings:
Distal LM 50% stenosis
Mid LAD 99% stenosis with TIMI 1 flow
Ostial D1 90% stenosis, mid D1 50% diffused lesion
Ostial LCX 90% stenosis
Proximal RCA 75% stenosis

[Interventional Management]
Procedural step:
A 6Fr EBU3.5 GC was used to engaged LCA. 2 Runthrough wires was passed into LAD and D1.
Mid LAD and ostial D1 lesions were dilated with 2.5*15 Sprinter balloon. LAD-D1 bifurcation lesion was decided to treated with double kissing (DK) crush technique. Unfortunately a 2.5*36 SES could not advance into D1 even with buddy wire technique. A 2.75*10 NC balloon was used to dilated ostial D1 lesion at 24 atm. Then the 2.5*36 SES was successfully advanced into D1 with mini protruding into LAD.
Before stent deployment a 2.5*15 balloon was put in mid LAD. Then I deployed D1 stent at 10 atm. After pulling out the D1 stent balloon and wire, I inflated the 2.5*15mm balloon in mid LAD to crush the D1 stent. Then rewiring D1 and performing the first kissing balloon. Another 2.5*33 SES was advanced into mid LAD and deployed at 10 atm. A long dissection was noticed in proximal LAD. A 3.5*36 SES was deployed from ostial LM to proximal LAD overlapping previous mid LAD stent with a jailed wire in LCX. Ostial LCX lesion was more significant. I rewired the LCX and do the kissing balloon inflation with 4.0 NC balloon and 2.5 balloon. After that I rewired D1 and do the final kissing balloon inflation with 3.0 and 2.75mm NC balloon at LAD-D1 bifurcation stenting site. Angiography at spide view still showed significant residual stenosis at ostial LCX. A pressure wire was put into LCX with FFR of 0.94 which meant the ostial LCX lesion was functionally insignificant. So I finished the procedure.