Case Summary. It is necessary to perform KBT for treatment of bifurcation lesion by the culotte stenting. The KBT requires crossing strut of a previously deployed stent with a wire and balloon, which is unsuccessful in 5-15% cases mainly because the balloon tip hits a SS. The Glider balloon is a dedicated balloon designed for crossing through struts of main branch. The tip shape of it is an oblique cut and can be rotated. We experienced the culotte stenting case that could bail-out with the Glider balloon. It could pass through to the SS even the small profile balloon couldn’t do it. The Glider is the bail-out device which offers an effective rescue strategy for recrossing SS during culotte stenting.

TCTAP C-066
The Most Worried Case in the Year: The Treatment Strategy with LCX Ostium Lesion
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[CLINICAL INFORMATION]
Patient initials or identifier number. CBL
Relevant clinical history and physical exam. Male, 70 years old
Chief complaint: Recurrent chest discomfort and chest pain in 2 years, worsen in 2 weeks
Coronary risk factor: Hypertension for ten years, and smoking for 20 years
Physical examination: No abnormal examination
Lab Examination: Myocardial biomarkers: normal
Echocardiogram: norm

Relevant test results prior to catheterization. No

[INTERVENTIONAL MANAGEMENT]
Procedural step. 7F EBU 3.5 was engaged in LCA 0.014”. Runthrough was advanced to LAD and Fielder was navigated to LCX

MEDINA of LCX subtype (0,0,1)
There is lesion in the proximal and distal segment of LM
The FFR < 0.79 in LCX, and the lumen area less than 2.4mm² in the proximal, and there is dissection in the proximal, which indicated unstable lesion.
Although the plaque seemed to be unstable, but the lumen area is large enough and the FFR > 0.80
3.0mm*15mm balloon (8atm*5s) was predilated, and 3.0mm*30mm DES was deployed to LM-LCX
The wire in LCX was pulled out to rewire in LAD, and the wire in LAD was rewired to LCX
We used 3.0mm*15mm NC and another 3.0mm*15mm NC Ballon Balloon to Kiss the stent (10atm*5s)
There is immediate thrombosis in the stent of LCX to LM, and there is a hazy lesion in the polygen Run through is rewired to LAD with Crusade double hole catheter
Repeat post dilatation & aspiration
Case Summary. 3.0mm*15mm balloon (8atm*5s) was predilated, and 3.0mm*30mm DES was deployed to LM-LCX
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- There is immediate thrombosis in the stent of LCX to LM, and there is a hazy lesion in the polygen
- Runthrough is rewired to LAD with Crusade double hole catheter
- Repeat post dilatation & aspiration
- The malposition is improved but the thrombus is still there

TCTAP C-067
Aortic Dissection Due to Coronary Intervention
Toshinobu Yoshida,1 Takao Morikawa,1 Ryo Yoshioka,1 Atsushi Hirohata,1 Keizo Yamamoto1
1The Sakakibara Heart Institute of Okayama, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. TK
Relevant clinical history and physical exam. A 60-year-old woman with hypertension, dyslipidemia, and no prior cardiac history presented to the emergency department with severe chest pain of 1 hour duration. The initial ECG showed sinus rhythm with ST segment elevation in leads I and aVL. She was referred for an emergency catheterization.
Relevant test results prior to catheterization. Initial angiogram of the left coronary artery in the LAO cranial view showing the occlusion of the diagonal branch. Significant stenosis was also found in mid circumflex and proximal to mid-RCA. We performed PCI for the diagonal branch. The lesion was dilated with Tazuna1.5/10mm. Finally coronary flow had significantly improved.
Relevant catheterization findings. 3 weeks later PCI on LAD was performed.

[INTERVENTIONAL MANAGEMENT]
Procedural step. Sion was placed in diagonal branch. Runthrough Extra Floppy was placed in the distal LAD. XienceXpedition2.5/33mm was deployed at proximal LAD. The lesion was postdilated with NC TREK2.5/12mm. However, coronary dissection was noticed at the proximal edge of the stent. We deployed XienceXpedition3.0/15mm from LAD ostium to the body of LMCA. Kissing balloon technique was performed in LMCA Bifurcation with LAXA2.0/15mm and NC TREK2.5/12mm. Unfortunately, staining of the aortic cusp, the dissection had propagated to the aorta. Spiral dissection was also extended to LCX. Another stent was deployed to cover the ostium with Xience Xpedition 3.5/12mm and Xience Xpedito n2.5/15mm proximally in LCX. We deployed Promus2.25/12mm distally in LCX. LMCA was dilated with NC TREK4/10mm.

Case Summary. The contrast to false lumen was remarkably decreased. 2 days later, CT showed the false lumen was thrombosed. 3 weeks later PCI on RCA. We deployed Xience Xpedition2.5/23mm, 2.5/33mm in RCA. She discharged 7 days later.