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-089
A Case of PCI to LAD CTO After Coil Embolization for Coronary Perforation
Takemori Iikoma, Hayato Ohtani
Seto Ikitsahara General Hospital, Japan

[Clinical Information]
Patient initials or identifier number: M11
Relevant catheterization findings:
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 collateral branches 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 microcatheter, Miracle 12g, Gaia 3rd and Confinenza 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 microcatheter crossing. We treated this lesion using rotational atherectomy 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 wire 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 coronary of antegrade. Therefore, 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-090
In Stent Occlusion Is Not Always Easy
Shinichi Ishizuka, Kenya Nasu
Toyohashi Heart Center, Japan

[Clinical Information]
Patient initials or identifier number: M11
Relevant catheterization findings:
This was 2nd attempt for RCA in stent occlusive lesion.

[Interventional Management]
Procedural step:
Baseline coronary angiogram showed in stent occlusion at proximal RCA and collateral branches 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 microcatheter, Miracle 12g, Gaia 3rd and Confinenza 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 microcatheter crossing. We treated this lesion using rotational atherectomy 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 wire 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 coronary of antegrade. Therefore, 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
Case of RCA CTO with Ostial In-stent Occlusion Where Guiding Catheter Could Not Be Engaged
Makoto Kadotani
Kakogawa East City Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
T.Y. 63 y/o female

[Interventional Management]
Procedural step:
Britetip8Fr.XB3.5SH90cm was engaged to LCA. I chose the retrograde approach, and SION was inserted through the 1st septal branch using Corsair. I then exchanged the wire from SION to XTR to cross from RCA#4PL to #1. RCA ostium was calcified and stiff so despite stepping up from XTR, Ultimatebros 3G, Progress 120, ConquestPro, Conquest Pro 8-20, wire could not cross through the Aorta. At the end, PILOT 200 was able to cross in the knuckle wire technique. Corsair and PILOT200 were advanced to the aortic arch, and then PILOT 200 was exchanged to RG3. RG3 was drawn into the Britetip8Fr.SAL1SH guiding catheter using a snare at the right external iliac artery. Guiding catheter was advanced to the RCA ostium, followed by balloon dilation from antegrade and stent placement.

Retrograde approach was chosen to treat stent occlusion at the RCA ostial to which GC could not be engaged. Treatment of CTO was successful and could be done relatively safely as a stent had already been placed at the RCA ostium.

TCTAP C-093
Successful Revascularization of the CTO Case by ‘Rotablator-pecking’ for Cracking Its Heavily Calculified Fibrous Cap
Ishibuchi Kasumi, Osamu Katoh
Higashi Takarazuka Satoh Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
H.K.
Relevant clinical history and physical exam:
A 72 years old male admitted to our emergent room due to acute coronary syndrome. He had past history of hypertension, diabetes mellitus, and dyslipidemia. Emergent coronary angiogram revealed triple vessel disease with severe stenosis in the proximal LCx and the CTO in the proximal RCA and LAD.
He received the first PCI to the culprit LCx lesion on that day and the second PCI to the RCA-CTO lesion one month later. LCx lesion was treated with Rotablator and DES (Resolute Integrity 3.0/25mm). Proximal RCA lesion was treated with DES (Nobori 3.0/14mm), and CTO in the distal RCA was not performed PCI because of good bridge collateral.
Relevant test results prior to catheterization:
ECG: Sinus rhythm with CRBBB, HR81/min small q wave in aVL lead,
Chest X-ray: CTR 51.7% congestion(-)

Restenosis of Xience
Hemodialysis patient
⇒ I chose Taxus Element.

Taxus Element
3.5x20mm
3.0x24mm
3.0x32mm