Case Summary. We experienced a CTO case with strong bend followed only by floppy guidewire with enhanced hydrophilic coating from retrograde approach.

The right guidewire has to be selected in the right place especially in the CTO PCI.

TCTAP C-082
Guideliner Is Useful for Percutaneous Coronary Intervention for Chronic Total Occlusion with Retrograde Approach via the Long Epicardial Channel
Makoto Hoyano
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[CLINICAL INFORMATION]
Patient initials or identifier number. KM
Relevant clinical history and physical exam. This is 50’s gentleman known history of STEMI, Diabetes mellitus, hypertension and dyslipidemia. He underwent PCI for inferior acute myocardial infarction in 2006. BMS (Driver 4.0/15 and Vision 4.0/23) were implanted to mid portion of RCA. And he underwent PCI for the stenosis of proximal portion of LCX in 2006. DES (Cypher 3.4/18) was implanted to proximal portion of LCX. He admitted to our hospital due to acute pulmonary edema on July 2014. After his condition got stabilized, we performed CAG.

Relevant test results prior to catheterization. Troponin T was negative. CK 122 IU/L, CK-MB 11 IU/L, HbA1c 9.8%, LDL-C 7 mg/dL.

His ECG showed normal sinus rhythm and the intraventricular conduct defect.

Relevant catheterization findings. We performed coronary angiogram after he got stabilization. Coronary angiogram showed total occlusion in stent of proximal portion of LCX and total occlusion of mid-LAD. LAD was filled through the collateral from RCA via septal branch and from diagonal branch. LCX was filled from RCA.

[INTERVENTIONAL MANAGEMENT]
Procedural step. At first, we implanted 1 stent at LCX. Next, we started PCI to LAD-CTO. GC: Hyperion SPB 3.5 SH 100cm from right femoral artery. GW: GAIA 1st supported by Corsair could not enter CTO. GAIA 2nd advanced into CTO but into false lumen. We attempted tip injection from diagonal branch by Finecross GT. Diagonal branch connected to distal LAD. GC: Hyperion SAL 1.0 SH 100cm from left femoral artery engaged to LCA (Double GC). GW: SION supported by 150cm Corsair advanced to diagonal branch. But SION cannot advance at distal of diagonal branch. We exchanged GW from SION to SION black. SION black could advance to the exit of CTO. Retrograde corsair advanced to mid portion of LAD. Antegrade GW: Conquest Pro 9g supported by 135cm Corsair advanced into CTO. Retrograde GW: GAIA 2nd supported by 150cm Corsair advanced into CTO. We attempted the RCCART with 2.75mm balloon. Retrograde GAIA 2nd could advance to proximal true lumen. Retrograde corsair was too short to get into antegrade GC because retrograde GC was 100cm and epicardial route was long. We advanced Guideliner to the just proximal of CTO entry from antegrade. Retrograde GW could easily get into Guideliner. We trapped retrograde GW in Guideliner and advanced retrograde corsair into Guideliner. We exchanged retrograde GW from GAIA to RG3. We could build up externalization. Antegrade corsair on RG3 advanced to distal of LAD. We exchange antegrade GW from RG3 to Fielder FC. We implanted 2 EES at LAD.
Case Summary. We chose 100 cm guiding catheter for PCI to LAD CTO. We used epicardial channel from diagonal branch to distal LAD. Retrograde guide wire could advance to proximal true lumen through CTO. But retrograde corsair could not reach antegrade guiding catheter because retrograde guiding catheter was 100 cm and epicardial route was long. We used guideliner from anterade and retrograde corsair could get into guideliner. Guideliner is useful for PCI with retrograde approach via long epicardial channel.

**TCTAP C-083**

Is Retrograde the Only Hope of Revascularization of CTO After Failed Antegrade Attempt?

Kuan-Chih Huang

1National Taiwan University Hospital, Taiwan

**[CLINICAL INFORMATION]**

Patient initials or identifier number. 6044270

Relevant clinical history and physical exam. This 61-year-old patient has a history of hypertension and dyslipidemia. He suffered from angina and CAG at another hospital showed a 1-vessel disease but RCA total occlusion. He was referred to our hospital but previous two attempts of PCI both failed. Those procedures are antegrade, IVUS guide wiring, but resulted in extravasation and false lumen creation respectively. 9 months after the last PCI, he was admitted again for CTO PCI. On admission, physical exam is essentially normal.

Relevant test results prior to catheterization. CXR: borderline heart size, tortuous aorta, increased bil, perihilar infiltration, increased interstitial infiltration at bilateral lungs.

ECG: atrial fibrillation