the double barrel lesion and there still was pseudo lumen out of the stent. Then we took the final angiogram. We could get the good blood flow to the RCA distal. After these procedures chest CT showed that the dissected right cusp of aortic valve did not proceed. She could discharge from our hospital 5 days after PCI.

Case Summary.
Summary:
It was occurred the RCA dissection made by the guiding catheter injury. We concerned about the advance of the coronary artery dissection by the contrast dye shot, so we performed the IVUS guided PCI.

Conclusion:
We could bailout the RCA dissection made by the guiding catheter injury under the IVUS guided PCI. IVUS guided PCI is useful of PCI for coronary artery dissection like this situation.

TCTAP C-156
Successful Percutaneous Coronary Intervention Treatment of Left Main Coronary Artery Malperfusion Due to Type A Acute Aortic Dissection
Soichiro Enomoto,1 Toshihiro Tamura,1 Yoshihisa Nakagawa,1 Yusuke Yoshikawa1
1Tenri Hospital, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. S.Y
Relevant clinical history and physical exam. A 77-year-old man was admitted for surgical treatment of acute type A aortic dissection. The entry tear was located in the ascending aorta proximal to brachiocephalic arteries and the surgical replacement of the ascending aorta was performed. One day after the surgery, his hemodynamic status got unstable and ventricular arrhythmia occurred frequently.
Relevant test results prior to catheterization. His ECG showed transient ST-segment elevation in precordial leads and he was referred to us for evaluations of coronary artery disease.

Relevant catheterization findings. An emergent aortography showed no residual dissection in ascending aorta and coronary angiography (CAG) showed no apparent abnormalities.
Procedural step. Intravascular ultrasound (IVUS) confirmed that intramural hematoma extended from aorta to left anterior descending artery (LAD) and compressed the true lumen of left main coronary artery (LMCA). The false lumen did not compromise the ostium of left circumflex. We implanted biolimus A9-eluting stent with 3.5mm from LMCA to LAD and performed post-dilatation of the stent with a non-compliant balloon with 4.5mm. Following IVUS findings confirmed the well-apposed stent struts and the symmetrical lumen of LMCA. After procedure, he got better and discharged without ventricular arrhythmia recurrence.
Case Summary. Coronary malperfusion due to acute aortic dissection is a relatively rare, but fatal condition. We experienced a case of acute coronary syndrome caused by compression of LMCA by a false lumen of aortic dissection. IVUS was a useful and necessary tool to detect the false lumen of LMCA in this patient whose CAG seemed to be normal. IVUS also provided important information about landing zone for the stent.

NON-INVASIVE CARDIAC IMAGING: CTA, MRI, 3D-ECHO, AND OTHER (TCTAP C-157)

TCTAP C-157
Giant Coronary Artery Aneurysm in the Septal Branch with 9-Year Follow-up
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[CLINICAL INFORMATION]
Patient initials or identifier number. 342-8791
Relevant clinical history and physical exam. Due to heart murmur, 61-year old woman was referred to our hospital. Doppler echo cardiography showed an abnormal cavity in the interventricular septum with the jet flowing from the LAD. Coronary angiography revealed a large aneurysm in the septal branch from LAD. We continued close observation without surgery.

[INTERVENTIONAL MANAGEMENT]
Procedural step. We continued close observation without surgery. After 9-year follow-up, coronary angiography and 320-slice computed tomography showed a growing accessory aneurysm. It was adjacent to the epicardium and might cause cardiac tamponade if ruptured. We recommended this patient to receive the operation. LAD was ligated at both sides of the aneurismal septal branch and the distal segment of LAD was grafted by the left internal thoracic artery. Post-operative computed tomography showed the intact left internal thoracic arterial graft. She was discharged without any complication.

Case Summary. Coronary artery aneurysms are rare, with a prevalence that varies from 0.25% to 2.6%. In this case, the patient had no past history of Kawasaki disease. The aneurysm is thought to consist of congenitally vulnerable arterial wall which gradually became aneurysmal. We conclude that the treatment strategy of patients with a giant coronary artery aneurysm should be decided after taking into consideration of the growth rate of the diameter of the aneurysm.