bars to LM bifurcation was done. POT to LM with NC sprinter 4.0/9mm (16 bars) was performed. Final result: TIMI-3 flow, RS<5%.

Case Summary. The problem of intervention for LAD chronic total occlusion with bifurcation lesion is to well preserve the side branch especially the diagonal branch. The Crusade microcatheter is a helpful instrument to overcome this problem. The IVUS is a necessary to identify the size of chronic total occlusion and the landing zone.

TCTAP C-123
Successful Percutaneous Coronary Intervention with Guideliner for Subtotal Occlusive Lesion in Anomalous Right Coronary Artery
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[CLINICAL INFORMATION]
Patient initials or identifier number. K.W.
Relevant clinical history and physical exam. A 58-year-old Japanese male was admitted to our hospital complaining of worsening exertional chest pain. He had old inferior myocardial infarction and underwent coronary bypass surgery. The left internal thoracic artery (LITA) was grafted to the left circumflex (LCX) artery and the gastro-epiploic artery (GEA) was grafted to the right posterior descending (PD) artery.
Relevant test results prior to catheterization. No abnormal finding was observed in laboratory examinations. Electrocardiogram showed sinus rhythm and no ST-T change. Echocardiogram revealed slight wall motion abnormality in the inferior wall.
Relevant catheterization findings. Blood flow both in the left anterior descending (LAD) artery and from the LITA to LCX artery was favorable. Grade 2 collateral channels from the second diagonal branch to the distal right atrioventricular (AV) branch were also visualized. The right coronary artery (RCA) originated from the left sinus of Valsalva. A subtotal occlusive lesion in the mid portion of the RCA was observed. The graft from the GEA to the right PD artery was patent, but showed string sign.
Procedural step. We performed percutaneous coronary intervention (PCI) for the subtotal occlusive lesion in the mid RCA with a right trans-femoral approach. Firstly, a 7Fr Sherpa NX Judkins left 4 guiding catheter was inserted through the left coronary artery (LCA) and Sion blue was passed through the LAD artery. Then, we slightly disengaged the guiding catheter from the LCA ostium and attempted to direct the catheter tip towards the anomalous RCA ostium by clockwisely rotating it. Sion with the Mizuki micro catheter could then pass into the anomalous RCA and was deposited in the right ventricular (RV) branch. Thereafter, GuideLiner catheter was introduced into the RCA by anchoring it coaxially with 2.0-mm semi-compliant balloon catheter in the RV branch. We could not pass Sion with the Mizuki micro catheter through the subtotal occlusive lesion, changed the guidewire to Fielder XT-A, and then finally passed the lesion. After 2-mm semi-compliant balloon inflation from the mid RCA through to the proximal AV branch, we deployed Xience Xpedition (2.5/C28 mm) by crossing over the PD artery. We additionally deployed Xience Xpedition (3.0/C28 mm) slightly overlapping the proximal edge of the first drug eluting stent. Final angiography demonstrated good dilatation from the mid RCA through to the proximal AV branch, and native blood flow in the RCA was completely recovered.

Case Summary. We encountered a complex PCI case with a subtotal occlusive lesion in the mid RCA that originated from the left sinus of Valsalva. The GuideLiner catheter facilitates coaxial guiding catheter engagement and appropriate back-up force, which can facilitate device delivery to target lesions in this kind of complex coronary intervention.

TCTAP C-124
Severe Stenotic Lesion at Mid RCA Treated with “Ikazuchi-10 Hyp” PTCA Balloon
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Relevant clinical history and physical exam. An 87 years old male, ex-smoker with hyperuricemia, was admitted with dyspnea at rest. He was diagnosed with heart failure due to cardiac ischemia. He had no history of chest pain and discomfort before admission.

Relevant test results prior to catheterization. The 12-lead electrocardiogram showed complete right bundle branch block and Q wave in III and aVF. Poor R progression was observed in V1-2. The transthoracic echocardiography showed diffuse left ventricular dysfunction especially antero-septal lesion. In the laboratory findings, cardiac troponin T was positive and brain natriuretic peptide was elevated at 1556.0 pg/ml.

Relevant catheterization findings. Left coronary angiography revealed 90% stenosis at proximal LAD and 75% stenosis at proximal LCX. Meanwhile, right coronary angiography showed 99% stenosis at mid RCA. The distal RCA was filled from distal LCX and conus branch.