**TCTAP C-092**

**Case of RCA CTO with Ostial In-stent Occlusion Where Guiding Catheter Could Not Be Engaged**

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**[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 B-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 dilatation 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 Calcified Fibrous Cap**

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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 3.0/26mm). 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(-)