Case Summary:
Excellent result with no residual stenosis.
LIMA spasm is very common after putting in balloon or stent and sometimes you have to inflate stent using anastomical landmarks.

TCTAP C-158
Successful Percutaneous Coronary Intervention for ST Elevation Myocardial Infarction with Arteria Lusoria and Severely Tortuous Descending Aorta by 5 French Guiding Catheter
Sho Torii
Tokai University, Japan

[Clinical Information]
Patient initials or identifer number: SM
Relevant clinical history and physical exam:
A 72 years old woman was admitted to our hospital complaining of chest discomfort.
Relevant test results prior to catheterization:
Electrocardiogram showed ST-T changes in II, III, aVF leads with elevation of cardiac enzyme in blood examination. She was transported to the catheter room for emergent coronary angiography.
Relevant catheterization findings:
After inserting a 4 French sheath to the right radial artery, Judkins catheter with a 0.035" guidewire had tried to advance to the coronary artery. However, because of heavily tortuous radial artery and Arteria Lusoria, engaging the guiding catheter to the coronary artery was impossible. We changed the strategy to trans-femoral approach. Although her descending aorta was also severely tortuous, we use 5 Fr catheter because catheter with large diameter sometimes causes difficulties in manipulation in tortuous vessel because of friction between catheter and curved vessel. His left coronary artery was almost normal. And 99 % stenosis in his right coronary artery

[Interventional Management]
Procedural step:
GC: 5Fr SAL-1.0
GW: Runthrough NS floppy
Balloon: Tazuna 2.0/20mm
Integrity 3.5/26mm was successfully deployed.
Her symptom relieved and discharged 8 days after the procedure.

TCTAP C-159
Nightmare After Ablation by Rotablator
Jun Yamashita
Tokyo Medical University, Japan

[Clinical Information]
Patient initials or identifier number: S.N. (03832031)
Relevant clinical history and physical exam:
The patient was male in 40’s. He had been treated with insulin due to type II DM for many years. Although he did not notice any symptoms at all, Negative T waves in precordial leads (V1-4) were recognized in his electrocardiogram and his echocardiogram showed asynergy of antero-septal wall. Past histories were gastric ulcer and colon polyps. Coronary risk factors were type II DM, dyslipidemia and past smoking.
Relevant test results prior to catheterization:
ECG was showed in Power Point file.
Relevant catheterization findings:
CAG revealed sever calcified stenosis in middle LCX and moderate stenosis in middle LAD. We planed PCI for LCX at first.
[Interventional Management]
Procedural step:
Approach site was right radial artery.
Guiding catheter was PB (power back-up) 3.5 with side hole. The french size was 7.5 Fr sheathless.
Guidewire: Neo’s Route (IVUS could not pass) → Rotalflorpy (for Rotablator) After wire crossing, IVUS could not pass the target lesion because of severe calcification. Therefore, I changed guidewire for Rotalflorpy from Neo’s Route and ablation by Rotablator (burr size 1.5mm) was done. After the ablation, coronary perforation occurred. For treating coronary perforation, I tried to use the perfusion balloon (balloon size was 2.5mm), however, the catheter laboratory staff who faced to this emergency situation was a newcomer and lost his cool. He gave me oversize perfusion balloon (3.5mm), however, I did not realize balloon size was bigger than my order and the injury was worsening. I could manage to stop bleeding by deployment of two stent grafts (Graftmaster).
Case Summary:
In catheter laboratory, unexpected accidents could occur during the procedure. It is important for operator to keep his cool in such situation. Routine training for sudden accidents is necessary for not only operators but also co-medical staff in catheter laboratory.