**Case Summary.** In usual retrograde approach, antegrade preparation is necessary to pass the retrograde wire to contralateral guide catheter. With this preparation, RG3 goes smoothly without any friction. However, in some circumstances, it may be impossible to do antegrade preparation such as our case. In such situations, there may be severe friction in moving RG3. It is easily presumable that only pushing and rotating guidewire may be weaker than pulling by gooseneck wire. Gentle manipulation of whole system may be, of course, warranted to avoid vascular injuries.

**TCTAP C-230**

Another Element of Retrograde Approach Tip-in Method and Retrograde Balloon Trapping Technique

Fa-Chang Yu¹

¹Mackay Memorial Hospital, Taiwan

[CLINICAL INFORMATION]

Patient initials or identifier number. H.S.L.

Relevant clinical history and physical exam. The 71 year-old woman with intermittent angina pectoris, class III dyspnea onset two days ago who presented with non-STEMI (Troponin-I: 74.41). She received PTCA with BMS deployment from ostial to distal RCA about four years before admission. Two years ago, she had non-STEMI and CAGB was done with LIMA to d-LAD, one SSVG to LAD-D1 and LCX-OM, one SVG to RCA-PDA.

Relevant catheterization findings. Angiography showed m-LAD 80% stenosis, d-LCX instent total occlusion, and os RCA total occlusion. Arterial graft (IMA to d-LAD) and SSVG (Ao to diagonal and OM) were patent, however, the SVG from Ao to d-RCA was totally occluded. Besides, left common iliac artery with severe stenosis was found during angiography,
Procedural step. Ipsilateral trans femoral double-puncture procedure was performed for both antegrade and retrograde approach. We used retrograde approach for the aorto-ostial lesion of RCA first, and selected guide wires with Sion then Ultimate bro 3g. After retrograde wire crossed the lesion, tip-in method was performed to pass through the antegrade microcatheter instead of corsair or tonus which the insurance in Taiwan did not offer. Then BMS to ostial to distal RCA were deployed after antegrade wire crossed the CTO lesion through the retrograde microcatheter. Besides, POBA to distal LCX ISR and BMS to proximal LAD were also performed with total revascularization.
Case Summary. Retrograde access is a very important technique which is not only a procedure to success complex CTO but also a method to rescue complication events. Tip-in method can be applied when the retrograde OTW catheter cannot be sent to antegrade GC. Together with balloon trapping wire in retrograde GC, the antegrade OTW catheter can cross the CTO lesion smoothly.