Case Summary:
A 82 years old woman received PCI for the LMT bifurcation lesion with heavy calcification.
We performed PCI with rotational atherectomy and crush stenting technique. The final angiographic result was excellent and IVUS showed excellent stent apposition.

TCTAP C-069
IVUS Guide PCI for LAD-ostium CTO Lesion with False Stump
Chun Hung Su
Chung Shan Medical University Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number: 8172383
Relevant clinical history and physical exam:
52 years old man
CAD Risk Factors: Hypertension, Hyperlipidemia
Chest tightness when exertion, relieved after rest for 2+ months
Relevant test results prior to catheterization:
Treadmill: Positive

Relevant catheterization findings:
Left main bifurcation lesion with LAD-ostium chronic total occlusion with a possible short stump
Proximal RCA severe stenosis, RCA-PDA collateral to P-D LAD

[Interventional Management]
Procedural step:
(1) RCA was cannulated by 7F JR4 guiding catheter and P-M RCA lesion was crossed by Filder-FC wire. P-M RCA lesion was predilated by 4.0*20 Trek balloon followed by 4.0*18 and 4.0*23 Xience-Prime stent deployment
(2) LCA was cannulated by 7F EBU3.5 guiding catheter and we tried to crossed LAD-ostium CTO lesion by Filder-XT followed by Conquest-Pro wire across the short stump but failed. We tried retrograde approach but also failed. Then we used IVUS guide and correct LAD-ostium route was detected and successful antegrade wiring was performed by Conquest-Pro wire with Finecross micro-catheter support. Then we performed LAD bifurcation lesion by Culotte stenting (3.0*38 Xience-Prime from LM to P-LAD and 3.0*33 Xience-Prime from LM to P-LCX) and optimal result was detected.

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TCTAP C-070
PCI Strategy for Very Elderly Man with Triple Vessel Disease Including Distal LM Lesion and Mid LAD CTO
Takahide Suzuki
JA Hokkaido Engei Kosei General Hospital, Japan

[Clinical Information]
Patient initials or identifier number: MN
Relevant clinical history and physical exam:
He complained of chest pain during walking with his dog.
He was introduced to our hospital and admitted for further examination and revascularization.

Relevant test results prior to catheterization:
Coronary CT showed triple vessel disease including LM lesion and mid LAD CTO.

Relevant catheterization findings:
mRCA 75%, 90%
LM 75%
pLAD 99%, mLAD 100%(CTO)
pLCx 90%

[Interventional Management]
Procedural step:
The first procedure was performed for RCA lesion by right TR1. A 6F ILA0 (Hearttrail) guiding catheter was engaged into the RCA. After passage of a guidewire, predilation was done with a 3.0/15mm balloon. Two 3.5/22mm Resolute Integrity stents were deployed at the mid and distal RCA respectively.
The second procedure was done for LCA lesion. A 7F sheath was inserted into a femoral artery and a 7FLauncher SL4.0DH guiding catheter was engaged into the LCA. At first, predilation was performed for pLCAx and pLAD. A 3.0/30mm Resolute Integrity stent was deployed at the LM to pLCx. A wire was advanced to the LAD-Dg across the stent strut using a Crusade catheter. Balloon dilation toward the pLAD was done. Then, a 7F Launcher JR4.0SH was engaged to the RCA for retrograde approach. A SION wire supported by a Corsair was advanced to the PDA and septal collateral. Fortunately, it was easily passed to the dLAD. However, a Corsair catheter could not be crossed to the LAD due to severe stenosis at the orifice of septal channel. In order to complete reverse CART method, an antegrade wire (Gaia 1st) was also advanced and balloon dilation was done. A retrograde wire (SION) could be passed to the pLAD and also to the LCA guiding catheter. Even at this setting, a retrograde Corsair could not be advanced in spite of strong support by balloon anchoring within the guiding catheter. Finally, we tried random-vous technique at the pLAD. A Corsair catheter was advanced to the pLAD lesion antegradely and a retrograde wire (SION) was successfully advanced into the antegrade Corsair. Then, the antegrade Corsair was passed to the CTO site according to the retrograde wire. After predilation, a 2.25/28mm Promus Element stent was implanted at the distal LAD, a 2.25/28mm Xience Prime at the mid LAD and a 3.0/38mm Xience Xpedition at the LM-pLAD. After final kissing balloon inflation at the LM to LAD and LCx for culottes stenting, the procedure was successfully finished.