2008, she underwent percutaneous coronary intervention (PCI) due to saphenous vein failure to mLAD and was implanted with endeavor stent (3.0/30mm, medtronic).

Relevant test results prior to catheterization:
- ECG showed normal sinus rhythm without ST changes. Cardiac enzymes were negative. (CK-MB/TnI 1.16/0.028 (CK-MB < 5.00, TnI < 0.78)) Echo showed no RWMA (EF=76%). Cardiac CT showed patent SV (aortic root) to LAD graft and severe stenosis in another SV (aortic root to OM) graft proximal segment and total occlusion of distal segment.

Relevant catheterization findings:
- Current coronary angiogram showed total occlusion of LAD os and minimal stenosis of LCX and total occlusion of OM and minimal stenosis of RCA and patent SV (aortic root) to LAD graft and total occlusion of SV (aortic root) to OM graft.

[Interventional Management]

Procedural step:
- I used a 6Fr AL #1 guiding catheter via Lt. radial artery and fielder XT & runthrough guidewire. The two coronary drug-eluting stent were inserted from SV graft os to distal lesion. (Resolute integrity 3.0/38mm and 3.0/22mm, Medtronic)

Case Summary:
- She had hypertension for 20 years and no other cardiovascular risk factors. She underwent coronary artery bypass graft (CABG, SV to mLAD & SV to OM) at 1994. In 2008, she underwent percutaneous coronary intervention (PCI) due to saphenous vein failure to mLAD and was implanted with endeavor stent (3.0/30mm, medtronic). ECG showed normal sinus rhythm without ST changes. Cardiac enzymes were negative. (CK-MB/TnI 1.16/0.028 (CK-MB < 5.00, TnI < 0.78)) Echo showed no RWMA (EF=76%). Cardiac CT showed patent SV (aortic root) to LAD graft and severe stenosis in another SV (aortic root to OM) graft proximal segment and total occlusion of distal segment. Current coronary angiogram showed total occlusion of LAD os and minimal stenosis of LCX and total occlusion of OM and minimal stenosis of RCA and patent SV (aortic root) to LAD graft and total occlusion of SV (aortic root) to OM graft. I used a 6Fr AL #1 guiding catheter via Lt. radial artery and fielder XT & runthrough guidewire. The two coronary drug-eluting stent were inserted from SV graft os to distal lesion. (Resolute integrity 3.0/38mm and 3.0/22mm, Medtronic) I used a 6Fr AL #1 guiding catheter via Lt. radial artery and fielder XT & runthrough guidewire. The two coronary drug-eluting stent were inserted from SV graft os to distal lesion. (Resolute integrity 3.0/38mm and 3.0/22mm, Medtronic)

TCTAP C-099
Achieve a Middle LAD Chronic Total Occlusion with Ipsilateral Double Guide Catheter

Hsin Ru Li, Sung Shih-Hsien
Taipei Veteran General Hospital, Taiwan

[Clinical Information]
- Patient initials or identifier number: MT Chen

Relevant clinical history and physical exam:
- 85 y/o male with history of CAD, HTN, exertional syncope one month ago

Relevant test results prior to catheterization:
- Coronary artery computer tomography showed middle LAD chronic total occlusion

Relevant catheterization findings:
- CAD with TVD and LAD-P total occlusion with severe calcification, LCX: patent, RCA -P to -D: instant patent

[Interventional Management]

Procedural step:
- We engaged LMCA with EBU 4/7 GC. One sion GW was advanc ed to LCX-D under the support of Finecross MC. Distal injection showed poor distal collateral. Therefore, we decided to use FR 4/7 GC to engaged RCA. One sion GW was advanced to RCA-PDA under the support of Finecross MC. However, we failed to advance the Finecross MC through the stent strut. Then, we tried the RV branch and failed again. Therefore, we tried the antegrade approach again. We used sion GW under the support of Finecross MC and we managed to advanced the sion GW into LAD-D. Then, we shift to Corsair MC and man age to cross the collaterals. Then, we used One Pilot 200 GW was advanc ed to distal cap and we try to cross the distal cap but failed. Then, we used Miracle 6 GW and manage to cross the lesion. However, false lumen was impressed. Therefore, we used Conquest pro 12 and placed one runthrough floopy GW for marker wire in LAD-P. However, we still failed to advanced to retrograde wire. Then, we used one Conquest 8-20GW and cross the lesion successfully into LM. During exchange wire, we dislodge the wire and we recross the lesion again but failed. Then, we used one Fielder FC, Provia 12 GW and one conquest 8-20 sequentially and finally cross the lesion. Then, we used another FL 4.5/7GC to engaged LMCA. One Runthrough floopy GW under the support of Finecross MC and exchange into the retrograde Corsair MC in Fl 4.5/7 GC with Rendervous technique. And we change the runthrough floopy GW into LAD-D1 antegradeley. Then, we we used one 2.0*20mmBC to inflate LM to LAD-M with pressure up to 4 atm. Then, we try to used the IVUS to check the true lumen and failed to advanced to LAD-D1. Therefore, we used sprinter legend 2.5*30mmBC to inflate LM to LAD-M with pressure up to 8 atm. Then, we try to used the IVUS to check the true lumen and failed to advanced to LAD-D1. Then, we used sprinter legend 2.5*28mmBC to inflate LM to LAD-M with pressure up to 12 atm. Then, we used sprinter legend 2.5*28mmBC to inflate LM to LAD-M with pressure up to 14 atm. Then, we used sprinter legend 2.5*15mmBC was inflated in LAD-P to D with pressure up to 14 atm. The IVUS showed patent LCX-Os and D1-Os. Due to post POBA dissection type B, one Promus element...