**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** We performed percutaneous coronary intervention (PCI) for the subtotal occlusive lesion in the mid RCA with a right trans-femoral approach. Firstly, a 7Fr Sherpa NX Judkins left 4 guiding catheter was inserted through the left coronary artery (LCA) and Sion blue was passed through the LAD artery. Then, we slightly dis-engaged the guiding catheter from the LCA ostium and attempted to direct the catheter tip towards the anomalous RCA ostium by clock-wisely rotating it. Sion with the Mizuki micro catheter could then pass into the anomalous RCA and was deposited in the right ventricular (RV) branch. Thereafter, GuideLiner catheter was introduced into the RCA by anchoring it coaxially with 2.0-mm semi-compliant balloon catheter in the RV branch. We could not pass Sion with the Mizuki micro catheter through the subtotal occlusive lesion, changed the guidewire to Fielder XT-A, and then finally passed the lesion. After 2-mm semi-compliant balloon inflation from the mid RCA through to the proximal AV branch, we deployed Xience Xpedition (2.5/28 mm) by crossing over the PD artery. We additionally deployed Xience Xpedition (3.0/38 mm) slightly overlapping the proximal edge of the first drug eluting stent. Final angiography demonstrated good dilatation from the mid RCA through to the proximal AV branch, and native blood flow in the RCA was completely recovered.

**Case Summary.** We encountered a complex PCI case with a subtotal occlusive lesion in the mid RCA that originated from the left sinus of Valsalva. The GuideLiner catheter facilitates coaxial guiding catheter engagement and appropriate back-up force, which can facilitate device delivery to target lesions in this kind of complex coronary intervention.

**TCTAP C-124**

Severe Stenotic Lesion at Mid RCA Treated with “Ikazuchi-10 Hyp” PTCA Balloon

Kanichi Otowa1

1Municipal Tsuruga Hospital, Japan

**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** KT

**Relevant clinical history and physical exam.** An 87 years old male, ex-smoker with hyperuricemia, was admitted with dyspnea at rest. He was diagnosed with heart failure due to cardiac ischemia. He had no history of chest pain and discomfort before admission.

**Relevant test results prior to catheterization.** The 12-lead electrocardiogram showed complete right bundle branch block and Q wave in III and aVF. Poor R progression was observed in V1-2. The transthoracic echocardiography showed diffuse left ventricular dysfunction especially antero-septal lesion. In the laboratory findings, cardiac troponin T was positive and brain natriuretic peptide was elevated at 1556.0 pg/mL.

**Relevant catheterization findings.** Left coronary angiography revealed 90% stenosis at proximal LAD and 75% stenosis at proximal LCX. Meanwhile, right coronary angiography showed 99% stenosis at mid RCA. The distal RCA was filled from distal LCX and conus branch.
Procedural step. The first procedure was performed for proximal LAD by left TFI. A 6F JCL4 (Taiga) guiding catheter was engaged into the LAD. After the passage of guidewire (Runthrough NS), 2.5*18 mm Xience V stent was deployed at proximal LAD.

The second procedure was done for mid RCA by right TFI. A 7F ALIST (Launcher) guiding catheter was engaged into the RCA. The guidewire (XT-R) passed through RCA distal, but the micro catheter (Corsair) could not pass through the CTO lesion. Furthermore, the balloon (Hiruyu 2.5*15 mm) could not pass through the CTO. The balloon (Hiryu 2.5*15 mm) was then placed at the conus branch and sustainably inflated for anchor balloon technique, but the Corsair catheter still could not pass through the CTO. Next, the XT-R was exchanged for a 0.010 inch guidewire (Eel Slender). Fortunately, the balloon (Ikazuchi-Hyp) could be advanced to the CTO lesion and dilated twice, enabling the Corsair catheter to pass through RCA distal. Therefore, I replaced the Eel Slender with the next guidewire (Route), and a sequential balloon dilatation using 1.0*10 mm (Sapphire) and 2.25*15mm (iBP22) and 2.5*12mm (iBP32) and 2.5*38 mm Xience Prime stent was deployed at distal and mid RCA. Finally, 2.75*28 mm Xience V stent was deployed at proximal RCA.
Case Summary. The Ikazuchi-10 Hyp PTCA balloon system is compatible with a 0.010 inch guidewire and consists of a regular rapid-exchange balloon catheter component. Every part of this balloon is smaller than conventional 0.014 inch compatible balloons. When 0.014 system balloons cannot pass the severe stenotic lesion, Ikazuchi-10 PTCA balloon will be helpful for small tip diameter.

TCTAP C-125
Severe Tortuous RCA PCI Successfully Treated by Using Guideliner Catheter

Hisao Otsuki,1 Kazuho Kamishima,1 Masashi Nakao,1 Kentaro Jujo,1 Jun-ichi Yamaguchi,1 Nobuhisa Hagiwara1
1Tokyo Women’s Medical University, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. KS
Relevant clinical history and physical exam. The patient was 68 years old man. He was aware of chest discomfort on effort, and the symptom gradually got worse. Therefore he referred to our hospital. His coronary risk factors were hypertension, dyslipidemia and past smoking. His physical examination was normal.
Relevant test results prior to catheterization. His baseline ECG and cardiac markers were unremarkable.
Relevant catheterization findings. The left coronary angiography showed subtotal occlusion of proximal LAD and 75% stenosis of mid LAD. The right coronary angiography showed severe tortuosity and 75% stenosis of mid RCA. At first, we performed PCI to LAD and deployed 2 drug eluting stents (Promus Premier 3.0x24mm, 2.5x28mm) at LAD. This time we tried to perform RCA PCI.