Case Summary. CTO converted to perforation induced by a guiding catheter was managed by immediately protecting the vessels and stenting was done using the TAP technique. The patient has been totally asymptomatic post procedure was successfully done with TIMI III flow in LAD and LCx. No thrombus or restenosis has been observed in the follow ups as well.

TCTAP C-062
Guide Wire Fracture in the Coronary Artery and Aorta During Percutaneous Coronary Intervention
Takayuki Shimazu,1 Masumi Shimizu1
1Kyoto Kuo Hospital, Japan

[CLINICAL INFORMATION]
Patient initials or identifier number. S.N.
Relevant clinical history and physical exam. A 73 year-old woman was admitted with effort related chest pain for one month. Her coronary risk factors were hypertension, dyslipidemia and chronic obstructive pulmonary disease. The physical examination was normal.
Relevant test results prior to catheterization. Baseline ECG showed nonspecific ST-T changes. The cardiac enzyme was normal and the echocardiography showed normal LV systolic function (EF=74%) without regional wall motion abnormality.
Relevant catheterization findings.
1. Left coronary angiogram showed focal 75% narrowing of mid LAD.(-movie 1)
2. Right coronary angiogram showed normal.(movie 2)

We checked LAD FFR, which was 0.75. Therefore we performed PCI to LAD.

[INTERVENTIONAL MANAGEMENT]
Procedural step. An 6 Fr EBU 3.5(Medtronic) guiding catheter was engaged at the left coronary ostium via right femoral artery. And then, we inserted 0.014 inch Sion blue (Asahi Intech) wires into LAD and 0.014inch Etna (Volcano) wire into first diagonal branch. An IVUS (Volcano) revealed. We examined lesions with IVUS to make a decision. IVUS examination revealed relatively normal diagonal ostium. So, we implanted Promus Element® 2.5mm×20mm at the middle LAD. When we exchanged the guide wires to perform kissing balloon angioplasty, Etna guide wire was stuck in stent. (Movie3) When we pushed the microcatheter Fine Cross MG(Terumo) to
remove Etna guide wire, a fracture occurred at the distal tip of the Etna. (Movie 4)
Sion guide wire was inserted to perform a beaded wire rotation, and use of biopsy forces were attempted, in order to remove the fractured guide wires. This attempt, however, was ineffective. Finally, we used a goose neck loop snare to remove the fractured guide wires. Multiple forward and backward movement of the snare successfully removed all of the fractured guide wire. (Movie 5)
Then we could finish safety this strategy.

**Case Summary.** If we felt a bit of resistance to recross the guide wire, we had better use the microcatheter or small balloon. This is why deploying the stent. We should exchange the guide wire carefully in order to avoid the guide wire fracture, at that time we confirm no deformation of the guide wire angiographically.

**TCTAP C-063**
Successful Management of LM STEMI Complicated with Cardiogenic Shock and Multiple Organ Failure
Tung-Lin Tsui
Puli Christian Hospital, Taiwan

**[CLINICAL INFORMATION]**
Patient initials or identifier number. 032371
Relevant clinical history and physical exam. This is a 78-year-old woman who had hypertension with irregular medical therapy. This time, she suffered from sudden onset of dyspnea and orthopnea 1 hour before visiting our emergency room by her family. At ED, initial vital signs revealed blood pressure: 68/44 mmHg, heart rate: 111/min, physical examination revealed bilateral rales breathing sounds and wheezing, pitting edema over bilateral lower limbs with anuria was noted and EKG showed diffuse ST depression with aVR ST elevation.