**Case Summary.** After failed antegrade approach, retrograde approach is usually taken as the only solution for CTO PCI. However, even after destruction of previous failed PCI, the channels of success may still exist in the antegrade vessel. In this case, broken-tip technique passed most part of the tortuous collateral artery, but in the end, this wire advance into branches of collateral rather than the distal RCA true lumen. With IVUS guide channel wiring and delicate parallel wiring, finally we achieved revascularization of CTO by antegrade approach. As advance of PCI tools, we should broaden our strategies of antegrade approach. After all, retrograde approach is potentially more risky for the patient.

**Relevant catheterization findings.** CAG showed native RCA total occlusion and patency of GEA graft. To prevent cardiac ischemia, we performed PCI for RCA chronic total occlusion (CTO) before gastrectomy.

**TCTAP C-084**
Retrograde PCI via Right Gastroepiploic Artery (rGEA) and 2nd Stage PCI for RCA Chronic Total Occlusion in a Post CABG Patient with Gastric Cancer
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**[CLINICAL INFORMATION]**
Patient initials or identifier number. SS
Relevant clinical history and physical exam. 71 year-old male was admitted to our hospital due to gastric bleeding. He had a past history of coronary artery bypass grafting using gastroepiploic artery graft (GEA) 13 years ago.
After examinations, he was diagnosed as gastric cancer and scheduled surgical operation (gastrectomy) with removal of the GEA and dissection of lymph nodes.
Relevant test results prior to catheterization. The result of pathology showed moderate-poorly differentiated adenocarcinoma.
Procedural step. We used 6Fr JR-4 as a guiding catheter, Sion Blue as a retrograde guide wire, and Corsair as a microcatheter. The retrograde guidewire reached to the distal end of CTO, but could not pass the lesion. Antegrade guidewire crossing was also difficult, even using side branch anchor balloon technique and parallel wire technique. Finally, antegrade guidewire could pass through the lesion after retrograde balloon dilatation (CART technique). We deployed bare metal stents and recanalized the RCA successfully.

Case Summary. Additionally, we performed 2nd stage PCI for distal RCA lesion after the gastrectomy because we can use only bare metal stents at 1st session. Retrograde approach via GEA graft may helpful for the patient after CABG who needs gastrectomy and GEA removal.