**INTERVENTIONAL MANAGEMENT**

**Procedural step.** The whole procedure was done under low frame rate (7.5fps) with 0.8 low radiation fluoroscopy.

PCI in RCA was first performed with 2 BVS. 6 weeks later, stage PCI on left side was performed under right femoral approach in biplane approach.

- LAD and LCx were wired and predilated with 2.0 balloon under 6 ATM, then Pre IVUS was performed.
- LAD and LCx were further predilated with NC Balloon.
- DK Crush Technique was used.
- LCx was stented with DES (2.5 x 23) and the DES stent was crushed. After rewiring LCx, post stent high pressure ballooning was done up to 22 ATM with 3.0 NC Balloon. First 2 steps kissing was done.
- mLAD was stented DES (2.75 x 38). Post stenting high pressure ballooning was performed.
- LM to pLAD was stented with DES (3.5 x 38). Post stenting high pressure ballooning was performed.
- Second 2 steps final kissing was done.
- Proximal 4.0 NC Ballooning for optimization.
- Final angiogram and Post IVUS were performed.
- Good angiographic and IVUS result were obtained.

**Case Summary.** The final result was good despite high syntax. Patient was free of angina after the procedure.

1. Low frame rate PCI for high syntax LM PCI is possible.
2. Use rSyntax and 4C consideration in LM and TVD PCI
3. BVS for RCA is a good choice.

**TCTAP C-052**

LM Ostial Occlusion and Guiding Catheter Alignment

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**CLINICAL INFORMATION**

Patient initials or identifier number. 5754132

Relevant clinical history and physical exam. A 63-year-old woman had exertional angina

1 year after coronary artery bypass graft surgery including 4 SVGs
**Relevant test results prior to catheterization.** Thallium scan revealed lateral ischemia. Elective coronary angiography was indicated for suspected graft failure.

**Relevant catheterization findings.** Coronary angiography showed LM ostial occlusion and segmental LCx total occlusion. SVG-OM was occluded which making the lateral wall jeopardized. LCx was supplied retrogradely by SVG-Dx.

**INTERVENTIONAL MANAGEMENT**

Procedural step:

Choosing the Treatment strategy?

1. Retrograde approach:
   a. Long retrograde path through SVG
   b. Risk of SVG injury
   c. Risk of compromising diagonal flow

2. Antegrade approach:
   a. Where to launch the drilling point?
   b. Risk of aorto-ostial injury
   c. Sequential total occlusion
   d. Treating LM and treating LCx occlusion
   e. Faint LCx distal flow

1. Antegrade approach: 8 Fr. EBU 3.5, Finecross 150cm + Conquest 12G
2. Diagnostic catheter was engaged to SVG-Dx (which supply LCX retrogradely) to facilitate antegrade approach (to visualize the vessel lumen distal to LM occlusion)
3. However, we failed to cross it.
4. Changed GC to 8 Fr. JL3.5 and manipulated it for better coaxial alignment
5. Advanced GW to distal LAD successfully
6. POBA to LM shaft with 1.25x5mm balloon and antegrade flow was reconstructed
7. Advanced GW to distal LCX (Finecross 150cm + Conquest PRO)
8. POBA to LCX with 1.25x5mm and 2.5x23mm balloon sequentially
9. Deployed 2.5x23mm DES to LM-LCX
10. Deployed 2.5x23mm DES to LCX
11. Final result was good
Case Summary. CABG was utilized to treat LM + 3VD, but may develop graft failure and native LM occlusion later on. LM occlusion can be treated with PCI. Guiding catheter coaxial alignment is sometimes more important than adding extra-support guiding catheter.

TCTAP C-053
Reverse Wiring Could Be Very Difficult in the Presence of Critical Lesions Both Before and After the Targeted Calcified True Bifurcation Lesion
Wen-Lieng Lee
Taichung Veterans General Hospital, Taiwan

[CLINICAL INFORMATION]
Patient initials or identifier number. H.R.L.

Relevant clinical history and physical exam.
- Her RL, 1489XXXF, 83 Y/M
- Admitted on 2014/10/18 due to chest pain
  - Dx as of NSTEMI
- Past history
  - Bilateral carotid stenoses, no stenting was done
  - CKD, stage IV-V
- Elective CAG on 2014/10/20

Relevant test results prior to catheterization.
- 2014/10/18
  - WBC15000 (89/7), Hb 11.7
  - CK/MB951/32
  - Troponin-I12
- Chol 150, LDL 88, TG 67
- CR3.6

Echo:
- LV 48/38mm,
- Distal 1/3 IVS, inf and distal 2/3 inferolateral akinetic; others hypokinetic
- EF27%
- AR+, MR+

Relevant catheterization findings.
- CAD, TVD, with NSTEMI
- No CABG option
- PCI, RCA first
  - The risk of no flow expected high due to large plaque burden
  - Patient would die if no flow occurs
- PCI, LCA first
  - Technically challenging
  - May need emergent bypass if anything goes wrong
  - If D1 lost a tragedy