

Case Summary. We successfully conducted PTCA and stenting to LM ostial CTO with double anterograde approach.

Followings are the discussion points of this case.

1. What is the most important guidewire technique in dealing with LM CTO case?
2. How can we confirm the guidewire is in the lumen when doing LM CTO PCI?
3. What is your stenting strategy in case of LM CTO?

TCTAP C-087

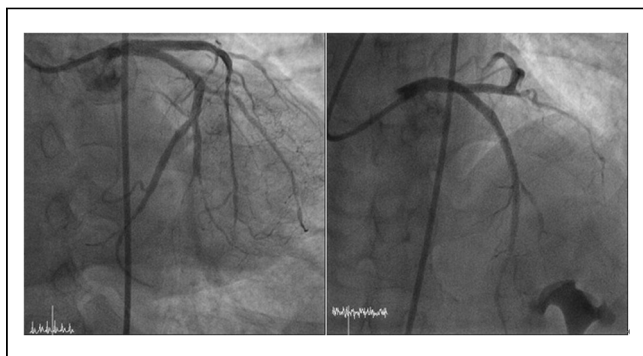
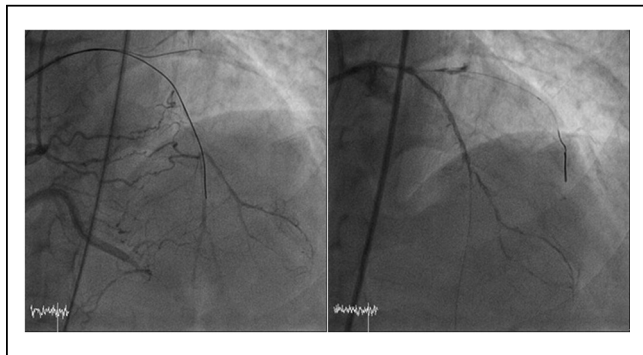
Retrograde Approach for RCA CTO Lesion Through LAD Stent

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[INTERVENTIONAL MANAGEMENT]

Procedural step. The right coronary artery was engaged with 5Fr. JR diagnostic catheter and the left coronary artery was engaged with 7 Fr. XB guide catheter. First we tried to negotiate with Fielder XT guidewire which was loaded in the Cosair micro catheter. The wire seemed to pass through into the Cx, but we were not confident that it was in the lumen. The second wire, another Fielder XT was tried to penetrate the lesion into the LAD. However, the lesion was too hard to penetrate it. We changed guidewire to Sion wire, but we also failed to penetrate it. Finally Miracle 3g made success to pass the lesion under the guidance of previous Cx guidewire. Contra-lateral contrast injection confirmed the two wires were in the true lumen. Stepwise balloon dilatations were done using 1.5mm and 2.0mm sized balloon at pLAD and Cx. Using balloon mini-crush technique, left main bifurcation stenting was successfully performed. Two overlapping Xience Prime stents sized 3.5x38mm and 2.75x33mm was implanted at LM-pLAD. Final kissing balloon was done with 3.0x20mm and 3.5x20mm (Ika-zuchi). The patient was stable during and after the procedure.



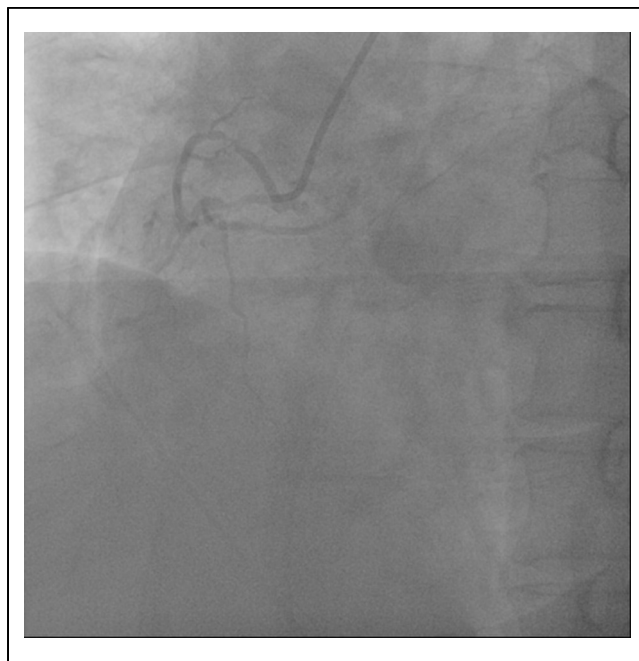
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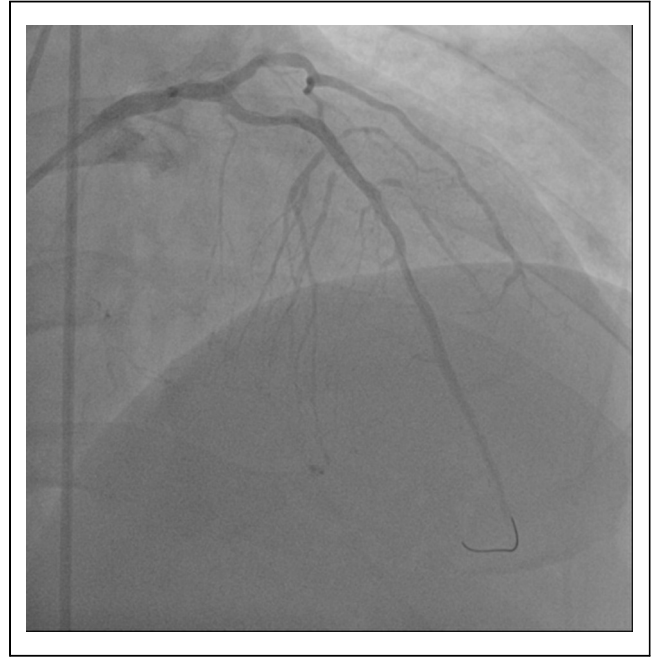
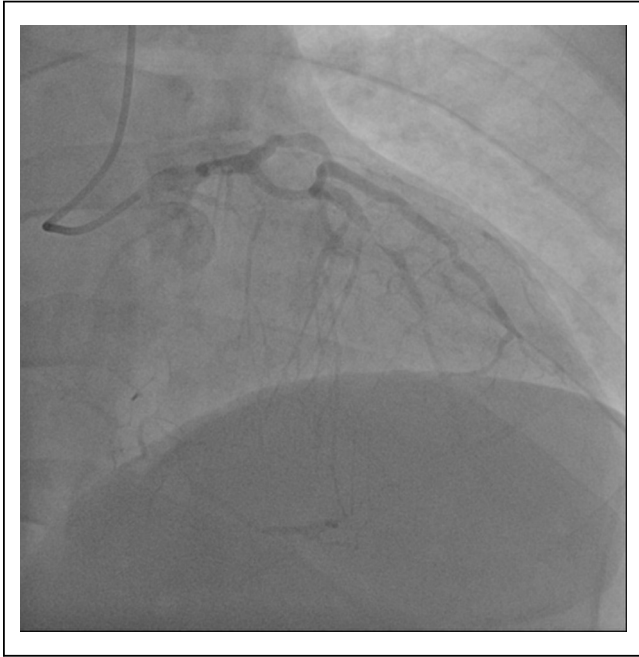
Patient initials or identifier number. JSO

Relevant clinical history and physical exam. A 51 year-old male patient presented with effort chest pain for several days. He suffered from crescendo chest pain. His coronary risk factors were hyper lipidemia and smoking. The echo cardiography showed ischemic insult of LAD territory with lower LV systolic function (EF=48%).

Relevant test results prior to catheterization. The echo cardiography showed ischemic insult of LAD territory with lower LV systolic function (EF=48%). ECG showed non-specific finding, and biomarker was slightly elevation.

Relevant catheterization findings. Coronary angiography showed sub-total occlusion of mid LAD(Figure 1) and proximal RCA was total occluded (Figure 2).

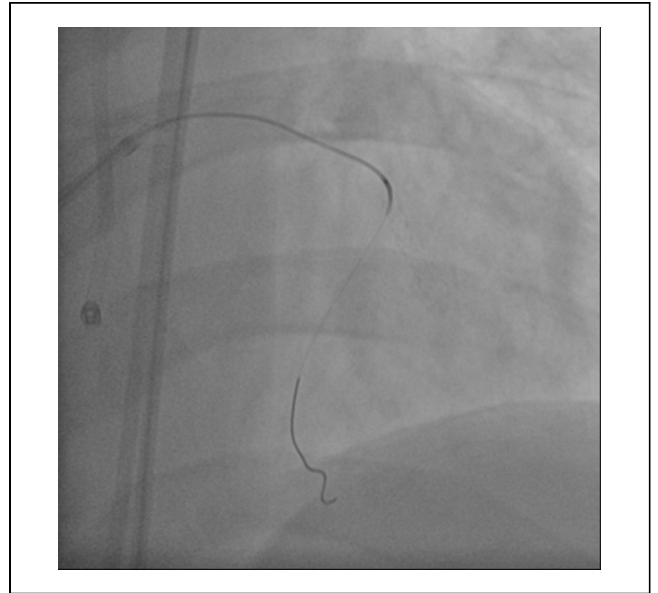


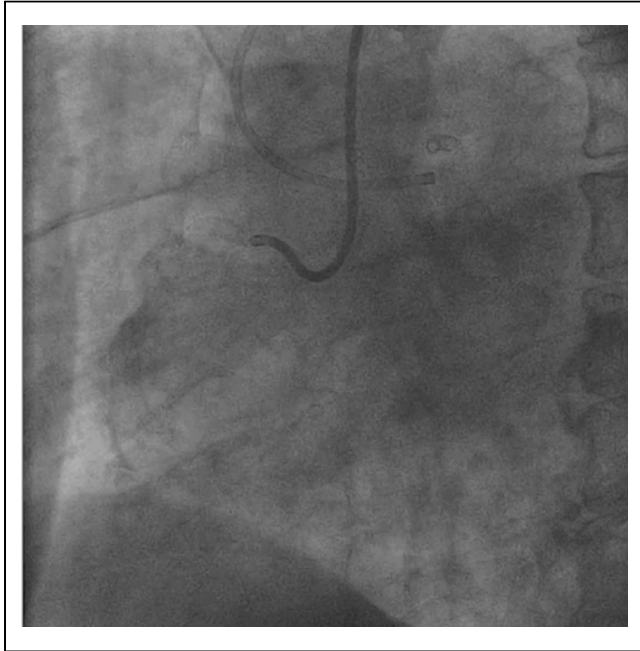
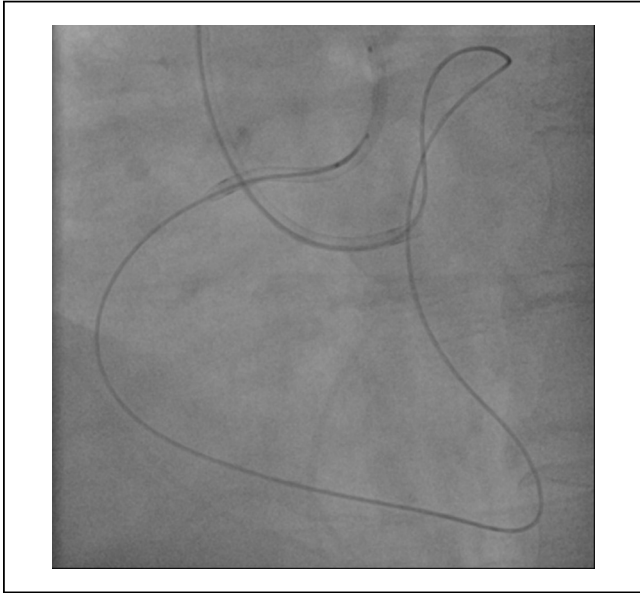


[INTERVENTIONAL MANAGEMENT]

Procedural step. An 6 Fr sheath was inserted through right femoral artery, and the left coronary ostium was engaged with an 6Fr XB 3.5 catheter. A 0.014 inch Runthrough wire was inserted into the LAD. We pre-dilated the LAD using a Ryujin 2.0x15mm. There after, we deployed a Biomatrix stent 2.75 x 18mm at mid LAD (Figure 3).

Right coronary artery was cannulated with a 7 Fr AL1 SH guiding catheter through the right-femoral approach. Initially, we tried to insert a 0.014 inch Filder XT guide wire with antegrade approach using a Corsair® 150cm microcatheter, but the wire entered a false lumen (Figure 4). And then left coronary artery was positioned with 7 Fr XB 3.5 guiding catheter through the left-femoral approach. Next, a 0.014 inch Runthrough guidewire with a Corsair® 150cm microcatheter was tried via LAD stent struct collateral septal channel by retrograde approach (Figure 5). However, the Corsair® 150cm microcatheter was not easily advanced to distal RCA. We performed balloon dilatation with an IKAZUCHI balloon 1.2x6mm at distal RCA and septal branch. And the Corsair® 150cm microcatheter was successful advanced into a 7 Fr AL1 SH guiding catheter. And then, the retrograde wire was exchanged into a 0.014 inch 300cm RG3 wire. And then we performed balloon dilatation at mid RCA with an IKAZUCHI 1.2x6mm balloon. After predilatations, we deployed 2 consecutive stents with overlapping at RCA (Resolute integrity stent 2.5x30 mm and 3.0x34 mm).





Case Summary. And then we performed balloon dilatation at mid RCA with an IKAZUCHI 1.2x6mm balloon. After predilatations, we deployed 2 consecutive stents with overlapping at RCA (Resolute integrity stent 2.5x30 mm and 3.0x34 mm). The final angiogram showed successful revascularization at RCA CTO lesion.

TCTAP C-088

Retrograde Approach in RCA Full Metal Jacket with Low Ejection Fraction

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[CLINICAL INFORMATION]

Patient initials or identifier number. 56 y/o M.
168 cm, 92 Kg.

Relevant clinical history and physical exam. 56 y/o M.
168 cm, 92 Kg.

HTN, Hyperlipidemia, Stable Angina. CCS FcII
Old inf. MI (2004) s/p PTCA with stenting over RCA. Step PCI over LAD (2005)

RCA-ISR total occlusion since 2007. Failed PCI over RCA at local H.
PE: Distal displaced PMI with S3, and LV heave

Relevant test results prior to catheterization. Cardiac SPECT: reversible ischemia over basal inferior wall

Relevant catheterization findings:

[INTERVENTIONAL MANAGEMENT]

Procedural step. The ejection fraction was 28%, and we tried antegrade approach,

The full metal jacket was from RCA ostium to RCA-D bifurcation. and antegrade approach failed initially.

The wire seemed goes outside the stent. We tried retrograde approach and the wire was hard to pass, due to previous full bare metal jacket from RCA os to RCA-D. At last the antegrade wire pass to RCA-D. On angiogram, the wire was outside the stent, but from IVUS finding, the antegrade wire was in vessel true lumen, but indeed, outside previous bare metal stent due to under size of stent.

