

18 years old requiring PCI. Study period was since February 2012 to February 2013. Primary PCI were excluded from this study. The patients were randomized to 5 F and 6 F guide catheter group. Primary endpoint of this study for CAG was procedural success and secondary endpoint was amount of contrast volume, use of "buddy wiring" and predischage MACE and all cause mortality. Total 400 patients for PCI were enrolled and performed by single operator. Total study population were divided into 5 F arm ($n = 200$) and 6 F arm ($n = 200$). Procedural success was 97.3% vs. 98.5% ($p = 0.6$) in 5 F vs. 6 F arm. Procedural failure of 5 patients in 5 F group was because of its crossover to 6 F guide catheter for use of thrombus extraction catheter. 3 of 6 F group switched over to 5 F group because of extremely narrowed radial artery. Though the lesion characteristics, number of vessels and number of stents in both groups were not significantly different, amount of contrast volume used for PCI was significantly lower in 5 F group ($p = 0.006$) and prevalence of "buddy wiring" to perform the PCI was significantly higher in 5 F group ($p = 0.001$). Predischage MACE and all cause mortality were not statistically different in both groups.

Conclusions: PCI by left radial approach is feasible in diabetic population. 5 F guide catheter is a safer alternative to 6 F guide catheter in terms of procedural success and lower amount of contrast volume. Of course, more number of "buddy wiring" can be expected for successful PCI by 5 F guide catheter.

Crossing of mitral valve by using a Swan Ganz catheter in a case of Balloon mitral valvotomy (BMV)



Vishwa Deepak Tripathi*, R.K. Sharma,
Madhumita Kula, Abhishek Saha

Department of Cardiology, NRS Medical College, Kolkata 700014, India

Introduction: BMV is commonly performed procedure in our part of world. During performance of BMV one may face various technical difficulties from start of procedure till completion. Here we present an uncommon technique of mitral valve crossing from LA to LV after transseptal puncture by using Swan Ganz catheter for a case where it was not possible to cross the mitral valve by conventional method.

Case report: A 15-year-old female presented to us with dyspnea (NYHA 4) due to severe rheumatic mitral stenosis (Mitral Valve area 0.8 cm^2). BMV was planned. After performing convention transseptal puncture and septal dilatation, we tried to cross Inoue balloon across mitral valve by conventional technique. After multiple failed attempts, we decided to cross the mitral valve by using Swan Ganz Catheter. Swan Ganz catheter crossed easily across the mitral valve, after we passed PTCA wire through Swan Ganz catheter from LV to aorta and tracked this catheter to aorta. Now PTCA wire was removed and Coiled Spring LA wire was introduced. Swan Ganz Catheter removed and Inoue balloon was again tracked over it, LA wire was removed and balloon inflation was performed successfully. (**Image:** right – Swan Ganz Catheter is across Mitral valve; middle – coiled LA wire is seen inside LV; left – Inoue balloon inflation.)



Discussion and implication in clinical practice: Even in presence of Severe mitral stenosis mitral valve can be crossed easily by flow

directed Swan Ganz Catheter. In difficult case of crossing the mitral valve in BMV, this technique may help the operator.

Transcatheter closure of ruptured sinus of Valsalva aneurysm



K.S. Kolpakwar*, A.U. Phatarpekar, M.S. Phadke,
H.C. Shah, C.P. Lanjewar, P.G. Kerkar

Seth GS Medical College and King Edward Memorial Hospital, Mumbai, India

Background: Ruptured sinus of Valsalva aneurysm (RSVA) is a rare cardiac shunt lesion. Although RSVA is traditionally repaired surgically, there are several case reports and few series of successful transcatheter closure (TCC) too. We report the largest series of TCC of RSVA.

Aim: To assess immediate outcome of TCC of RSVA using the Amplatzer or Lifetech devices.

Methods and material: Thirty-three patients (11 females, 22 males) aged 17–52 years (mean 31.6 years) with RSVA were selected for TCC after excluding infective endocarditis, coexisting ventricular septal defect (VSD) and significant aortic regurgitation (AR) requiring surgery. Most (19/33) were in NYHA class III or IV. Three had previous cardiac surgeries (CABG, VSD repair, RSVA patch closure). Associated defects were bicuspid aortic valve in 3, trivial pre-existing AR in 6, mild AR in 2, coarctation of aorta in 2 and large ostium secundum ASD in 2. Echocardiography revealed RSVA from right coronary sinus to RA in 9 and right ventricular outflow in 6, and from non-coronary sinus to RA in 16 and RV inflow in 2. At cardiac catheterization, the defect size was 4–14 mm (mean 8.38 ± 2.48) at aortic end, as measured by online transesophageal echocardiography or angiography. In all patients, defect was closed from venous side forming an arterio-venous loop. The devices used were Amplatzer duct occluder (ADO) in 31 (size range 8/6 mm to 16/14 mm), Amplatzer septal occluder (22 mm) in 1, and Lifetech duct occluder (18/16 mm) in 1.

Results: The procedure was successful in 28 out of 33 (84%). Of these 28, at 24 h of procedure, 20 had complete closure, 7 had small residual shunt (RS) and 1 had moderate RS with self-abating hemolysis. Trivial to one-grade increase procedure-related AR occurred in 7. Out of 5 failures that were repaired surgically, 2 had deployment failure, 2 devices embolized to pulmonary artery. 1 had severe RS causing hemolysis.

Conclusion: In appropriately selected patients with ruptured SOVA, TCC is a safe and effective alternative to surgery with encouraging immediate outcomes. A long-term follow-up is desirable.

A vital supply by Vieussens ring



S. Srikumar*, K. Anand

Frontier lifeline Hospital, Chennai, India

Introduction: The human heart is in most cases vascularized by two coronary arteries, the right and the left and rarely by Super-numerary coronary artery, which arises independently from the right aortic sinus. Awareness of the presence and distribution of supernumerary coronary arteries is significant for proper interpretation of coronary angiograms and coronary revascularization.

Case report: A 45-year-old diabetic female came with complaints of recent onset exertional angina. Her ECG was suggestive of old anterior wall myocardial infarction and Tread Mill test was positive. Her coronary angiogram revealed proximal left anterior