Case Summary:
This is a challenging case of a 60 years old gentleman presented with STEMI (LBBB), cardiogenic shock then he developed cardiac arrest. PCI was done post CPR and under mechanical ventilation, IABP, temporary pacemaker and Extracorporeal Membrane Oxygenation (ECMO) support. Coronary angiogram revealed subtotal occlusion of the three coronary arteries. PCI was performed to proximal to distal LAD (culprit lesion) using three bare-metal stents (BMS) (Integrity 2.75x30, 3x30 and 3x18 mm) with Guideliner support, to LCX subtotal occlusion using one BMS (Integrity 2.75x22 mm) and to RCA subtotal occlusion using three BMS (Integrity 3.5x12mm, 3.0x30 and 3x30 mm). Patient was discharged in good medical condition after one month.

TCTAP C-151
Percutaneous Coronary Intervention for Bilateral Coronary Ostial Stenosis with Aortitis
Kou Hoshino
Tokyo Medical University, Japan

[Clinical Information]
Patient initials or identifier number: T.K
ID: 12454015
Relevant clinical history and physical exam:
A female in her 70s who was treated for 40 years as a diagnosis of the aortitis syndrome was hospitalized with congestive heart failure. Coronary angiography showed high-grade stenotic lesions with severe calcification of bilateral coronary ostia. Furthermore, there were severe stenosis of the left subclavian artery, and total obstruction at the high level of abdominal aorta. Previously we performed angioplasty to the left subclavian artery and axillo-femoral bypass. This time, she admitted on emergency because of unstable angina and congestive heart failure. Therefore we decided to perform percutaneous coronary intervention for bilateral coronary ostial stenotic lesions.
Relevant test results prior to catheterization:
The ECG showed a decrease of the ST segment in II, III, aVF, V5, V6. And we could see pulmonary congestion and effusion image in the chest roentgenogram.

Electrocardiogram

Relevant catheterization findings:
CAG revealed severe stenotic lesions with severe calcification at the bilateral coronary ostium.

[Interventional Management]
Procedural step:
At first, we treated the LM lesion. After the observation of the lesion by IVUS and the evaluation by FFR, we performed rotational coronary atherectomy (Rota) using the burr of 2mm in diameter and plain old balloon angioplasty (POBA) using the balloon of the 4mm diameter. And then, we performed POBA to RCA using the balloon of the 4mm diameter.

TCTAP C-152
Stent Migration After Using Cutting Balloon
Shozo Ishihara
Mimihara General Hospital, Japan

[Clinical Information]
Patient initials or identifier number: K.O
Relevant clinical history and physical exam:
A 68-year-old woman underwent percutaneous coronary intervention (PCI) for severe stenosis in right coronary artery (RCA) ostium. Her past history was CRF on HD, inferior OMI, and Severe PAD with foot amputation.
Relevant test results prior to catheterization:
She had renal failure on hemodialysis. She also had a past history of inferior MI (#4PD occlusion) 2 weeks before, and POBA was performed. UCG showed hypokinesis of inferior wall. Coronary Risk Factor: HT(+), HL(+), DM(-), smoking(-), HD(+)
Relevant catheterization findings:
CAG showed severe calcified lesion at RCA ostium and mid RCA.

[Interventional Management]
Procedural step:
Heavy calcified lesion was not expanded enough by 3.75mm low compliant balloon dilatation, so we performed additional dilatation by 3.5mm cutting balloon. After that, we inserted a Biolimus eluting stent (BES) and started to inflate. Subsequently, we noticed the contrast leakage and the occurrence of balloon rupture. Immediately, we deflated the balloon and tried to retrieve the stent and delivery system. But we could not pull the system into the guiding catheter because the proximal side of the stent was already half-expanded, and the stent was stripped from the delivery system during the procedure. We tried to retrieve it using a loop snare, a small profile balloon catheter and a large size guiding catheter, but could not. Unwillingly, we decided to implant the stent into brachial artery and implanted a new stent into RCA ostium.
Case Summary:
After the procedure, we found that the tip of guiding catheter was damaged by cutting balloon. We will report a stent migration case and the result of some examinations about a guiding catheter damaged by cutting balloon and a ruptured stent delivery balloon.

TCTAP C-153
Stride Micro-catheter for Tortuous Diagonal Angioplasty
Maddury Jyotsna
Nizam’s Institute of Medical Sciences, India

[Clinical Information]
Patient initials or identifier number:
F4793/2013

Relevant clinical history and physical exam:
79 yr old female pt undergone CABG in 2002 with LIMA to LAD and SVG to D1. In 2010 had USA, then CAG showed native mid LCX tight stenosis, patent LIMA to LAD occluded SVG to D1. Then PCI to LCX with DES was done and attempted to D 1 angioplasty, but failed. Now on maximal medical therapy Pt. come with CSA – AP cl2.

Relevant test results prior to catheterization:
ECG showed NSR with ST depression in lateral leads. LV function was normal on 2D Echocardiogram. TMT was positive for inducible ischemia in stage 2.

Relevant catheterization findings:
CAG showed patent stent in LCX and LIMA to LAD. D1 is very large vessel with ostial 80% stenosis followed by tortuous 2.5 mm vessel with complete loop immediately after the proximal segment stenosis. SVG to to D1 blocked.

[Interventional Management]
Procedural step:
As first attempt 3 yrs back was a failure and as there is significant tortuosity, the risk of vessel dissection and closure while crossing the lesion were explained to the pt. Judkin’s left 3.5 guide through femoral route was used to engage the left coronary system. As softer wire can negotiate the tortuosity, first ATW wire was tried, but it buckled in proximal D1 and not able to further advance. Balloon support was not helpful. Stride micro catheter (Ashahi, 2,2F) with stabilizer plus wire could cross the proximal lesion but negotiation of 360 degrees loop was difficult. Close proximity of micro catheter to wire in different views and advancing wire with micro catheter mm by mm, facilitated the advancement of the wire. We thought that the coronary wire may not give good support for delivery of stent in this loopy vessel, after reaching the distal bifurcation site, Choice PT wire was exchanged for Stabilizer with micro catheter and micro catheter was removed by Nanto technique. 2.5x28mm Promus element plus stent was deployed from ostium to prox D1 with good result.

TCTAP C-154
Leriche Syndrome: Subintimal Dissection and Re-entry Technique
Linda Lison, Teguh Santoso, S. G. Kang
Medistra Hospital, Indonesia

[Clinical Information]
Patient initials or identifier number:
Mr. S

Relevant clinical history and physical exam:
Intermittent Claudicatio, fatigue leg, importance, history of nephrectomy and PCI Impalpable pulses of lower extremity, ECG: old antero-septal MCI Chest X ray and Physical Examination unrevealing Echocardiographic: Hypokinetic in anterior septal wall, LV EF 54% Relevant test results prior to catheterization:
MSCT Scan:
Total occlusion of the abdominal aorta Single (left) renal artery (post-right nephrectomy)
Collaterals from the superior & inferior mesenteric arteries and intercostal/subcostal arteries to the hypogastric arteries, retrogradely supplying the common iliac arteries.