Case Summary. We sometime experience difficult stent delivery due to severe tortuous calcified lesion. We could deploy the stents with successful Cokatte passage by balloon sealed calcified lesion. “Slip through technique” might be useful such like situation.

TCTAP C-127
Usefulness of Corsair and Coronary CTO Guidewire in Successful Re-Wiring After the Pull-out of Guidewire from Dissected Lesion During PCI for Heavy Calcific, Angulated Lesion

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[CLINICAL INFORMATION]
Patient initials or identifier number. CYS
Relevant clinical history and physical exam. A seventh five year-old woman was admitted to our hospital due to effort induced chest pain. As a coronary risk factor, she had the history of diabetes, hypertension, and dyslipidemia. There was no significant finding in physical exam.

Relevant test results prior to catheterization. Initial electro-cardiogram showed normal sinus rhythm. Transthoracic echocardiogram showed that normal left ventricular systolic function.

Relevant catheterization findings. Coronary angiogram showed tight stenotic, angulated lesion at mid portion of left anterior descending artery (LAD) with heavy calcification and another intermediate to severe tandem stenosis at mid portion of LAD. Also, there was the tight stenotic lesion at mid portion of right coronary artery (RCA) (Fig.1)

[INTERVENTIONAL MANAGEMENT]
Procedural step. First, PCI for RCA lesion successfully finished (Bio-matrix 3.5x18 mm). Immediately after RCA PCI, PCI for LAD lesion was performed. EBU 6F Guiding catheter was engaged into LM. Run-through guidewire was selected. The passage of guidewire into target lesion was not easy due to calcific nodules and severe angulation but finally was successful after supported by finecross microcatheter. Next, ballooning with Maverick 2.0x20 mm was done and stent deployment was tried but could not be passed into target lesion. Next, more larger size balloon (quantum 2.5x15 mm) was used. The attempt to put the stent was retried but failed. Unfortunately, instead of stent passage, guidewire was pulled out in ballooned, heavy calcific lesion during the trial to pass the stent into target lesion. The multiple attempts to re-pass the guidewire were failed and coronary dissection progressed into TIMI flow 0-1 (Fig.2). Next, Fielder XT supported by the Corsair catheter was successfully passed into dissected LAD lesion in the same way using wire tracking for CTO lesion (Fig 3). And then, after sequential ballooning was done many times, stent could not be passed at angulated portion. So, after the miracle wire was changed into gland slam wire, stent passage was re-tried but also failed. Finally, using SFHeatrail catheter, the anchor-ballooning technique was performed and two stents were successfully implanted (Fig 4).
Case Summary. When devices (balloon, stent etc) are changed or manipulated in complex lesion, it cannot be emphasized enough that guidewire keeping is very important. However, if the pull-out of guidewire unexpectedly happen in the dissected lesion during PCI for heavy calcific, and angulated lesion, CTO devices such as Corsair and CTO guidewires can be useful.

TCTAP C-128
Successful Rescue of Life Threatening Coronary Perforation
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[Clinical Information]
Patient initials or identifier number. PIC
Relevant clinical history and physical exam. 71 year old male, non-DM, non-HTN presenting with class II symptoms of Dyspnea and angina for last one year and progressed to NYHA class-III since three years months. His P 78/ min. BP - 140/90 and Cardiovascular Examination was normal. Chest X-ray was normal with a cardiothoracic ratio pf 0.5. Resting ECG s/o no significant ST-T changes.

Relevant test results prior to catheterization. Echocardiography shows Valves were structurally normal, no Regional wall motion abnormality, preserved left ventricular systolic function (EF~ 60%) and evidence of diastolic dysfunction, No significant PH.

Relevant catheterization findings. Coronary angiogram:
Left Main: Normal
LAD: Proximal 80% stenosis, 50% mid segment lesion.
LCx: Non-dominant, Normal. OM1: proximal 70% stenosis.
RCA: Dominant, Proximal 70-80 % stenosis and two tandem lesions of 70% imid and distal segment.