Case Summary:
After the procedure, we found that the tip of the 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:
F4397/2013

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 and 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:
Intermiitent Claudicatio, fatigue leg, importance, history of nephrectomy and PCI
Palpable pulses of lower extremity,
ECG: old antero-septal MCI
Chest X ray and Physical Examination unrevealing
Echocardiographie: 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.