10027

A successful PCI case of LCX CTO via ipsilateral collateral channel limiting the amount of contrast agent

A 70 years old man with a history prior PCI to RCA and LCX in 2010 presented with worsening angina. Coronary angiogram revealed a long diffuse disease in LAD and a short CTO in LCX. LCX was supplied via ipsilateral apical collateral channel. His estimated GFR was 34ml/min. Access was obtained from left radial artery and 8Fr guide catheter was used, because of the incomplete expansion of stent graft for aortic abdominal aneurysm. We performed PCI to LAD and implanted 2 DESs, subsequently performed PCI to LCX CTO. First, we crossed Sion wire through collateral channel and then advanced a Corsair. At this time, we noticed the length of Corsair was not enough to externalization, we continued the procedure. Antegrade Gaia 1st did not cross the CTO lesion, we changed the retrograde guide wire to Gaia 2nd and manipulated. Gaia 2nd easily crossed the lesion, however the Corsair did not advance even using balloon anchor technique. So we antegradely penetrated the lesion using Confienza Pro 12g, and advanced Tornus successfully. Rotational atherectomy with 1.25mm to 1.5mm Burr was done and then we put 2 DES to LCX and KBT was performed. Finally 26ml contrast agent was used in this session. Discussion Fortunately, we succeeded CTO PCI limiting the amount of contrast agent, the strategy was restricted because of the length of Corsair was not enough. When we will plan to use distal part of collateral channel we have to prepare a short guiding catheter (Medtronic, Inc).